Imposed volunteering: Gender and caring responsibilities during the COVID-19 lockdown

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Abstract

This article contributes to the sociology of care-relational justice by identifying, conceptualising and unpacking 'imposed volunteering' as a mechanism that shapes societal caring arrangements. Contemporary societies allocate care work disproportionately to women, ethnic minorities and working-class citizens, which exacerbates social inequalities. Distribution of caring responsibilities is a political question but often not recognised as such, because it is deeply immersed in everyday routines. Our study uses the context of the COVID-19 pandemic to dissect the distribution mechanisms that became unusually palpable when the lockdown of public welfare provision in Denmark relocated some forms of care work from professionals to volunteers. With the term *imposed volunteering*, we conceptualise the feeling of being coerced into taking on new caring responsibilities, which some women – and men – experienced during the lockdown. Drawing on a national, representative survey, we document that, compared to men, women carried out significantly more voluntary care work and organised voluntary work through informal personal networks rather than through formal civil society organisations to a significantly higher degree. We unpack the experience of imposed volunteering as it unfolded during the lockdown through qualitative case studies, and clarify how relational and institutional factors, such as gendered expectations and the sense of personal obligation, imposed volunteering. Our study illuminates the importance of public care, reciprocal caring relationships and care for carers, and demonstrates

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why the mobilisation of care work volunteers must take gendered implications into account if it is to be consistent with democratic commitments to justice, equality and freedom for all.

Keywords
care, gender, imposed volunteering, informal civil society, social justice

Introduction

As humans, we depend on care from birth, and we journey through life as recipients as well as providers of care. However, the burdens and joys of care work remain unequally distributed. Women, ethnic minorities and working-class members of society bear the brunt and the 'care-relational dimensions of social injustice' (Lynch et al., 2021, p. 53) urgently call for attention. Societies' distribution of caring responsibilities is a political question, but we often fail to recognise it as such because the 'division of responsibility is deeply embedded in our collective habits, practices, institutions, and political life' (Tronto, 2013, p. 46). We need a language suitable to shed light on the mechanisms that shape caring arrangements, and COVID-19's disruption of societal caring arrangements can help develop this because it suspended habitual routines and made the distribution mechanisms unusually apparent. Drawing on a study of the gender distribution of unpaid care work in Denmark during the COVID-19 lockdown, our study makes a novel theoretical contribution to the sociology of care-relational justice (Lynch et al., 2021) by identifying, conceptualising and unpacking 'imposed volunteering' as one mechanism in the societal distribution of care work. We introduce the term to conceptualise the feeling of being coerced into taking on new caring responsibilities, which some women – and men – experienced during the lockdown.

Our study draws on insights from feminist literatures on care work and social justice, while it also speaks to and advances the volunteering literature. Historically, the status of care work has been disputed in volunteering research (La Cour & Højlund, 2008; Overgaard, 2019; Wilson, 2000). Some scholars have argued that informal care carried out for family members should not be classified as voluntary work because it unfolds in the domestic sphere embedded in interpersonal relations and obligations (Tilly & Tilly, 1994). Other scholars, inspired by feminist critique, argue that informal care work should count as voluntary work and a contribution to the public good (Einolf, 2011; Einolf et al., 2016; Wilson & Musick, 1997). We align with the second position that recognises informal care as voluntary work and with scholars who acknowledge that volunteering is not always unequivocally experienced as voluntary (Kelemen et al., 2017; Tõnurist & Surva, 2017). Our study concerns care work that participants describe as voluntary even though they may experience a strong sense of 'moral duty' to do what is needed (Overgaard et al., 2018). This approach excludes some forms of care work, e.g. work related to one's own children, which is not described as voluntary, while it includes voluntary care work carried out for other family members.

Denmark is a case example of a Scandinavian public welfare model that provides extensive, universal care (Borchhorst & Siim, 2008). Ordinarily, volunteers do not play an important role in the provision of care in Denmark (Boje et al., 2019). However, facing the pandemic, the Danish Prime Minister called for 'civic mindedness'

[*samfundssind*] and encouraged people to help fellow citizens in need. The combination of a lockdown of public welfare provision and a call for civic action implied a temporary relocation of some care work from welfare professionals to volunteers. The mobilisation of civil society was very successful in Denmark, and citizens volunteered to help in large numbers (Andersen et al., 2020). Yet, the political and gendered implications of the mobilisation remain obscure, and this is what we shed light on in the present study.

In this article, we first document the prevalence and distribution of voluntary care work during the COVID-19 lockdown through a quantitative analysis. The results show that, compared to men, women carried out significantly more voluntary care work and organised voluntary work through informal personal networks to a significantly higher degree. Second, we present qualitative case analyses to unpack the experience of imposed volunteering as it unfolded during the lockdown. We end by bringing the two parts together to discuss how institutional and relational factors impose volunteering and how the distribution of caring responsibilities demands public deliberation to ensure consistency with democratic commitments to social justice.

Care, social justice and COVID-19

In this section, we present our theoretical framework, situate our article in the wider feminist debates on care-relational dimensions of social justice and outline previous research on care work during the COVID-19 pandemic.

Care, following Joan Tronto (2013), is defined as 'everything we do to maintain, continue, and repair our "world" so that we can live in it as well as possible' (p. 19). As humans, we can care about others and ourselves as well as animals, plants and eco-systems. To comprehend the complex process of caring, Tronto introduces a model (2013, pp. 22–23) that identifies the following five steps:

1. Caring about – noticing unmet needs
2. Caring for – taking responsibility to ensure that these needs are met
3. Care-giving – doing the actual care work
4. Care-receiving – evaluating whether the care was adequate
5. Caring with – deliberating whether the ways of caring are consistent with democratic commitments to justice, equality and freedom for all.

The person that notices unmet needs (step 1) and takes responsibility to ensure that needs are met (step 2) does not have to be the same person that does the actual care work (step 3). For example, if a person notices an elderly relative's need for help she can hire someone else to take care of it or apply for public elder care on behalf of her relative. Regardless, of how the care work is organised, the final phases of care require her to step back to evaluate (step 4) and consider the fairness of the caring arrangement in a democratic perspective (step 5). Originally, step 5 was not part of the model (Fisher & Tronto, 1990), but Tronto added the deliberative phase in her later work arguing that:

> Care also involves the larger structural questions of thinking about which institutions, people, and practices should be used to accomplish concrete and real caring tasks. (Tronto, 2013, p. 139)

The wider feminist debate has long addressed these structural questions as problems of social justice (Bubeck, 1995). Theoretically, Nancy Fraser's (2009) identification of redistribution, recognition and representation as key justice dimensions remains influential, and empirical studies continue to document unequal distribution of care work (Cancian & Oliker, 2000; Oxfam, 2020), under-recognition of the value of care work (Lewis, 2000; Müller, 2019) and underrepresentation of women with caring responsibilities in political, economic and cultural life (Kremer, 2007; Meyer, 2002). Recently, Kathleen Lynch has suggested the addition of relational justice as a fourth dimension that intersects with the inequalities based on class (redistribution), status (recognition) and power (representation):

> The affective care domain of life, arising from human dependencies and interdependencies, constitutes a distinct sphere of social relations. . . . [L]ove, care, and solidarity relations are sites of political import that need to be examined separately in social justice terms. (Lynch, 2021, p. 118)

Relational justice is not merely a private, interpersonal matter; political institutions such as welfare states 'play a powerful role in enacting laws regulating political, economic, and cultural relations, that impact on caring relations' (Lynch, 2021, p. 124). Hence, while 'care is widely believed to be the province of the private sphere' (Lewis, 2000, p. 41) feminists have long unravelled the politics of care to document the injustices of social reproduction in patriarchal structures (Federici, 2020).

Welfare states vary in their capacity to support women's choices to perform care work, and the universal Scandinavian programmes are often appraised for their potential to provide equitable caring arrangements (Borchhorst & Siim, 2008; Meyer, 2002, p. 164). However, even when unpaid care work is transferred to the public domain it remains undervalued and characterised by low wages, low status and poor working conditions (Dahl, 2004; Fraser, 2016; Müller, 2019; Wood & Skeggs, 2020). Furthermore, when public systems fail to provide care – and neglect may be part of the institutional design (Skeggs, 2017) – the caring responsibilities tend to be borne by women (Meyer & Storbakken, 2000).

A growing body of research demonstrates that a disproportionate part of the unpaid care work during the COVID-19 pandemic spurred by national lockdowns has fallen on the shoulders of women. Measures such as the closing of schools and public institutions shift care responsibilities back to families, and studies from the UK, the US, Australia, Italy, Canada and Germany indicate that women spend more time on unpaid care work than men (Aldossari & Chaudhry, 2020; Calarco et al., 2021; Collins et al., 2020; Craig & Churchill, 2020; Manzo & Minello, 2020; Qian & Fuller, 2020; Zoch et al., 2021). Even in Iceland, a country celebrated as a gender equality frontrunner (World Economic Forum, 2020), the pandemic entailed more new caring responsibilities for women than for men (Hjálmsdóttir & Bjarnadóttir, 2020).

For the individual citizen, the choice to take on new caring responsibilities is influenced both by a personal sense of obligation to others rooted in the interdependence fundamental to human existence (Kittay, 1999; Tronto, 2013) and the moral expectations of society's institutions, among which gender roles are particularly salient to care work

(Kremer, 2007). Empirical research demonstrates that the moral imperative to care is 'strong and compelling especially for women' (Lynch, 2007, p. 558), who experience a stronger sense of 'moral duty' (Overgaard et al., 2018, p. 166). Hence, ethics of care (Held, 2006) merge the personal and the political; existential matters are public issues.

The Danish context

In this section, we briefly outline the national context of our study. In Denmark, the public sector is responsible for welfare services such as free and universal health care, elder care and day care for children (Borchhorst & Siim, 2008). The structural characteristics of the welfare state care coexist with a culture that celebrates the advantages of professional care as an ideal (Kremer, 2007, pp. 247–248). Volunteers have played a marginal role, in contrast to other European countries where volunteers play an important role in care and welfare provision (Boje et al., 2019). However, recently researchers have found indications that the Danish welfare sector might be changing:

> [D]ue to economic constraints in the welfare sector, we might expect in the future that more and more caring activities will be unpaid work, either in the context of voluntary work done through one of many civic organizations or informal help organized in the local communities. (Boje et al., 2019, p. 158)

While volunteering in the care and social work sectors has been on the political agenda in Denmark, as in other Western welfare states, since the 1990s (La Cour & Højlund, 2008), the advent of COVID-19 saw the previously slowly increasing demand for volunteers turn into an urgent demand. When the Danish Prime Minister, Mette Frederiksen, announced the national lockdown on 11 March 2020, she concurrently urged Danes to help those in need of care. She made a reverberating plea: 'We are going to need civic mindedness [*samfundssind*]. We are going to need helpfulness', and she thanked citizens, organisers, companies and NGOs in advance.

Observers suggest that her call had a rallying effect (Gardiner, 2020; Johanson, 2020) that contributed to a successful and wide-reaching mobilisation of volunteers in Denmark (Carlsen et al., 2020). Globally, the rapid mobilisation in the wake of the coronavirus was portrayed as 'a superbloom of altruistic engagement' (Solnit, 2020). Our study adds nuance to this romantic portrayal by explicating the political and gendered implications of the mobilisation as the burdens of altruistic engagement disproportionally fell on the shoulders of women.

Data and methods

Our study combines quantitative and qualitative data. The quantitative data are from a cross-sectional survey carried out by Statistics Denmark on a random sample of 7964 individuals from the general population in Denmark aged 16–99. The collection mode was respondent-administered, computer-assisted web interviews. Statistics Denmark used 'e-Boks', a secure communication system that the vast majority of the Danish population use to communicate with public authorities. The minority without e-Boks received

a postal invitation. Reminders offered the opportunity of a telephone survey interview. The invitation to participate framed the purpose of the survey in general terms in order to avoid respondent self-selection effects, in particular related to the respondents' history of volunteering. We asked respondents about their provision and reception of voluntary support during the period from 3 April to 11 May 2020; the period with the strictest lockdown measures in Denmark. A total of 3389 respondents completed the questionnaire, amounting to a response rate of 42.6%, which is comparable to similar studies (Toubøl & Frederiksen, 2019). The response sample has an underrepresentation of immigrants and overrepresentation of elderly people and people with higher education and incomes. The underrepresentation of immigrants (sample: 6.8%; population: 11.9%[1]) likely reflects a lack of resources to translate the survey into other languages than Danish. Therefore, we make the reservation that the findings should not be generalised beyond residents of Danish origin. To account for small biases related to age, income and education, we weight the results in terms of age, occupation and gender.

Our qualitative data are generated through interviews with survey respondents who consented to a qualitative interview. We sampled 32 respondents, selecting individuals with extensive experiences as givers or receivers of voluntary care work during the COVID-19 lockdown. We contacted the participants by email, and 20 promptly accepted the invitation to an interview in May 2020. The interviewees included 16 women and four men aged between 25 and 66 years. We offered the participants a choice of medium for the interview (Skype or telephone), explained our code of research conduct and protection of personal data. Telephone interviewing was a form of 'methodological pragmatism' (Lamont & Swidler, 2014) in the pandemic context of social distance requirements. Generally, the telephone appeared to be an appropriate interview medium as it offered interviewees a private and comfortable setting, anonymity and flexibility (Block & Erskine, 2012). Nonetheless, conducting qualitative interviews from a distance during COVID-19 raised practical and ethical considerations. People can feel more anxious during a lockdown, and the private setting of the telephone interview may encourage interviewees to share more personal experiences than they usually would (Tarrant & Hughes, 2020). With this in mind, we were keen to ensure transparency of the research project and sensitivity towards participants' boundaries. We always adjusted the semi-structured interviews to the specific situation in terms of duration and questions. The interviews lasted between 30 minutes and two hours, and we obtained informed consent for audio recordings. In the analysis, we do not present identifiable characteristics of interviewees, and we have changed distinctive biographical details.

The quantitative and qualitative parts of our analysis serve different but complementary purposes. The quantitative data enable us to map the gender distribution and the coordination of voluntary care work during the COVID-19 lockdown across formal and informal civil society sectors. The qualitative data allow us to delve into the personal experiences, dynamics and consequences of voluntary care work. This part represents the core of the analysis as it unpacks the experience of imposed volunteering. While the random survey sample enables an examination of prevalence and patterns, the purposely sampled qualitative interviews provide depth rather than breath. Hence, the qualitative analysis aims to produce a deeper understanding of imposed volunteering as it unfolded in a specific time and place. The methodology of case studies is ideal for this purpose (Flyvbjerg, 2006).

Table 1. Variation in the qualitative sample along dimensions of experience, relation and gender.

		Type of experience			Total
		Giving voluntary care	Receiving voluntary care	Transformed voluntary care	
Type of relation	Family	2 women/0 men	1 woman/0 men	1 woman/0 men	4
	Friends	7 women/2 men	5 women/1 man	1 woman/0 men	16
	Professionals	7 women/1 man	2 women/0 men	2 women/0 men	12
	Total	19	9	4	32

Note: The sum total exceeds the number of cases in the qualitative sample because some participants had more than one type of experience.

We selected three cases for the qualitative analysis. Selection criteria prioritised maximum variation (Flyvbjerg, 2006, p. 230) along two dimensions: type of experience and type of relation. Taken as a whole, our interviewees had three types of experiences: (1) some experienced *giving* voluntary care that welfare professionals ordinarily provide; (2) some experienced *receiving* care from volunteers ordinarily provided by welfare professionals; (3) some experienced that their paid care work was *transformed* into voluntary care work during the lockdown. We selected three cases that represent these different types of experiences. Furthermore, the cases vary in the type of care relations: the voluntary care work is embedded in a family network in case 1, a network of friends in case 2 and a professional–client relation in case 3. Finally, we selected cases involving women because the quantitative analysis shows that women do more voluntary care work than men. We also interviewed men with experiences of voluntary care work, and in the discussion we return to the question of how institutionalised gender roles intersect with the relational sense of obligation. Table 1 provides an overview of the variation in our qualitative sample.

Analysis

The first part of the analysis investigates prevalence and distribution of voluntary care work during the COVID-19 lockdown through survey data, while the second part delves into the experience of this through qualitative case studies.

Quantitative analysis

This subsection presents findings from our survey on voluntary support during the COVID-19 lockdown in the spring of 2020. It shows that 53% of the Danish population took part in a rapid, nationwide mobilisation of volunteer efforts related to the COVID-19 pandemic, a pattern observed across the globe in, for instance, China (Miao et al., 2021), the UK (Mak & Fancourt, 2020) and Germany (Koos & Bertogg, 2020).

Citizens enacted a broad repertoire of aid: they volunteered to help people who needed childcare or transportation, they provided economic support and other types of support
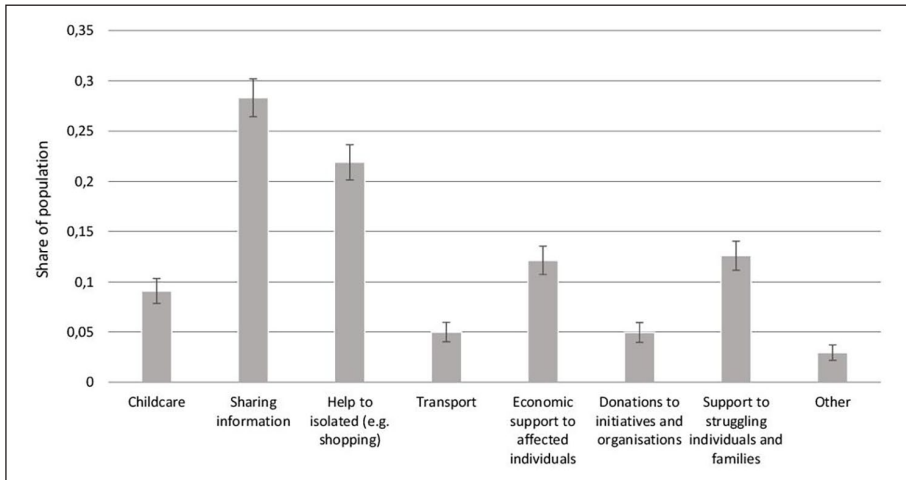
Figure 1. Repertoire of voluntary support during the lockdown in spring 2020 (95% CI).
Notes. *N* = 3044–3264. Population is the Danish population aged 16–99. The diagram sums to more than 100% because a volunteer can provide more than one kind of support. Data are weighted by gender, age and occupation.

to struggling families and individuals. Figure 1 displays the prevalence of the various forms of voluntary help. The most common ways of helping were sharing of information and supporting people isolated in their homes due to health risks by running errands.

The time and effort that goes into various forms of help differ vastly. While sharing information about how to prevent the spread of coronavirus may be easy, a commitment to help a person that self-isolates for several months requires a much greater investment of time as well as practical and emotional effort. We focus on the distribution of the more demanding types of voluntary care work corresponding to the third step of Tronto's conceptualisation of the care process, that is, the actual acts of *doing* care work (Tronto, 2013). While we recognise activities such as information sharing and economic donations as forms of care, they represent activities in steps 1 and 2 of the care process.

For these reasons, we distinguish between care work and other types of voluntary help, in order to investigate who responded to the most demanding needs for care during the pandemic. We define care work as activities with manifest elements of carrying out care work such as childcare, help to isolated persons and support of struggling families/individuals, while sharing information, helping with transport, economic support and donations are categorised as other types of help.

Next, we investigate the gender distribution of care work and other kinds of voluntary support. In this study, we choose to focus narrowly on the factor of gender and leave out other important dimensions of social differentiation, including age, social class, ethnicity and race. With this choice we intend by no means to suggest that the average distributions presented below are uniform for men and women across different strata related to, for instance, social class, ethnicity or age, but simply to limit the focus of our analysis to gender.
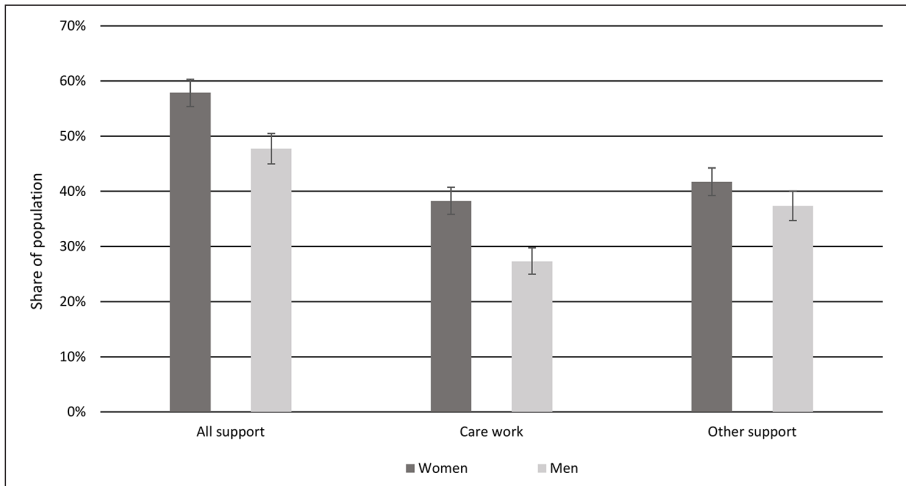
Figure 2. Gender distribution of care work and other kinds of support (95% CI).
Notes: *N* = 3340. Population is the Danish population aged 16–99. Data are weighted by age, gender and occupation.

The gender distribution of volunteering is displayed in Figure 2. Overall, women were more involved in voluntary work during the COVID-19 lockdown. Around 21% (10 percentage points) more women than men carried out some kind of voluntary work related to the corona pandemic and lockdown. The difference increases when we zoom in on voluntary care work. Around 41% (11 percentage points) more women than men provided voluntary care work. When considering the other kinds of support, the difference is smaller, at 11% (5 percentage points), which, however, is still statistically significant. These patterns align with the only comparable study we could identify on the gender distribution of volunteering during COVID-19 in the UK (Mak & Fancourt, 2020), which suggests that the patterns are likely not to be unique to the Danish context.

These gender differences of voluntary care work relate to different gender patterns of participation in civil society by men and women. Figure 3 shows the distribution of organisational settings utilised by the volunteers, revealing the dominance of personal networks (67%). People most often volunteered to care for people in their personal networks, i.e. people they know. Furthermore, our survey demonstrates a gender bias in this pattern: 9% (6 percentage points) more women than men organise voluntary care work through personal networks, and personal networks were the favoured organisational setting for organising care work. A total of 72% of the volunteers who used personal networks carried out care work. This is significantly higher than the average of 55% across the other organisational settings.

Our findings contrast with recent research on formal volunteering in Scandinavia, which argues that gender differences are waning in Denmark (Boje et al., 2019). In the context of the COVID-19 lockdown where informal volunteering dominates, we find that gender differences continue to prevail and are of significant size along the dimension of care. We also find that care work to a higher degree than other kinds of voluntary
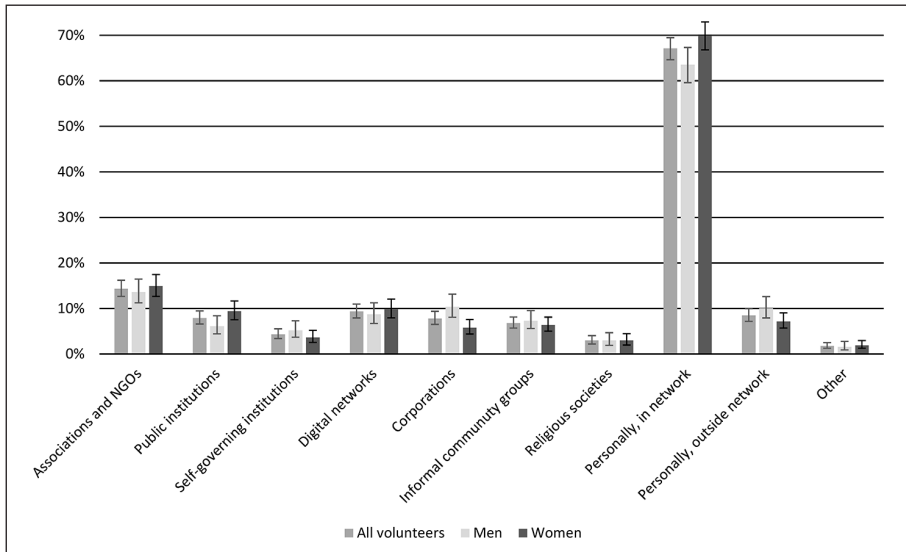
Figure 3. Organisational setting of volunteers in total and by gender (95% CI).
Notes: All volunteers, *N* = 1753; Men, *n* = 740; Women, *n* = 1013. Population is volunteers in the CO-VID-19 lockdown in the Danish population aged 16–99. Data are weighted by gender, age and occupation. Each data series sums to more than 100% because an individual can help in more than one setting.

support is organised in personal social networks and that women to a higher degree than men organise their voluntary support in the informal sectors of civil society.

These findings suggest that engaging in voluntary care work is driven by different logics than, for instance, the dominant resource theory developed in relation to volunteering in formal civil society. Resource theory stipulates that possession of more human capital and other resources increases the individual's propensity to volunteer because resources make it easier to meet the demands in terms of the time and energy required to engage in voluntary work (Smith, 1994; Wilson, 2000). Our findings suggest that social ties of friendship and kinship and the social expectations related to these roles and relations are likely to play a central role in relation to voluntary care work, and these expectations of caring for others appear not to be gender neutral (Overgaard et al., 2018). To explore this in more detail, we must go beyond statistical correlations and turn to qualitative case studies to gain a deeper understanding of the dynamics of care work in the context of the COVID-19 lockdown.

Case studies

This section presents case studies structured around the five steps in the process of care (Tronto, 2013) in order to unpack the experience of giving or receiving care through imposed volunteering in the context of the COVID-19 lockdown.

In the first case, we delve into an experience of voluntarily *giving* care that the Danish welfare state would ordinarily provide. The case involves Karla, aged 48, and her older

brother, Alfred, who suffers from Alzheimer's disease. For Alfred, the lockdown meant a breakdown of his everyday routines as he had to stay at home and could not take part in his usual activities. Karla began to notice his unmet needs: 'I talked with him on the phone and he was not making sense anymore. It became worse and worse and worse.' The stream of pandemic news terrified Alfred and made him come up with schemes that left Karla worried. One day, she was afraid he would set fire to his apartment. She felt there was a need for care and that she had to take responsibility to alleviate it: 'I couldn't stand that he was suffering like this [. . .] He didn't get any help. There was no one except me [. . .] So, I said "You must come and live with me".'

The initial steps of care – noticing needs and taking responsibility– was followed by the third step, doing the care work. For Karla this was hard. She is a single parent of two children and was already struggling with the demands of home schooling during the COVID-19 lockdown. She did not have the money to buy appropriate computers nor technical know-how to support her children's digitalised learning, and when Alfred moved into her small apartment it added to the lack of time and space. Alfred did not acknowledge that he was suffering from Alzheimer's disease and wished to help the family, but he ruined things and required constant attention. Karla experienced the care work as 'a very heavy burden', and she noted that 'having him in the apartment all the time distresses the children'. However, in terms of the fourth step of evaluating the care-receiving, she witnessed that the care did Alfred good: 'I could feel how he gradually became more and more himself because he benefitted from the company of other people.' The lockdown halted the process of diagnosing Alfred in the health care system and the process of referral to appropriate care. However, the public authorities did eventually provide the needed dementia care, and it made Karla extremely relieved when she felt welfare state professionals took over the burden of care: 'I could feel it lifting from my shoulders, like really physically.'

The final phase of care requires a consideration of whether the caring is right and consistent with democratic commitments to justice. On the one hand, Karla felt that helping her brother and letting him move in for a period was the right thing to do: 'I could have been an arse and said "Well, someone else just has to do it". But that's not me.' Karla contrasted her own efforts to those of Alfred's daughter, who remained reluctant to help with the actual care work: 'She is not around much. She's not [pause – sentence left unfinished]. She takes care of his budgets and paperwork and stuff like that, but when it comes to actually being with him, she is not there.' Karla did not want to blame her niece. She focuses attention on the responsibility of the welfare state:

> Actually, I fundamentally believe, I mean, I'm one of those who thinks the state should take care of needs in many respects. We must pay our taxes and then the state must do all sorts of things. That's me. I don't believe in outsourcing to charitable volunteers [*hattedamer*], I mean, there has to be an infrastructure and a safety net so that it is not coincidental who gets help. That's my basic way of thinking. (Karla, 48 years old)

When Alfred started receiving public elder care, Karla felt she was able to focus on her career and shortly after Alfred moved out of her apartment, she attained a new job. Karla kept on calling Alfred daily and visited him once or twice a week, but left the practical care work to the professionals.

In the second case, which examines an experience of *receiving* volunteer-provided care that is usually provided by professionals, we learn from Charlotte, aged 39, who usually receives various forms of public care due to physical handicaps and mental vulnerability. Charlotte described an experience of 'betrayal by the welfare system' during the COVID-19 pandemic. Authorities cancelled services she depends on, such as help to get a shower, do laundry and shopping. Charlotte was in contact with an old friend through Facebook during the lockdown and the friend noticed and took responsibility for alleviating some of Charlotte's unmet needs by doing the care work herself. The friend helped Charlotte with groceries and other practical things, but Charlotte was reluctant to receive the more personal types of help from an old school friend. For example, Charlotte's laundry basket was overflowing and the friend helped Charlotte wash four or five machine loads of clothes. However, this help did not seem appropriate to Charlotte:

> She is not supposed to come and take over the responsibilities of the public home care [. . .]. That is their work. They get paid to do it. [. . .] Well, she did help me with the laundry, and I have said to the home care, I have said 'You know what, you have to help me with this. You have to' [. . .]. They [the care system authorities] are, like, dismissive. (Charlotte, 39 years old)

Charlotte contrasted her experiences of insufficient care during the lockdown with the time before COVID-19 when she visited a local care centre six days a week. That place had been a cornerstone of her life for years, and she described it as a caring community where 'there is room for everyone, all are welcome and if you have any problems, you will get help'. Sometimes Charlotte sold coffee and sandwiches as a volunteer in the centre cafe, and she offered her companionship to other users. 'We can see in the centre that it is very important. Some users are very mentally vulnerable [. . .] and when they are helped by the care centre, I mean, they really flourish.' In that way, Charlotte described herself as both a giver and receiver of care, exposing caring relationships as 'a two-way street' (Lynch et al., 2009, p. 131). In relation to the last step in the process of care – deliberating on whether the ways of caring were consistent with democratic commitments – Charlotte thus reminds us of the importance of reciprocity.

Our third case presents an example of how paid care work was *transformed* into unpaid care work during the COVID-19 lockdown in Denmark. The case involves Susan, aged 58, who, in her job as a care worker, visited vulnerable citizens in their homes to alleviate various needs. When the lockdown started, authorities cancelled these visits:

> Corona meant that those of our citizens who live in their own apartments stopped getting home visits. We [the care workers who usually make visits] simply called and asked 'How are you doing?' for the first 5–6 weeks and just talked over the phone. (Susan, 58 years old)

However, these citizens had cognitive impairments, psychiatric issues and struggled to manage on their own. Susan explained: 'One of my clients said "Oh, I miss you so much!" [and I responded] "Okay, let's meet in your garden". So we did. And when I had started visiting one, I thought I might as well visit the others as well.' As a professional care worker, Susan could not avoid noticing the unmet care needs (cf. La Cour & Højlund, 2008, p. 52; Müller, 2019, p. 8), she felt responsible for ensuring these needs were met and therefore felt compelled to visit her clients again voluntarily.

At the same time, Susan was also working during the lockdown at a care home for citizens with complex needs who could not live in their own apartments. The various COVID-19 measures made the work in the care home strenuous, and adding the visits to the citizens who lived in their own apartments produced a lot of pressure: 'It meant that when I came home, I was just completely exhausted. I just basically sat like a zombie in my sofa, waiting for the next day of work.' In terms of evaluating the care-receiving, Susan says the citizens endured the lockdown period surprisingly well. In contrast, Susan herself experienced burnout (Aldossari & Chaudhry, 2020). She explained that she tried to provide care beyond her ability: 'It was the responsibility in my job, the obligation to care for my clients that made me forget about myself.' Susan's case reminds us that 'Caring with' (step 5) must also include care for care givers if it is to be consistent with a democratic commitment to justice.

In summary, we coin the term imposed volunteering to conceptualise the sensations forcefully conveyed by the women: Karla's experience that she had to help her brother because 'There was no one except me'; Charlotte's reluctant acceptance of her friend's help even though 'She is not supposed to come and take over the responsibilities of the public home care'; and Susan's feeling of 'obligation' that made her pay a heavy personal price. In all cases, the needs for care would ordinarily have been met by paid care work organised by the Danish welfare state, and the feeling of being coerced into giving and receiving voluntary care reflects this context. The narratives of the three women in our cases convey a protest and an insistence that these needs ought to be met by public care rather than being made the responsibility of individuals.

Discussion

The distribution of caring responsibilities is a political question but is often not recognised as such because providing and receiving care are so integrated into our everyday routines that we take it for granted (Tronto, 2013, p. 46). The COVID-19 pandemic turned lives upside down and spurred rapid changes in caring arrangements. In Denmark, the welfare state suddenly stopped providing some forms of essential care, and those who stepped in to take over the caring responsibilities did so in a conscious rather than habitual manner. For a moment, then, the subtle allocation of caring responsibilities became palpable and the pandemic worked as a lens that exposed the distribution processes that ordinarily go unnoticed. One aspect made clear by the pandemic is how voluntary care work can be experienced as imposed. In this discussion, we will argue that our study points to two sources of this imposition – relational and institutional.

The *relational* sources of imposition work through the sense of personal obligation to care for others. Care-relational justice (Lynch, 2021) is not about freeing humans from relations that impose these kinds of obligations:

> [E]ven if we could be free from all forms of dependence, that would not be a free life, it would be a life devoid of meaning. Dependence marks the human condition from birth until death. What makes us free, actually, is our capacity to care and to make commitments to what we care about. (Tronto, 2013, p. 94)

Care-relational justice must embark from the premise of interdependence: 'Interdependency is not a contract but a condition; even a pre-condition' (Puig de la Bellacasa, 2012, p. 198). While the moral duty to care may impede carers' participation in political, economic and cultural life (Kremer, 2007) it also enables meaningful relations between 'members of human communities engaged in interdependencies' (Kittay, 1999, p. 17). The way to promote care-relational justice is continuously deliberating how to align caring arrangements with democratic commitments to justice, equality and freedom for all. Outlining a caring democracy (Tronto, 2013) and a caring state (Wood & Skeggs, 2020) is of course a complex process raising myriads of questions. The care-relational aspects pointed out by our study include the importance of the provision of public care (cf. case 1), reciprocal relations (cf. case 2) and care for carers (cf. case 3).

The *institutional* sources of imposition include gendered role expectations. Our study documents how voluntary care work is highly gendered and primarily occurs in established personal networks. Therefore, we must look beyond the sense of personal obligations to care originating from the interdependence fundamental to human existence and include the effect of institutionalised gender roles to understand the uneven gender distribution of voluntary care work. The presumption that women devote themselves selflessly to the needs of others implies that a 'compulsory altruism' is structured into women's lives (Land & Rose, 1985, p. 93). Care work in personal networks, as illustrated in all our cases, begins with a need being directly or incidentally expressed by the other, and hence the care givers are reactive rather than proactive, which distinguishes the voluntary care workers from typical volunteers in formal organisations (Wilson, 2000). The volunteers in our cases did not search for people in need of care because they were motivated by a desire to help, rather, their personal network required help. Gendered expectations work from both the giver and receiver's points of view. Those needing help might be more inclined to disclose their needs to women, like Charlotte did, and allow women to take care of them, like Alfred did. In this way, personal networks seem to demand more of women than men.

Our study draws attention to how caring arrangements exist in the intersection of private and public spheres. On the one hand, the voluntary care work reflects personal commitments enacted in the private sphere. On the other hand, the voluntary work reflects political strategies determined by public authorities. Our cases illustrate how the personal 'choice' to volunteer was framed by decisions produced by public authorities. Charlotte's friend decided to offer her help with laundry and Charlotte (reluctantly) chose to accept; these are personal decisions in the private sphere. However, before the moment arose when a friend noticed the overflowing laundry basket, public authorities had decided that Charlotte's public home care was to be partially cancelled during the lockdown. Political decisions produced unmet needs, and these decisions were made in political forums where low-income women such as Karla, Charlotte and Susan (representing groups that do the most care work and depend the most upon care work) remain underrepresented (Tronto, 2013).

The possibility of transferring practical care work to welfare states improves women's opportunities to participate in political, economic and cultural lives significantly (Kremer, 2007). However, our study indicates that in times of crisis the caring responsibilities still befall women. In future crises, gendered aspects of emergency responses must be taken much more into account.

Conclusion

This article presents findings from a national, representative survey and case studies on voluntary care work in Denmark during the COVID-19 lockdown. The quantitative analysis documents how women did more voluntary work than men and how the voluntary care work was primarily organised through informal, personal networks rather than through formal organisational sectors of civil society. The qualitative analysis examines cases of giving or receiving care that is experienced as imposed volunteering impelled by a lack of alternatives in the context of the pandemic lockdown of public welfare provision.

The article contributes to the much-debated question of what role volunteers can and should play in the provision of care in welfare states. While there may be good reasons to involve volunteers to a greater extent (La Cour & Højlund, 2008), our article suggests that we must be aware that voluntary care work can be experienced as imposed. Both women and men may experience care work being imposed on them, but gendered expectation structures make women particularly susceptible to feelings of imposition. Gendered norms sensitise women to the needs of others, making them notice needs (step 1, cf. Tronto's model of the caring process [Tronto, 2013]), feel a responsibility (step 2), do care work (step 3) and evaluate whether the care is sufficient (step 4). This means that we must deliberate whether the ways we recruit and include volunteers in the provision of care promote or challenge social justice; strategies for increased involvement of volunteers in the social sector must assess the consequences of such involvement for gender inequality (step 5).

If we wish to have caring arrangements that are consistent with democratic commitments to justice, equality and freedom for all, we must ensure that increased involvement of volunteers in the social sector does not compromise the carer's possibility of pursuing full citizenship in the labour market and in political forums. Developing caring democracies (Tronto, 2013) and caring states (Wood & Skeggs, 2020) requires that we recognise the allocation of caring responsibilities as a political question, develop a language suitable to comprehend the mechanisms that shape caring arrangements and nurture an ongoing public deliberation on how to distribute care work fairly.

Note

1. Source: Statistics Denmark, StatBank Denmark at www.statistikbanken.dk/FOLK1C (accessed 4 May 2021).

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