



GENDER and CARE
Overview Report

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BPfA	Beijing Platform for Action
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSG	Child Support Grant
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
ICW	International Community of Women Living with HIV/AIDS
ILO	International Labour Organization
MDG	Millennium Development Goal
NGO	Non-governmental organisation
PPA	Participatory Poverty Assessment
SEWA	Self-Employed Women's Association
SNA	System of National Accounts
SRC	Supporting Resources Collection (another part of this Cutting Edge Pack)
TGNP	Tanzania Gender Networking Programme
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNRISD	United Nations Research Institute for Social Development
VSO	Voluntary Services Overseas
WWHR	Women for Women's Human Rights

EXECUTIVE SUMMARY

Why is care important?

Providing care can be both a source of fulfilment and a terrible burden. For women and girls in particular, their socially prescribed role as carers can undermine their rights and limit their opportunities, capabilities and choices – posing a fundamental obstacle to gender equality and well-being.

For example, while education is every child's right, many girls have to drop out of school to help with domestic activities or to care for siblings when their mothers are sick or out working. Women who cannot afford to pay for care for their dependents are often unable to take up paid work, or are restricted to low-paid, low-status jobs, such as home-based or sub-contracted work. Their capacity to save for old age or contribute to a pension is reduced as a consequence, intensifying longer-term insecurity. Juggling paid work and care work also leaves many women working a 'double day' – squeezing leisure time and leading to stress, exhaustion or 'burnout'.

Care obligations also create obstacles to women's full and meaningful participation in the public sphere – making it difficult for them to enter debates about social policy, stand as representatives for local, national and international decision-making bodies, or even exercise their right to vote. The result is that women's specific priorities are often overlooked by the men and male-dominated institutions responsible for making public policies and allocating budgets.

Even when care activities are paid, the work remains undervalued. Jobs in care are highly female dominated and are notoriously low status and badly paid. This is the result of gender ideologies which portray care work as something requiring few skills that all women and girls are able to do. Working conditions also tend to be poor, and much of the work is informal, meaning that care workers lack access to basic labour rights and entitlements – to minimum wages, decent working conditions, benefits and protections, and the freedom to form associations and trade unions.

Why now?

While these are not new concerns, they are taking on a new urgency in the light of emerging 'care crises' in many regions of the world. At the root of these crises is the decreasing availability and willingness of women and girls to do unpaid care work – linked to positive trends such as near-universal rises in female participation in the labour force and girls' increasing school enrolment. At the same time, the need for care is escalating. An estimated 33.2 million people are living with HIV worldwide, and large numbers of children have been orphaned or made vulnerable as a result. Rapid population ageing is creating a huge demand for elderly care in middle- and high-income countries. And health sector reforms are exacerbating these already fragile situations, leading to greater commercialisation of health care and a heavier reliance on private payment and user fees. As a result, institutional health care has become unaffordable for many, shifting responsibility for care to the household. While affluent households may have the option of paying for care, in poorer households intense care needs are often met only at increasing cost to women's and girls' physical and emotional well-being.

Addressing the challenges

Clearly there are many compelling reasons why care should be on the development agenda. But what changes are needed? And what approaches offer the best prospects for change? This report seeks to move towards a world in which individuals and society 'recognise and value the importance of different forms of care, but without reinforcing care work as something that only women can or should do' (Razavi 2007a: iv). Realising this vision requires strategies to 'de-feminise' care-giving – challenging assumptions that care work is the domain of women and not men. This can help create the foundations for a more equal sharing of care responsibilities between women and men. At the same time, strategies are needed to help re-conceptualise unpaid care as valuable and productive – a key step in terms of ensuring that public investment serves the needs of those engaged in care work.

Through examples of initiatives taking place around the world, this report shows how policies and programmes can be designed in ways which expand women's opportunities and choices, rather than restricting them only to traditional gender roles tied to motherhood and the domestic domain. One strategy is the provision of subsidised, high-quality public care services to enable women's more active presence in the public sphere. A promising example of innovation in this regard is the Elderly Care Insurance, introduced by the South Korean government to provide care services for elderly people. Gender training workshops and media campaigns can also play an important role in challenging the stereotyping of certain tasks as 'men's work' or 'women's work' – opening up new possibilities for men and boys who may feel inhibited from taking on a more active caring role due to entrenched cultural norms. One exciting initiative is Instituto Promundo's *Entre Nos* campaign in Brazil which uses soap opera to encourage youth to reflect on rigid gender roles.

Equally important are strategies to ensure that carers receive the appreciation they deserve and the support they need to carry out their work without undermining their rights and dignity. A number of policy options are considered in this report. Some focus on reducing the burden of unpaid care work through the provision of accessible electricity and water or subsidised public care services. Others seek to mitigate the disadvantages experienced by unpaid carers through providing cash transfers or tax credits to offset the costs incurred in providing care. In respect of measures to protect the rights of *paid* carers, at a very minimum governments must guarantee care workers the same basic labour protections available to other workers. In Argentina, Chile and South Africa, lobbying efforts by gender advocates have been successful in achieving exactly this.

Yet political commitment and dedicated resources are a prerequisite if these innovative approaches are to be translated into action; at present, both remain sorely lacking. Challenging this calls for strong commitment from gender advocates – to make a compelling case for the importance of care, to get the issues heard, and to generate sustained pressure for action. It also calls for greater solidarity among those working on the full range of care issues – to build a broad and diverse alliance of organisations and individuals fighting for change.

Recommendations

Among the recommendations made in this report, there are four key, overarching recommendations which are relevant for all development actors to take up in their own ways.

1. **Care work must be recognised as a core development issue** which needs to be accounted for and addressed in *all* development interventions, across all sectors, in gender-sensitive ways. Tools and checklists should be developed to support policymakers and practitioners to mainstream care issues into their work – particularly in the fields of education, political participation, economic participation, social protection, and migration.
2. **Development policies and programmes must challenge stereotyped assumptions about gender roles** – for example that care work is the domain of women and not men. Policies and programmes should be designed in ways which expand women’s opportunities and choices, rather than restricting them only to traditional gender roles tied to motherhood and the domestic domain. Policies should also involve men in ways that break down gender stereotyping and open up possibilities for men and boys to take on a more active caring role.
3. **Initiatives to promote women’s economic participation must include an analysis of the interrelationship between paid work and care work**, as well as comprehensive measures to redress the double burden of paid and unpaid work shouldered by many working women.
4. **Greater solidarity is needed among those working on the full range of care issues** – gender, HIV and AIDS, ageing, disability and so on – from diverse disciplines and perspectives. In particular, opportunities for greater dialogue and collaboration between those working on the economic and social aspects of care are key for holistic solutions to be developed.

1. INTRODUCTION

What is 'care'?

Care involves both the direct care of persons – such as feeding and bathing a young child – and the domestic tasks that are a precondition for care giving, such as preparing meals, cleaning sheets and clothes, purchasing food, or collecting water and fuel. Those with intense care needs include young children, frail elderly people, and people with various illnesses and disabilities, but able-bodied adults also require and receive care. Care can be unpaid, being performed for one's own family or community without any explicit monetary reward. Care may also be paid, being performed by nannies, domestic workers, nurses, or carers in homes for elderly people.

Adapted from Razavi 2007a: 6

It is a striking fact that women continue to provide a larger amount of care than men across *all* societies, especially in respect of unpaid care (United Nations Development Programme (UNDP) 1995, 2007; Budlender forthcoming). More striking still is that these inequalities persist in spite of marked increases in female participation in the labour force in almost every region of the world¹ (Elson 1999, 2005; Kabeer 2007, 2008; Molyneux 2007b; Pearson, in Cornwall et al. 2007). Certainly there are exceptions: some men and boys reject rigid gender divisions and are actively involved in providing care, showing that resistance to prevailing gender norms *is* possible (Barker et al. 2004; Flood et al forthcoming; Peacock 2003; Peacock et al. 2008). Further variations in the organisation of care exist across different contexts and over individual life cycles, while also reflecting diverse family arrangements and household forms. But, for the most part, men have been unwilling to assume a larger share of unpaid care and domestic work – even in the face of women's willingness to share men's 'breadwinning' responsibilities (Kabeer 2007). At the same time, there has been little improvement in the provision of state-subsidised care services in the majority of countries. The subsequent predicament many women face was captured persuasively in a commentary on women's work in Lebanon:

'Lebanese women are caught in an unenviable position. While their participation in the workforce has increased, gender stereotyping and discrimination mean that they have retained the primary burden of household work. Their task has been made harder by a society that clings to the importance of a well-kept home while at the same time disparaging cooking and cleaning as unimportant in comparison to the "real" work of making deals at an office or clocking hours at a factory.'

Varia 2008: 1

¹ The exceptions are the transitional economies in Eastern Europe and Central/Western Asia, which have seen a decline in female labour force participation rates, as well as countries in the Middle East and North Africa, where rates remain low (UNDP 1995; UNRISD 2005).

So what is the scale of the problem? The table below, from the Human Development Report 2007/2008 (UNDP 2007), provides information on how much time women and men (aged 20 to 74) spend on an average day on cooking and cleaning, caring for children, and resting, socialising and other leisure activities. It also shows the total time they spend working in market and non-market activities on an average day. In all these countries, women spend more time on domestic tasks and childcare than men, and have less free time. Women also work longer hours than men – the biggest gap being in Mexico, where women work an average one hour and three-quarters more than men each day.²

Gender, work and time allocation: Examples from the Human Development Report 2007/2008 (hours and minutes per day)

Country	Year	Total work in market and non-market activities		Cooking and cleaning ³		Care of children ⁴		Free time ⁵	
		women	men	women	men	women	men	women	men
Spain	2002–3	7:54	6:51	3:22	0:37	0:30	0:12	4:34	5:34
Italy	2002–3	8:08	6:51	4:02	0:31	0:28	0:11	4:15	5:29
Republic of Korea	2004	7:30	6:51	2:36	0:20	0:55	0:15	5:03	5:34
Mexico	2002	8:10	6:25	4:43	0:39	1:01	0:21	2:37	3:01
South Africa	2000	6:52	6:01	3:06	1:00	0:39	0:04	4:08	4:53
Madagascar	2001	7:14	7:03	2:51	0:17	0:31	0:08	1:45	3:15

Adapted from UNDP 2007: 342

While these are not new concerns, they are taking on a new urgency in the light of emerging ‘care crises’ in many regions of the world. An estimated 33.2 million people are living with HIV worldwide (UNAIDS 2007), and large numbers of children have been orphaned or made vulnerable as a result. This places a heavy demand on unpaid care, especially in sub-Saharan Africa, where over three-quarters of AIDS-associated deaths occur (ibid.). Meanwhile rapid population ageing is creating a huge demand for elderly care in high- and middle-income countries, such as Mexico and South Korea. Many countries face the added challenge of coping with the adverse health impacts and depleting natural resources predicted to result from accelerating climate change. The likely consequences include a greater proportion of women’s and girls’ time and energy being absorbed by caring for the sick and walking longer distances to access scarce fuel and water resources (Brody et al. 2008). Health sector reforms are exacerbating these already fragile situations, leading to greater commercialisation of health care and a heavier reliance on private

² Section 4.2.1 explores how to measure care, and explains how time-use surveys, while valuable, can still underestimate the time involved in caring responsibilities

³ Includes the following activities: dishwashing, cleaning dwelling, laundry, ironing and other household upkeep

⁴ Includes physical care of children, teaching, playing, etc. with children and other childcare

⁵ Includes social life, entertainment, resting, doing sports, arts, computers, exposure to media, etc

payment and user fees (Razavi 2007b). As a result, institutional health care has become unaffordable for many poor women and men, shifting responsibility for caring for the sick to the household.

All this is happening at a time when the benefits of 'getting women into work' are being widely acclaimed in donor circles – reflected, for example, in the World Bank's Gender Equality Action Plan for 2007–10: Gender Equality as Smart Economics. But invariably there is a complete failure to account for or redress women's existing unpaid care workloads; instead, the task of earning an income is 'simply incorporated into an ever-expanding portfolio of maternal obligations' (Chant 2002a: 467). While affluent households may have the option of paying for care, particularly in times of crisis, in poorer households intense care needs are often met only at increasing cost to women's and girls' physical and emotional well-being.

Addressing the challenges

This report seeks to move towards a world in which individuals and society 'recognise and value the importance of different forms of care, but without reinforcing care work as something that only women can or should do' (Razavi 2007a: iv). Realising this vision requires efforts to radically 'de-feminise' care-giving – challenging assumptions that care work is the domain of women and not men. This entails fundamental shifts in thinking and attitudes concerning the work that women and men can or should do, the roles they are expected to fulfil, the conditions under which they work, and the value society attributes to this work. Through concrete examples of initiatives taking place in low- and middle-income countries around the world, this report shows how policies and programmes can be designed in ways which expand women's opportunities and choices – particularly in relation to waged work – rather than restricting them only to traditional gender roles tied to motherhood and the domestic domain. One strategy is the provision of subsidised childcare, elderly care and care for people with disabilities, to enable women to be more active in the public sphere (see section 4.3).

Equally important is that policies recognise and affirm the care work that men carry out, and involve men in ways that break down gender stereotyping (men being branded as uncaring, lazy or irresponsible). This can open up new possibilities for men and boys who may feel inhibited from taking on a more active caring role due to entrenched cultural norms, even when they feel they should – or might want to – be involved (Flood et al. forthcoming) (see section 4.1).

Yet not all women want to be 'liberated' from the social obligation to provide care. For the many women in all societies who gain much fulfilment and status as a result of their caring roles, it is *recognition* and support for the care work they do which is important to them. This report subsequently calls for a radical change in the value that society accords to care, so that carers – paid and unpaid – receive the appreciation and respect they deserve, and the support they need to carry out their work without undermining their rights, well-being and dignity. Drawing on diverse examples from Africa, Asia and Latin

America, this report shows how the provision of gender-sensitive social protection measures⁶ – such as unconditional cash benefits, tax allowances and pension schemes – can be effective in helping to offset the costs incurred in providing care. It also argues that major structural and institutional changes are necessary, including shifts in how governments allocate their spending so that public investment serves the needs of those engaged in care work – for example, through the expansion of public health and education services. Greater commitment is also needed from those working within the development sector – to recognise and act on the fundamental links between care work and the core goals of poverty reduction, sustainable development and human well-being.

Below is a summary of the priority areas of action that are explored in this report.

What changes are needed?

- **Recognition that care work is a crucial issue for development and must be accounted for and addressed in *all* development interventions, across all sectors.**
- **Recognition of unpaid care work as *work*, and greater appreciation of the value of this work** – for the economy and for human development more broadly – with the result that policymakers and economists factor in care as a serious issue when making policies and allocating budgets.
- **The breakdown of assumptions that care work is the domain of women and not men** – to facilitate a more equal sharing of unpaid care responsibilities between women and men at the micro level, and a less gender segmented labour market in the care professions. Attitude and behaviour changes need to take place among men and women at household and community levels, as well as among decision-makers and employers in public and private institutions.
- **Better state provision of affordable, accessible, high-quality care services**, including childcare, elderly care, care for people with disabilities and chronic illness, and education and health services. This is important to reduce the burden of unpaid care on family and community members, and to expand the choices available to women and men – for example, enabling women to take up more highly paid work outside the home and participate more actively in local or national political processes, while also having more time for resting and leisure.
- **Better protection of the rights of unpaid carers**, to education, good health, decent work and participation in public life - in part through the provision of social assistance to ensure that carers are not discriminated against because of care responsibilities.
- **Better protection of the rights of paid carers, including migrant care workers** – to ensure decent working conditions, minimum wages, basic benefits and protections including parental leave, and the freedom to form associations and trade unions.

⁶ In this report, social protection is used to refer to particular policy approaches and instruments that prevent, manage and overcome problems of risk and vulnerability, including various forms of social insurance and social assistance such as pensions, cash transfers, and public services (Kabeer 2008)

Who is this report for?

This report has been written for a broad audience of gender equality, social justice and human rights advocates, as well as decision-makers in mainstream government ministries, donor agencies and civil society organisations. It is particularly relevant for:

- gender specialists working on social and economic policy;
- gender specialists responsible for designing and implementing women's empowerment programmes or initiatives to engage men and boys in promoting gender equality;
- gender trainers and community educators;
- gender equality, social justice and human rights activists;
- gender advisors with a mainstreaming remit in government, donor or civil society organisations;
- mainstream development actors and government officials working on issues such as HIV and AIDS, migration, labour rights, social protection, ageing and disability.

What does it set out to do?

It maps the links between different care issues and actors

As this report will show, the scope of care is enormous. But the links between different care issues are not always made, particularly with respect to the intersections between unpaid and paid forms of care. As a result, there is little dialogue or sharing among people working on related care issues. This report seeks to bring these links into sharper focus by providing a comprehensive synthesis of the latest thinking and practice on gender and care issues – mapping out key debates, approaches and actors. While it covers all types of care, the focus of the report is on unpaid rather than paid care, and on the connections between the two.

It teases out the social, gendered dimensions of care

While recent years have seen an emergent body of literature from diverse disciplines converging around questions of care (Razavi 2007a), care issues have received little attention in a gender and development context. This report seeks to tease out the gendered dimensions of care, grappling with the complex realm of social norms which dictate women's and men's relationship to work and, more broadly, their sense of self-worth and well-being. This is not simply a question of adding 'culture' to existing analysis, but is more fundamentally about unpacking how gender relations are constructed and how people are socialised – and exploring strategies to reconstruct gender relations in the domestic and public spheres.

It gives visibility to existing work on care

While innovative work on care is taking place, little is known about the initiatives already taking place – in disparate, small-scale projects in communities, and at the national and international levels. How can governments, donors and non-governmental organisations (NGOs) better engage with and learn from these existing initiatives? In an effort to make visible the work already taking place – as a source of knowledge and inspiration – this report highlights a range of case studies and examples of exciting interventions taking place in countries throughout the world. Many relate to practical initiatives – such as

the Entre Nos ('Between Us') campaign in Brazil, which uses soap opera to encourage youth to reflect on rigid gender roles (see section 4.1). Others relate to government or donor policies, such as the Elderly Care Insurance introduced by the South Korean government to provide care services for elderly people (see section 4.3 of this report). Yet others relate to research, advocacy and activism, including the pioneering work of the African Home-Based Care Alliance, which is building the capacity of those caring for people living with HIV and AIDS to represent themselves in local, national and international decision-making forums (see the 'Gender and Care' In Brief bulletin that forms part of this Cutting Edge Pack).

Structure of the report

Beginning with the question 'what is care?', section 2 explores the range of activities that constitute care, both unpaid and paid. Section 3 discusses why care matters for poverty reduction and gender equality, and why it matters *now*. Section 4 then turns to the strategies needed to bring about more equitable and effective ways of providing care, focusing on three main approaches: challenging gender norms to encourage a more equal sharing of unpaid care responsibilities between women and men; bringing about greater recognition of the huge amount of unpaid care work performed, and of the value of this work; and putting in place the social policy measures needed to ensure that care-givers are not disadvantaged because of their unpaid care responsibilities. Section 5 focuses on how to deal with the challenges of providing care in contexts of HIV and AIDS – providing ideas for action and suggestions on how to mainstream gender and care issues into HIV and AIDS work. It then considers the measures needed to protect the rights of paid care workers, particularly domestic workers. Section 6 presents reflections and recommendations.

This report forms part of the Cutting Edge Pack on 'Gender and Care'. In addition the Pack contains the In Brief bulletin and the Supporting Resources Collection (SRC). The In Brief bulletin provides a short overview of this report and two inspiring case-study articles. The SRC provides summaries of key texts on gender and care, case studies of promising initiatives, and practical tools and guidelines. It also lists useful web resources and provides networking and contact details of organisations working on care issues.

2. WHAT IS CARE?

What is 'care'?

- A girl minding her younger siblings?
- A woman caring for her elderly husband?
- A man assisting his disabled brother to do daily tasks such as bathing and dressing?
- A nurse caring for an ill patient in a hospital, clinic or the person's home?
- A migrant domestic worker cooking and cleaning in her employer's house?
- A woman cooking in her own home for her family?
- A community care provider visiting the home of a person with chronic illness to attend to their needs?

All of the above are forms of care – and this list could be expanded to cover many more pages!

As shown by the range of examples above, care involves many different activities and takes multiple forms. Differences exist in terms of where the care is done (for example, within the home or in a public or private institution); whether and how well those providing the care are paid; and who (government, the recipient of care or their family, the care-giver, or someone else) covers the financial and other costs of care. Further variations exist in terms of how care is understood and defined, particularly across different disciplines. For instance, some people argue that 'care' is as much about caring *feelings* on the part of a care-giver as is it about carrying out certain *activities* (see, for example, Folbre and Nelson 2000).

As such, this section does not focus on a single understanding of care, nor does it provide hard and fast definitions (see the box at the start of this report for a definition of care). Instead, it explores a range of understandings and types of care, and considers the relationship between them.

2.1 Unpaid care

2.1.1 Unpaid family care for those who are 'vulnerable' and 'dependent'

Virtually everybody will agree that a mother or father feeding or bathing their baby is providing care. They will also agree that when adults attend to the physical and emotional needs of their frail elderly parents or disabled members of the household, this represents care⁷. Members of the household who are not normally dependent may also require intensive care for temporary periods. They might become ill and

⁷ Of course, just because someone is disabled or elderly does not mean they are dependent. Many elderly and disabled people, particularly women, both receive and provide care. As such they are not immune to the heavy care responsibilities that fall on women in general. Particularly in contexts of high HIV prevalence or out-migration of women, elderly women are often the primary care providers (Kabeer 2007; Ogden et al. 2004; Orbach 2007).

need care at home, or need to be taken to health services. In some cases, care might be required over an extended period.

As well as direct physical care, carers often provide 'passive care' or supervision, when they must remain near to the person being cared for in case they should require assistance. Passive care can be carried out at the same time as other activities, but these activities must be able to be interrupted at short notice and be performed near to the person being supervised.

Care encompasses more than activities such as feeding and bathing – the direct care of persons. The food needs to be cooked, the utensils cleaned, and the clothes washed. In order for the food to be cooked and the clothes washed, fuel and water must also be collected. Domestic tasks like these, which are not done directly to or with the person being cared for, constitute another essential aspect of care⁸.

2.1.2 Unpaid care beyond vulnerable people

Care is not only carried out for those who are very young, elderly, ill or disabled. When the same tasks are performed for the benefit of more independent household members, this is also care. It is, therefore, necessary to distinguish between the care that is done for someone who is unable to do it for themselves and the care that is carried out for someone who could do it themselves but does not do so (Bubeck, in Anderson 2006).

2.1.3 Unpaid care beyond the household

Unpaid care may also be carried out for people who are not members of a person's own household. On the one hand, unpaid care beyond the household refers to the unpaid assistance individuals provide to family and friends when they are ill, elderly or disabled, or when their children need care. On the other hand, it includes a range of community care providers working in what is sometimes called the not-for-profit sector, made up of NGOs and community-based and religious organisations. For example, in countries affected by HIV and AIDS, home-based care has become a widespread strategy which involves community members visiting and providing support to AIDS-affected households – often for little or no pay (see section 5.1). These carers are sometimes collectively termed 'volunteers'.

2.2 Paid care

In other cases, carers are paid. Paid care may be done within the home, for example by nannies or domestic workers. It may also be done beyond the home, for example in orphanages or homes for elderly or disabled people. Paid care beyond the home can also be argued to include some of the work done by nurses, cleaners, and teachers of young children.

⁸ Water and fuel collection are not technically classified as 'unpaid care work' according to the classifications used in time use surveys. However for the purposes of this report, water and fuel collection will be regarded as a form of care because these activities are an essential pre-condition for the direct care of people.

Some of this care is provided by the state in the form of public health and social welfare services. In the state sector, care providers will almost always be paid. Those who receive state care will sometimes be required to make direct payments in the form of user fees. The public more generally will often contribute through taxes, such as goods and services tax and value added tax, which the majority of people in all countries pay.

In other cases, paid care is provided through a commercial service – paid for either directly by the care recipient and their family or through insurance contributions. Market provision includes a corporate sector made up of big companies who invest to make profits; for example, a high proportion of elderly care in high-income countries is provided by large corporate companies. In low- and middle-income countries, on the other hand, paid care services tend to be provided at the informal end of the market by nannies and domestic workers.

3. WHY IS CARE IMPORTANT IN DEVELOPMENT WORK?

Care is a cross-cutting issue with relevance to multiple areas of development: human rights, education, HIV and AIDS, health more broadly, nutrition, migration, labour rights, social protection, economic growth – even climate change. And of course, it is also relevant to almost all aspects of gender equality. In other words, it is an issue so fundamental that it should be considered in all development interventions, across all sectors. So why is there such reluctance to engage with care issues?

3.1 Why the reluctance to engage with care as a core development concern?

For some, care is perceived as secondary to more ‘important’ development issues such as income generation or education, even though it is a major obstacle to both. Others argue that women’s care-giving roles are specific to local culture and are best left alone – overlooking the commitment of Southern feminists to getting these issues heard. Yet others shy away from meddling in the ‘private realm’ of the family. This ignores the fact that, as many feminists have persuasively argued, and as is explicitly recognised in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)⁹, what goes on in the private realm *is political*.

For mainstream economists in institutions like the World Bank or the International Monetary Fund, and within government institutions, unpaid care tends to have no place in their macroeconomic models and analysis – even though such work is critical to maintaining the labour force and to the functioning of the market economy (see section 3.1.3). Others argue that the gender division of care work within the household is economically rational because men’s earnings are generally higher than women’s, so it is better for the household to lose the woman’s earnings than the man’s (see, for example, Becker 1981). Those who put forward this argument generally do not discuss the reasons why men tend to earn more than women – reasons that include the clustering of women in low-paid and care-related occupations and industries, as well as outright discrimination (International Labour Organization (ILO) 2003a). The argument also relies on a circular logic: the fact that women’s earnings tend to be lower than men’s is partly the result of their domestic and care responsibilities; at the same time, the fact that women ‘specialise’ in domestic and care work is partly because they earn less than men in the labour market (see Waring 1998 for a detailed critique of Becker).

For governments, particularly in contexts of severely constrained state resources, it may be that the care work provided without charge by family members offers a conveniently low-cost form of welfare provision. But this ‘solution’ is not low cost for the women who are left shouldering this burden (see section 3.1.2). At the same time, those in power may benefit from existing arrangements of care at a more personal level – freeing them from obligations to cook the dinner or do the housework, for example.

⁹ CEDAW clearly stipulates that state responsibilities to eliminate discrimination against women extend to private as well as public life.

Others argue that women *naturally* belong to the realm of the family, children and care. Many political and religious institutions or movements propagate these ideologies, yet such ideas are not uniform or fixed. For example, the Islamic movement of Hamas initially promoted the idea that women's roles should be confined to the realm of the household but now actively encourages women to excel in many spheres, including the public sphere (Jad 2008). There are also some Shi'ite movements like Hizbollah in Lebanon and Iraq which are very supportive of women's role in the public sphere, whether in employment or politics (ibid.).

While being far from exhaustive, the examples above help explain why care issues have remained so invisible on development agendas. But there are many compelling reasons why care issues *should be a priority* – because heavy care responsibilities both pose a fundamental barrier to achieving gender equality and hinder progress towards other important development goals. In an effort to effect greater awareness of the importance of care in development, this section will describe why care matters for poverty reduction and gender equality, and why it matters *now*.

3.2 Why *should* we care about care?

3.2.1 *Because providing care has a major impact on people's lives*

'Unpaid care work is exhausting...it breaks down any difference between work and non-work time. Caring for a child or sick person makes demands for 24 hours of the day. A person doing this by himself or herself is always 'on call.'

Elson 2005: 8

'Providing care to her changed my life because I felt like I was sick as well; I thought about her [all the] time, even when I was asleep; she was also the first person I had to see every morning.'

A 31 year-old female voluntary care-giver for people living with HIV, in Akintola 2006: 243

Much care is provided in complex social relations between people in their everyday lives. It can be both a source of fulfilment and a terrible burden. For women and girls in particular, their socially prescribed role as carers may significantly shape how they see themselves and how society sees and values them.

For many people, caring is a valued source of self-esteem and social legitimacy (Chant 2002a; Molyneux 2007a), rather than an injustice. But for others – particularly the poorest people – the time, effort and other resources used in providing care can violate their right to health and undermine their quality of life and well-being.

There may be particular points during the life cycle or particular circumstances which markedly increase the care workload. For example, the impacts of providing care may be felt most intensely in households

caring for dependents such as young children, frail elderly people, or people with chronic illnesses or disabilities. Impacts are also severe in contexts of declining agricultural productivity and food insecurity, or conflict and disaster – particularly for very poor people. For example, in drought-prone areas affected by desertification, the time and energy absorbed by water collection increases as women and children have to travel greater distances to find water (Brody et al. 2008).

But the exhaustion and stress resulting from the mundane burden of everyday care is also acute. This is unsurprising when we consider the huge amount of time and energy absorbed on a daily basis by arduous care-related activities, including shopping for food, preparing meals, washing clothes, washing dishes, looking after children (washing, dressing, feeding and supervising them), looking after elderly household members, cleaning the house, and so on. In low-income countries, the time and effort required to meet everyday care-related needs is often exacerbated by underinvestment in public infrastructure and inadequate domestic water and fuel supplies, especially in rural areas (UN Millennium Project 2005a).

Impacts of caring can be physical, such as headaches, backaches and physical exhaustion, as well as the added risk of infection for those caring for people with infectious diseases (Akintola 2006). These impacts may be particularly debilitating in cases where carers are themselves very young, elderly, HIV-positive or suffering from other forms of ill-health. Impacts can also be emotional and psychological, including high levels of stress. For those caring for chronically ill people, feelings of guilt, anxiety and anguish about the state of the person they are caring for are common, particularly in contexts where carers lack appropriate support such as access to necessary medicines and equipment (ibid.). As Jennifer Gatsi Mallet from the International Community of Women Living with HIV/AIDS (ICW) explains:

‘Much of the stress experienced by caregivers [of people who are sick from AIDS-related illnesses] is in the nature of the work itself – the fact that they are working with largely incurable conditions that kill mainly young people and are heavily stigmatised causes terrible suffering.’

Voluntary Services Overseas (VSO) 2006: 9

For carers of children, the emotional and psychological impacts are particularly severe:

‘Children [caring for family members living with HIV and AIDS] are put in the position of having to watch their parents and elders sicken and die, to intimately handle their bodies and excreta, to wonder and worry whether they are ‘doing it right’ or ‘doing it enough’, while at the same time dealing with their sorrow, grief and facing an uncertain future.’

Ogden et al 2004: 9

In addition to the physical, emotional and psychological costs of care, women's and girls' rights to education, work, and access to decision-making fora may also be compromised (see section 3.2.2 below).

3.2.2 Because care work creates and reinforces gender inequality

In most cultures, children are taught from a young age that a man's role in the family is to provide financially for their wives, children and other dependents – to be the 'breadwinner'. Caring, by contrast, is seen as a job for women and girls – the nurturers, mothers and 'homemakers'. Yet women's and girls' socially ascribed responsibilities for care can undermine their rights and limit their opportunities, capabilities and choices – particularly for poor women who are unable to pay for care, and for their school-age daughters.

Girls' education

'I have many things to do when I come back home [from school] even if I am tired. I sweep the floor, I go to buy things for my mother, and I play with my brother. I do not have much time to do my homework.'

Balovi Eliane, aged 10, Benin, cited in Plan 2007: 52

'I still live with my aunt. I still do domestic work there, after school...I have to finish my domestic work first, so I do my homework late at night or sometimes I don't do it.... I still fetch water too, but around 7 a.m. I have to be at school at 8 a.m., so I don't come on time...'

Claudine K, aged 14, domestic worker in Guinea, cited in Human Rights Watch (HRW) 2007: 67

While education is every child's right, many girls have to drop out of school to help with domestic activities or to care for siblings if their mothers are sick or out working, or to take on care responsibilities in households which are child-headed (Plan 2007). Child domestic workers, many of whom are girls, are also frequently denied an education – often remaining at home to do the housework while their guardian's children attend school (HRW 2007). This undermines the potentially positive effects of girls' education, including improvements in income-earning potential later in life, enhanced bargaining and decision-making power, control over their sexuality and fertility, and participation in public life (UN Millennium Project 2005a).

Even where girls do attend school, they often have to juggle their education with heavy care workloads. This reduces the time available for studying and may leave them too exhausted to learn. It also reduces time for play – recognised as a right of all children – and can undermine their right to the highest attainable standard of health. The table below provides a comparison of the different activities that girls

and boys in the Gambia generally spend time on during an average school day. It shows that girls typically sacrifice time for sleeping, studying and play in order to fit in their care-giving responsibilities.

Daily timetable from the Gambia (data from 1999)

Time	Girl in school	Boy in school
6am	Gets up, bathes, prays	Sleeping
7am	Sweeps compound, fetches water, washes dishes	Gets up, bathes, prays, revises lessons
9am	Goes to school	Same
9.30am	In school	Same
2pm	School day ends, extra studies until 6pm	Same
6pm	Takes food to mother on farm, helps her	Fetches water, bathes
7pm	Cooks dinner, bathes	Various (play, study)
8pm	Dinner, washes dishes	Dinner
9–11pm	Goes to teacher for extra studies	Goes to teacher for extra studies
Midnight	Goes to sleep	Goes to sleep

Adapted from Kane, E. and M. O'Reilly deBrun, in Plan UK 2007

Measures to tackle the opportunity costs for girls' education that arise from their heavy burden of household chores

The Millennium Project Task Force Report on Achieving Gender Equality and Empowering Women¹⁰ proposes several measures to tackle the opportunity costs for girls' education that arise from their heavy burden of household chores:

- Establishing day care centres and preschools for younger siblings or students' children to reduce the need for girls' labour;
- Improving the supply of accessible water and fuel to reduce the time taken up by unpaid care and domestic activities;
- Providing take-home food rations for the families of school-attending girls to offset the loss of the girls' labour to the household – making it less likely that they would be withdrawn from school.

UN Millennium Project 2005a: 59

These options largely focus on reducing girls' time spent working, rather than also seeking to challenge the gender division of labour which results in girls rather than boys being expected to do this work in the first place (see section 4.1).

¹⁰ The Task Forces were part of the United Nations Millennium Project, an independent advisory body commissioned by the former UN Secretary-General Kofi Annan to propose the best interventions and policy strategies for meeting the MDGs.

Economic empowerment

Like education, the right to work is an inalienable right of all human beings, including equal employment opportunities, choice of profession and job security (CEDAW, Article 11). Following the setting of the third Millennium Development Goal (MDG3) on gender equality and women's empowerment, there has been a renewed focus on equal employment opportunities for women (see, for example, the World Bank's Gender Equality Action Plan for 2007–2010). What tends to be overlooked in the drive to get women into work is the fact that women who cannot afford to pay for care for their dependents are often unable to take up paid work, or are restricted to low-paid, low-status and often part-time jobs because of their unpaid care responsibilities (Budlender 2004a; Orloff 2002 in Razavi 2007a; Rubery et al 2001 in *ibid.*; UNDP 1999).

The 2007 Global Monitoring Report shows, for example, that the greatest gender gap in labour force participation occurs between the ages of 25 and 49 (International Bank for Reconstruction and Development/The World Bank 2007). This is not surprising, since heavy domestic and childcare responsibilities make it difficult for women to continue with or enter formal waged labour, particularly when they are without access to public care services. In Mexico, for example, on an average day, women devote five and three-quarter hours to domestic activities and childcare – severely limiting the time available for income-generating activities (UNDP 2007). The apparent gap in labour force participation between the ages of 25 and 49 may also reflect the types of work women are obliged to take up in order to accommodate care responsibilities, such as home-based or sub-contracted work¹¹. Such work is not formally registered and so remains on the margins of official reporting.

Restrictions on the type of work available to women arise both because of the time absorbed by care and because the carer has to remain near to the person requiring care. For example, while a woman can take a young child with her when she goes to sell fruit on the street or to work in the family field, she cannot take an infirm elderly person with her in this way. And she cannot take a young child to more formal workplaces – for instance, if she is a teacher or factory worker. Although home-based work should provide a good compromise for women who want to work but cannot migrate or travel far from home because of care responsibilities, the fact that it is largely unregulated means that the pay and working conditions are often extremely poor. It is also insecure, with no compensation for sickness and no maternity leave. While it is true that self-employed or home-based work may allow the continuance of some degree of care, it also means that many women end up working a 'double day' – squeezing leisure time and leading to stress, exhaustion or 'burnout' (Moser 1989). Rather than enhancing women's capacity to exercise greater control over their lives, this is likely to undermine their health, well-being and dignity –

'It is not reasonable to assume that the improvements required for the genuine empowerment of poor women can come solely from selling their labour without resourcing collective provision of services and rewarding women's responsibilities in reproductive activities.'

Pearson, in Cornwall et al. 2007: 211

¹¹ Worldwide it is estimated that women make up 30 to 90 per cent of home-based workers and 80 per cent of industrial sub-contracted homeworkers (ILO 2002).

The fact that women's working lives are often interrupted to care for dependents also limits opportunities for career advancement, meaning that they cannot move beyond these low-status and poorly paid jobs. Women's capacity to save for old age or contribute to a pension is reduced as a consequence, intensifying longer-term financial insecurity (Kabeer 2008; Razavi 2007b). All this leaves many women in a position of financial precariousness, particularly for single parents who lack the contribution of a second adult earner (Chant, in Cornwall et al. (eds) 2007).

The links between unpaid care work and women's participation in the labour force in Turkey

Turkey has one of the lowest rates of female participation in the labour force in the world, ranking 10th from bottom among 130 countries, according to UN 2005 statistics. It is often assumed by policymakers, employers and academics that this is due to low levels of female education, and the presumed 'solution' has been to expand women's educational opportunities.

But women's organisations have criticised the sole focus on education, pointing to two other major obstacles. The first is women's unpaid care responsibilities within the family; the second is the gender division of labour, which produces sharply defined gender roles and creates inequalities in the opportunities available to women and men with respect to education, work and participation in the public sphere. These obstacles are exacerbated by poor state provisions for working mothers – limited to three months paid maternity leave and one clause in the labour code which requires employers to provide childcare centres if they have more than 150 female employees. The latter can in fact work to the disadvantage of women, who are discriminated against as a result when applying for jobs.

In response, Women for Women's Human Rights – New Ways (WWHR), a Turkish NGO, is conducting research into the links between unpaid care work and women's participation in the labour force in Turkey and globally. The aim is to promote more holistic approaches to the problem of low levels of female participation in the labour force.

Ilkcaracan 2008, personal communication

Political participation

Women's political participation is also receiving more attention from national governments and international donors in line with the principles of CEDAW, the Beijing Platform for Action (BPfA) – which calls for an interim threshold of women holding 30 per cent of national decision-making positions, and MDG3 – which includes a specific indicator on the proportion of seats held by women in national parliaments. Recent years have seen some progress towards these goals, particularly with the introduction of gender-sensitive mechanisms such as the electoral quota system and national women's machineries in government (Brody 2009). But care obligations limit women's access to the public sphere – making it difficult to enter debates about social policy, stand as representatives for local, national and

international decision-making bodies, or even exercise their right to vote. For the minority who do enter political life, the strain of trying to reconcile domestic and care demands with their political roles has been shown to lead to their resignation from government posts in some cases (see Evertzen 2001, in Brody 2009). Care responsibilities also inhibit women's involvement in participatory development processes such as poverty assessments, budget processes and service delivery processes. The result is that women's specific priorities are often overlooked by the men and male-dominated institutions responsible for making public policies and allocating budgets.

Facilitating women's participation requires at the very least that opportunities to participate are at a time and place that is convenient to all participants, and that childcare services are available (see the example below).

Supporting women's participation in the budget process by taking care needs into account

In 2001, the municipal government of Recife, Brazil, developed a strategy to increase popular consultation and women's participation in the formulation of the municipal budget. As part of this initiative, mobile recreation spaces for children were installed in the places where the budget meetings were held – intended to facilitate participation by women with childcare responsibilities. Initiatives such as these are a key step in terms of ensuring that policy design and the allocation of resources responds to the needs of *all* citizens, including those with care responsibilities, who often have differing needs for services, transport and so on.

Based on BRIDGE 2002

Freedom from violence

Responsibilities for care and domestic work can also put women and girls at greater risk of gender-based violence. For example, the fact that men tend to do more and better-paid work while women do more unpaid work makes it difficult for women to leave abusive men on whom they and their children depend financially. Walking long distances to fetch water and fuel can also expose women and girls to harassment or sexual assault, especially in areas of conflict – there are many accounts of women and girls being attacked when searching for water and kindling in refugee camps around Darfur (Médecins Sans Frontières 2005).

As is clear from the preceding discussion, heavy unpaid care burdens are a major obstacle to achieving gender equality, particularly in contexts where increasing female participation in the labour force is resulting in many women having to work a 'double day'. For national and international commitments to gender equality and women's rights to be realised, governments, therefore, need to implement policies and programmes which offset the various disadvantages experienced by care providers, rather than relying on families and individuals to bear all the costs of care (see sections 4 and 5). Equally important is that donors ensure that policies to promote women's economic empowerment include an analysis of the

interrelationship between paid work and care work, and incorporate comprehensive measures to reduce the burden of unpaid work that falls disproportionately on women (see section 4 for a discussion of various strategies for achieving this).

3.2.3 Because care is linked to poverty and ill-being

‘Sometimes I am unable to sleep at night thinking of what to do and not to do. Because all the money I spend and everything I do just disappears.’

A female breadwinner and head of a multi-generational household in South Africa,
who had spent a lot of money caring for her daughter and granddaughter,
in Akintola 2006: 244

Poorer households are generally less able to deal with crises, such as a sudden illness or disability, because they have less capacity to accumulate assets and plan for the future. This is particularly the case in countries lacking well-developed safety nets such as social insurance policies or unemployment benefits. In times of crisis, providing unpaid care can have very immediate financial ramifications for the carer and their family, particularly for women, who – as noted above – often do informal, low-paid work and have no access to sick leave or other forms of compensation if they have to stay at home to care for a sick family member (Kabeer 2008). Opting for more flexible self-employment or part-time waged work in order to accommodate care responsibilities also means forfeiting the higher earnings available from waged work (ibid.).

The financial impacts of providing unpaid care are particularly severe in contexts of HIV and AIDS, because those most likely to be infected are adults in their prime economically active years. This has huge financial implications for household viability, as formerly productive adults are no longer able to earn an income – particularly since the majority of AIDS-affected households in developing countries are already severely resource-constrained (Ogden et al. 2004). A study in South Africa showed that two-thirds of HIV and AIDS-affected households reported a loss of income due to the time absorbed by providing care (Steinberg, in ibid.) (see section 3.2 for more discussion of care for people with HIV and AIDS).

Beyond financial implications, care work also affects well-being and human rights, which are increasingly seen as integral aspects of poverty reduction and development (Chambers 2005; Sen 1999). Unpaid care work can result in poor physical and mental health which undermines well-being; it can generate insecurity through limiting options for decent work and fostering financial dependence; it can limit voice by creating obstacles to full and meaningful participation in the public sphere; and it can undermine basic human rights and dignity when undertaken without adequate recognition, respect and support.

Participatory Poverty Assessments (PPAs) can be a useful tool for capturing the gendered aspects of poverty – such as women’s greater time burden or ‘time poverty’ – and for revealing gender differences in

needs and priorities. A PPA is a process for including poor people's views in the analysis of poverty and in the design of strategies to reduce it (Moser 2007). The methodologies are participatory and largely qualitative. One example is the World Bank's Voices of the Poor project which used qualitative methods to gather the views and experiences of more than 60,000 men and women from 60 countries on a range of issues (ibid.). Gender differences in priorities were revealed – for example, distance from and quality of drinking water sources were concerns almost exclusively voiced by women in sub-Saharan Africa, reflecting their primary responsibility in this area (Kabeer 2003). The PPAs also helped to make the connections between production and reproduction more visible. For instance, the ability of poor people to generate income in Guinea-Bissau was shown to be reduced because environmental degradation forces poor people (especially women) to spend so much time on routine household tasks such as collecting fuel wood and fetching water (ibid.).

3.2.4 Because care work is undervalued

'Human development is nourished not only by expanding incomes, schooling, health, empowerment and a clean environment, but also by care.'

UNDP 1999: 77

Unpaid caring activities are critical for the functioning of the economy – reproducing on a daily and intergenerational basis the labour force which works in the so-called 'productive economy' (Elson 1999; UNDP 1995). Yet much of the unpaid care work performed disproportionately by women is taken for granted by governments and remains unrecognised and undervalued by society at large (UNDP 1995). The reasons for this are complex. They include the fact that gender power relations have historically meant that the work men do (as well as that which is done in the public rather than the private realm) is valued more highly than the work women do. They include the fact that care is commonly perceived as an expression of affection or love, rather than a form of work. They also include the fact that care work is seen as low skilled – as something which comes naturally to women (England, Budig and Folbre 2002).

Unpaid care is particularly undervalued in economic terms, being typically taken for granted in macroeconomic analysis and policy (Elson 2004). In large part this is due to (and a reflection of) the exclusion of unpaid care from calculations of gross domestic product (GDP). GDP is the measure which is commonly used to calculate the size of a national economy and its growth over time. The set of rules that govern how countries calculate their GDP, known as the System of National Accounts (SNA), makes a distinction between production of goods and production of services. Cooking, for example, is regarded as a service, while growing the products that go into the cooking, and collecting fuel and water, are regarded as the production of goods. The distinction is important because the SNA states that the unpaid production of services for consumption in the home must *not* be counted when calculating GDP. Such

services would include many of the care activities described in section 2: meal preparation, cleaning and household maintenance, shopping, care of persons within the household, and volunteer services provided through organisations and groups (Elson 2005). In contrast, paid production of services, and paid or unpaid production of goods are included. So where a household hires a person to do their cooking and cleaning for them this work is included in GDP, but where exactly the same activities are done by members of the household this work is excluded. Because the majority of men's work is in paid SNA activities while much of women's work is in unpaid non-SNA activities, men receive greater economic recognition for their contributions than women.

Prevailing assumptions about women's aptitude and disposition for caring work, combined with sex-segregated labour markets (where men are recruited into certain types of jobs and women into others), mean that *paid* care work is also highly female dominated (ILO 2003a). Even when care activities are paid, the work remains undervalued (Chen et al. 2005). Jobs in care are notoriously low status and badly paid – justified by the same kinds of gender ideologies, referred to above, which portray care work as a natural part of women's role: as something requiring few skills, that 'all women and girls' are able to do (Razavi 2007a, 13). And because it can be obtained for free in other circumstances, it is accorded low worth (Budlender 2004a). Working conditions also tend to be poor, and much of the work is informal, meaning that care workers rarely have access to basic labour rights or entitlements. While this is true of all forms of paid care work, domestic workers are particularly vulnerable due to the invisible nature of much of their work, which takes place inside private homes (HRW 2006, 2007) (see section 3.2.3 for more discussion of the vulnerabilities faced by domestic workers). Finding better ways to protect the rights of those engaged in paid care work should, therefore, also be a priority for policymakers and employers as well as for civil society organisations engaged in women's rights and gender equality work (see section 5.2 for examples of strategies to achieve this).

3.2.5 Because attention to unpaid care is key to achieving the Millennium Development Goals

Care poses a major obstacle to making progress towards almost all the MDGs – not only MDG3. Although the MDGs do not specifically mention care, the UN Millennium Project Task Forces make several references to both unpaid and paid care in their review of what is required to achieve the goals (Elson 2005). The references to care are particularly extensive in the Task Force Report on Achieving Gender Equality and Empowering Women, but there are also references to care in other reports, such as on Education, Water and Sanitation, and Maternal and Child Health. The table below summarises some of these important links.

Millennium Development Goal	Examples of links with unpaid care
MDG 1: Eradicate extreme poverty and hunger	<p>Women are widely responsible for producing and processing family food crops, particularly in sub-Saharan Africa. Where the unpaid care workload is severe, women have less time and energy to devote to productive agricultural work, which threatens household food security and nutrition. They also have less time to invest in the unpaid preparation of food in the home.</p> <p>As discussed above (see section 3.1.4), providing unpaid care also has very immediate financial ramifications for the carer and their family, and affects people's rights and well-being.</p>
MDG2: Achieve universal primary education	<p>In most developing countries, children – particularly girls – provide many of the caring activities described in this report. As a result, they may be withdrawn from school to care for younger siblings while their parents are out working, or to care for parents or other family members who are ill or disabled. Even when girls do attend school, they often have to combine their education with heavy care workloads. This reduces the time they have to study and can leave them too exhausted to learn.</p>
MDG3: Promote gender equality and empower women	<p>The links between gender equality and care have been discussed at length above (see section 3.1.2).</p>
MDG4: Reduce child mortality	<p>An estimated 40 per cent of child deaths could be prevented with improved family and community care – not high-tech health equipment, but access to solid knowledge on infant feeding and breastfeeding, as well as support and basic supplies (UNICEF website).</p>
MDG5: Improve maternal health	<p>Women usually continue to shoulder heavy care workloads throughout pregnancy, putting their health at risk before childbirth. Assuming care responsibilities soon after giving birth is also likely to impede women's recovery, especially for those who already have several young children.</p>
MDG6: Combat HIV/AIDS, malaria and other diseases	<p>As discussed in more detail below, the HIV and AIDS epidemic has resulted in increased reliance on low-paid or unpaid 'home-based care' by family and community care-givers – mainly women and girls – as already inadequate public health services struggle to cope with this added burden of care. Care for orphans and other vulnerable children for whom the ill, dying or deceased would normally have provided care has also largely fallen back on women and girls, many of whom are themselves elderly and in need of care.</p>

MDG7: Ensure environmental stability	<p>Depletion of natural resources, water scarcity, lack of energy sources and decreasing agricultural productivity increase the demands on women's and girls' time and health, as they have to walk greater distances, often carrying heavy loads, to fetch the water and fuel needed to feed and care for their families. This reduces the time and energy they have available for income-generating activities, education, and participation in decision-making processes.</p> <p>Women also have distinct and valuable knowledge about the environment which is lost in cases where care obligations constrain them from participating in decision-making processes relating to the environment or climate change. This could jeopardise larger processes of reducing environmental degradation and its impacts and undermine the effectiveness of projects at the local level.</p>
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3.3 Why is it so important to address the issue of care *now*?

Clearly there are many compelling reasons why care should be on the development agenda. Put simply, gender equality and human rights goals and commitments will never be realised unless dedicated efforts are made to challenge inequitable arrangements of care – unpaid and paid. The same is true of goals relating to poverty reduction and human well-being.

These are not new concerns; feminists have long sought to challenge the invisibility of women's unpaid work in economic analysis and decision-making. However, in many countries, problems surrounding the provision of care are becoming more pressing in the light of emerging care crises in many parts of the world. At the root of these crises is the decreasing availability and willingness of women and girls to do unpaid care work in poor and rich countries. This is linked to positive trends such as rising female educational achievement and aspirations, and increases in female participation in the labour force. Another factor is girls' increasing school enrolment¹², which is leaving poor households without one of their major traditional sources of domestic labour. The crisis resulting from the diminishing availability of female caring labour is exacerbated by the continuing reluctance of most men to take up a larger share of unpaid care work (see section 4.1), coupled in some cases with the reluctance or inability of states to provide affordable and accessible welfare services. At the same time, the need for care is escalating in many regions – notably in low-income countries heavily affected by the HIV pandemic and in high- and middle-income countries with large ageing populations.

Of course, the implications of these trends for the women who are expected to provide care vary significantly according to class and wealth. Middle-income women can generally afford to turn to the market for paid help if they wish to continue working outside the home in the face of heavy care obligations (see section 3.2.3). They are also more likely to be employed in formal-sector jobs which come with benefits such as maternity leave and child support. Poorer working women generally do not have

¹² Between 1990 and 2005, girls' enrolment in primary education increased in virtually all regions; gains in girls' secondary school enrolment were also notable, particularly in East Asia and the Pacific, Latin America and the Caribbean, and the Middle East and North Africa (International Bank for Reconstruction and Development/World Bank 2007).

these options, relying instead on other coping strategies – most of which have adverse consequences for themselves and their children (Kabeer 2007). Many women work longer hours to cope with the dual responsibilities of providing care and earning an income – sacrificing time for rest and leisure. As described above, others may opt for self-employment to accommodate care responsibilities – in spite of the sacrifices this entails in terms of the money they can earn (Kabeer 2008). In other cases, women rely on usually female relatives or neighbours for help with childcare or elderly care, or withdraw older children from school. Sometimes they have no choice but to take their children to work with them.

The problem then is not so much that the squeeze on the time available for care means that the care does not get done; rather, it is that for poor women and girls in poor countries, care needs are being met at ever-increasing costs to their physical and emotional well-being. This section will discuss these particular care challenges in more detail, highlighting the scale and nature of the problems faced, and the implications for gender equality. It begins by exploring the escalating global *need* for care generated by ageing populations and HIV and AIDS. It then considers the growing global market for paid care – a consequence of the decreasing availability of women and girls to do unpaid care – and raises critical questions about the rights and well-being of those who carry out this work. Strategies to address these challenges are explored in sections 4 and 5.

3.3.1 Because of ageing populations

Success in reducing global mortality and fertility rates has meant that worldwide fewer children are being born and elderly people are living longer. As a result, elderly people are making up an increasing share of the total population in many countries, creating a huge demand for elderly care provision (Malhotra and Kabeer 2002; Razavi 2007a; United Nations Population Fund (UNFPA) 2002). Fertility rates have only recently started to decline in many countries in the South – most notably in East Asia and Latin America, and more recently in South Asia and countries of Southern Africa (Malhotra and Kabeer 2002). However, the speed and scale of ageing is most rapid in the South, and projected population ageing is considerable. According to the UN Population Division, during the next 45 years, the number of persons in the world aged 60 years or older is expected to almost triple, increasing from 672 million people in 2005 to nearly 1.9 billion by 2050 (UNFPA website). Today 60 per cent of older people live in developing countries; by 2050, that proportion will increase to 80 per cent (ibid.). The issue of elderly care and the capacity of family members to provide it is, therefore, gaining visibility in policy debates in many countries, particularly in parts of East Asia – raising crucial questions about state responsibility in the form of pensions and welfare services.

In practice, most governments continue to fall back on assumptions that traditional family-based arrangements of caring for elderly people remain sufficiently resilient as to make public provision unnecessary (Malhotra and Kabeer 2002). As with other types of care, it is generally women and girls who are expected to provide much of this care. So long as the family remains the main or sole source of care for people in their old age, elderly people who are unable to rely on family structures – such as elderly childless widows or parents of migrant children – are left with little access to care of any kind.

This does not have to be the case. Japan and the Republic of Korea are leading the way in this regard, putting in place social provisions to reduce the reliance on the family to provide care for elderly people (see section 4.3).

3.3.2 Because of the HIV and AIDS pandemic

Although the global HIV and AIDS pandemic has been the focus of much warranted attention and resources, the tendency has been to concentrate on prevention and treatment. Much less attention has been given to supporting those who provide ongoing care for the chronically ill, as well as for those, including children, for whom the ill, dying or deceased would normally have provided care (Ogden et al. 2004). At the same time, in many of the countries most affected by the pandemic, public health systems are severely under-resourced and overburdened as a result of decades of underinvestment and health-sector reform (Corby et al. 2008; Razavi 2007a). Already fragile health systems are being further weakened by depleting numbers of skilled health care workers due to illness and migration (VSO 2006). An estimated 20,000 qualified nurses and doctors migrate from Africa each year, typically to Canada, the United Kingdom, the United States and Saudi Arabia (UNFPA 2006). This fundamentally undermines the right to health of the people who depend on these severely understaffed healthcare systems.

The result is that responsibility for meeting primary health care needs, including for people in the later stages of AIDS who are in need of very intensive care, has largely fallen back on household and community members. As with other types of care, it is women and girls who generally assume primary responsibility for HIV and AIDS care, while not necessarily being assured of care themselves (Akintola 2006; Corby et al. 2008).

In some countries, governments are promoting alternative, non-family-based forms of care, such as community and home-based care¹³, which is provided by visiting nurses, health workers or community care providers from NGOs or community groups (Corby et al. 2008). This is meant to supplement the unpaid care provided by family and community members, and to compensate for the services that poorly resourced and overburdened public health facilities are unable to provide (Razavi 2007a). While care at home is likely to be the most appropriate option for most stages of the condition, there is little government provision for community and home-based care services in most countries (Corby et al. 2008). On the contrary, most care providers work without pay or for very little pay – and often with poor access to basic equipment. There are also concerns that the focus on community and home-based care is absolving the state of responsibility to meet social welfare needs, while disguising the fact that it is typically *women* who are providing this care (Razavi 2007b).

There is a strong age dimension to care provision for people living with HIV and AIDS, particularly in respect of primary care providers. With increasing numbers of middle generations dying from AIDS-related illnesses, care for dependents is often shouldered by grandparents, particularly grandmothers. This reinforces experiences of poverty for some elderly people and increases their vulnerability to illness and

¹³ The World Health Organization defines community and home-based care as: 'Any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities.' (WHO 2002: 6).

infection (Ogden et al. 2004). Research in South Africa and Mozambique (Schatz and Ogunmefun 2005) found that elderly women caring for AIDS patients and their children were paying for medical treatments, transportation and school fees for their children and grandchildren, as well as meeting household subsistence needs. As a result, many women had to sell off financial assets such as land or property, or use up savings or pensions. Despite their precarious position, elderly women are often overlooked by existing state-supported policies and programmes for people infected and affected by HIV and AIDS (Corby et al. 2008) (see section 5.1 for an example of an initiative to support older women care-givers).

Given the unsustainability of current arrangements of HIV and AIDS care, it is time that questions were asked about the needs and rights of care providers – including whether carers themselves are being adequately cared for. Designing policies and interventions that better protect the rights of HIV and AIDS care providers requires that we start by asking them about their own concerns and priorities, and ensure that community and home-based care organisations and networks are involved in the design, implementation and monitoring of HIV programmes at all levels (see section 5.1).

3.3.3 Because of the growing global market for paid care

'We have to face the reality that many of our women will be compelled to leave the confines of their own tidy bedrooms and their spotless kitchens only to clean another household, to mend another's torn clothes, and at the same time mend our tattered economy.'

Layosa, in Zimmerman et al. 2006: 52

Paid care services are making up a growing sector of the economy, particularly in middle- and high-income countries. The reasons for this have already been discussed. They include rising female education levels and aspirations, and resulting increases in women's participation in the paid labour force – reducing the availability and willingness of women to provide unpaid care. They include greater geographical mobility, which means that many women no longer live near their families who used to provide unpaid care. They also include the growing *demand* for care in many middle- and high-income countries – a consequence of ageing populations. While poor working women generally turn to family, kin and neighbours for help, more affluent women turn to the market (Kabeer 2007).

In low- and middle-income countries, commercial services providing quality care tend to be underdeveloped and are too expensive for most households (Razavi 2007a). Instead, it is mostly at the informal end of the market that care is provided – namely through the employment of domestic workers in middle-class homes. Domestic workers perform for remuneration the many tasks that housewives and others perform unpaid, such as cleaning and cooking, and caring for dependents. While many countries have a long history of women migrating from rural areas to take up domestic service in urban areas, this work is increasingly being performed by women migrating across national borders, particularly into Western Europe and North America, but also into many fast growing regions of the South (Kabeer 2007). In Latin America, for example, women are migrating from poorer countries such as Bolivia, Paraguay and

Peru to work for more affluent families in richer countries such as Argentina and Chile; in Asia, women are migrating from poorer countries into high-growth countries like Hong Kong, Japan, Malaysia and Singapore (ibid.).

This phenomenon has been described as a 'global care chain' (Ehrenreich and Hochschild 2003) of women leaving dependents in the care of extended family members and migrating to wealthier countries or cities where they relieve more wealthy women of care responsibilities. Rather than creating conditions that might enable existing ways of organising and valuing care to shift, importing care workers displaces the problem, leaving inequitable gender divisions of labour intact (Zimmerman et al. 2006). At the same time, it does little to encourage better state provision of care services, or improved social protection measures for care providers.

These trends are not simply a reflection of the fact that wealthier women need care services and poorer women need employment (Ehrenreich and Hochschild 2003; Kabeer 2007). More fundamentally, they are about the politics of unpaid care work and the reluctance of men on the whole to take up a larger share of care and domestic work in spite of women's increasing financial contribution (Kabeer 2007). They also reflect the reluctance of governments to provide affordable and accessible public care services. The result is that global inequalities among women of different ethnicities, races and classes are increasing.

All paid care work is poorly paid and lacks social status, as discussed in section 3.1.3. But the care work that takes place inside domestic homes is of particular concern because of the invisible nature of such work – especially for the vast majority of domestic workers, who live with their employers. There is much variation in the way in which domestic workers are remunerated. Some receive money wages only; some receive only in-kind payment; some receive a mixture of the two. Receiving no payment beyond board and lodging is particularly common in respect of children, typically from rural areas, whom the employer may refer to as 'relatives' for whom they are providing care in return for domestic services. A recent study of child labour in Guinea by the ILO, based on interviews with over 6,000 children, found that only 6.8 per cent of boys and 5 per cent of girls were paid (HRW 2007). Where schooling is less available in rural areas, the employers may also promise access to education – although promises are not always kept. At the age of five or six, Dora was sent to live with her aunt:

'A woman [Dora's aunt] came looking for me; she wanted me to take care of her child. She promised that afterwards I would go to school or do an apprenticeship. But since I am there, the child has grown up, goes to school now, but not me. Up to now, it is me who does everything in the house...'

Dora, aged 14, cited in HRW 2007: 27

Whatever the form of payment, domestic workers tend to be among the lowest paid workers in the economy. There are also indications that abuses against domestic workers and violation of their labour

rights are widespread – including physical, psychological and sexual abuse; non-payment of wages; excessively long hours and no rest days; and forced confinement in the workplace (HRW 2006).

‘As a domestic worker, I had to clean the house, cook the food, wash the dishes, and go to the market. I had no breaks. I was the first one to get up and the last one to go to bed. I got up around 4:30 in the morning, with the first prayer call. In the evening I worked sometimes until midnight, while the other children were watching TV.’

Susanne, aged 16, Guinea, cited in HRW 2007: 50

Migrant domestic workers may experience additional vulnerabilities as a result of their precarious legal status and social isolation (ibid.; ILO 2003b). Common experiences of exploitation reported by domestic workers registered at Kalayaan, a UK organisation providing support to migrant domestic workers, include exceptionally low wages, non-payment of wages and no day off (68 per cent) and no meal breaks (66 per cent) (see <http://www.kalayaan.org.uk/>). The fact that they work in private homes isolated from co-workers also makes it more difficult for domestic workers to organise themselves into unions and stand up for their rights to decent pay and working conditions. Finding ways to better protect the rights of paid care workers, particularly domestic workers, to appropriate pay, decent working conditions, social protection, and the right to organise is, therefore, essential if both women and men are to benefit from the decision to migrate for work (see section 5.2 for examples of strategies for achieving this).

4. ADDRESSING CORE CARE ISSUES

The multiple care challenges outlined above bring the unsustainability and inequity of existing arrangements of care provision into stark relief, making a compelling case for the urgent need to engage with care as a core development and gender equality concern. The second half of this report focuses on the options available to governments, activists and those working in the development sector to address these pressing problems.

This section explores three development responses which, used in combination, offer the best prospects for change. The first is to bring about a more equal sharing of care responsibilities between women and men by challenging the gender norms which prescribe care work as women's work. The second is to produce greater recognition of the huge amount of the unpaid care work performed, and of the significant contribution this work makes to the economy and to human development more broadly. Finally, the third approach is to ensure that appropriate state policies and services are in place to reduce the burden of care on the household, and to lessen the disadvantages experienced by carers because of unpaid care responsibilities. Strategies to protect the rights of domestic workers and care providers for people living with HIV and AIDS will be considered in the following section.

4.1 Towards a more equal sharing of care responsibilities

'We are socialised in this way. If a man is ill it is a woman who looks after him, failing that his daughter, failing that his mother. But if a woman is ill she is sent home to her mother. It is not socially and culturally the role of men to be carers.'

Director, gender and HIV/AIDS organisation, Harare, unpublished interviews
conducted by Elaine Mercer, BRIDGE, Zimbabwe 2007

The stereotyping of certain tasks as 'men's work' or 'women's work' – in both unpaid and paid work – is prevalent in societies throughout the world, and there are strong social pressures on both women and men to conform to specified gender roles. This section will explore the social and cultural norms which underlie and reinforce widespread perceptions of women as 'natural carers' and which deter men from providing care. It will also look for exceptions to these norms – both as a starting point for thinking about what it takes for men and women to reject fixed gender divisions, and as a step in the necessary process of breaking down unhelpful gender myths about women as always and inevitably caring, and men as incapable of providing care. Lastly, it will explore strategies for change, giving visibility to some of the innovative work which is creating spaces for women and men to challenge gender norms and stereotypes.

While much of this section focuses on changing attitudes and related practices at the household and community levels, such efforts must be accompanied by provisions at the state level – such as affordable health care, childcare and elderly care – as discussed in section 4.3.

4.1.1 Care work: an affront to men's dignity?

Researcher: What do you boys think about this man washing a baby?

Girls and Boys: People would say he is mad, why would he wash a baby when there is a woman...Some would say he is being held by the nose by his woman.

Researcher: Do fathers here cook?

Boy: No they don't cook.

Researcher: Why?

Boy: They will lose their dignity so mothers are taking charge.

Interviews with children in Nkandla and Mhlontlo districts of South Africa, in Clacherty 2008: 32–3

Men's resistance to more active involvement in care and domestic tasks is driven by deeply held gender norms which create social barriers to men assuming care-giving roles (Peacock 2003). In a study of care providers for AIDS-affected people in South Africa, two male carers spoke of how men in the community saw them as 'deviants', doing unmanly duties, and sometimes teased them as a result (Akintola 2006). Similar findings have emerged from other studies, suggesting that a major deterrent to men's involvement in care activities is a fear of being ostracised by peers for doing what is conventionally seen as women's work (Flood et al. forthcoming).

The Centre for Communication and Popular Education (CANTERA), a Nicaraguan NGO, has found that men are often particularly resistant to doing household chores that directly attend to the needs of women and children, such as washing and ironing family members' clothes. While activities of a more general character, such as cooking, mopping the floor and running errands, were occasionally being taken on by some men who had been through CANTERA's gender training processes, the less visible, more mundane and often dirty work continued to be carried out by women (Welsh 2001). As such:

'It would appear that many men are prepared to help out now and again when circumstances demand or when other activities and priorities permit. Few, however, change their ideas of domestic work and enter into real solidarity with women, taking part in domestic chores to put the principle of gender equity into practice.'

Welsh 2001: 46

This is not always the case, however; in Argentina, Bulgaria, Ecuador, Jamaica and the Kyrgyz Republic research revealed an almost complete gender role reversal in households where men are unemployed and are at home while women are out working – with men assuming the majority of care and domestic tasks (Narayan et al. 2000). Other evidence suggests that, to the contrary, in contexts where large numbers of men are without work and are struggling to come to terms with the loss of their breadwinning status, men's reluctance to assume a fairer share of care responsibilities can intensify (Kabeer 2007). For example, research in Costa Rica showed that men who had lost or abdicated their responsibilities as primary breadwinners strongly defended their exemption from domestic work (Chant 2000). A study of retired or unemployed men in the Dominican Republic similarly revealed that almost none of the men regularly helped their working wives with childcare or domestic work (Safa 1999, in Kabeer 2007). It may be that men are 'protecting the remaining vestiges of masculine identity in a world where women are increasingly encroaching on their breadwinning roles' (Kabeer 2007: 50). It may also be that men perceive it to be in their interests to preserve the privileges they have as a result of their positioning within an unequal gender order, which exempt them from having to do the 'dirty work'.

Women and girls often play a part in reproducing these norms. For some, this may be because they derive social legitimacy and status from their care-giving and domestic roles, particularly given the centrality of motherhood in cultural ideas of femininity in many societies (Chant 2002a; Molyneux 2007a). Providing care may also be bound up with proving one's own worth and avoiding societal disapproval for having 'failed' as a wife or mother. Or it may be that women resist men's help because this suggests to others that they do not have a 'real man' as a partner (Chant 2002a).

Women's resistance to men's involvement in domestic work – an example from Nicaragua

The complexities of challenging fixed gender norms and roles are starkly visible in an account of the work of the Nicaraguan NGO, CANTERA. CANTERA runs a course on Masculinity and Popular Education which includes reflections on fatherhood and responsibility for domestic work. One challenge they have encountered is women's resistance to sudden attempts by men to take on greater responsibility vis-à-vis domestic work. Many men, when they do try to implement small changes, often do so from a position of power – suddenly helping in the kitchen with no previous communication or consultation. Women often experience a sense of their space being invaded and of disempowerment, of losing control over an area of life that has been their domain and a source of identity and usefulness. This can lead to conflict, as the men feel their efforts are not being appreciated. To try to avoid these tensions, CANTERA works in alliance with women's organisations which are engaged in processes to bring about women's empowerment. This enables greater dialogue to take place and reduces the risk of men imposing changes (even when well meant) from their position of power.

Based on Welsh 2001

4.1.2 Exceptions to the rules

'In all parts of the world there are men who are aware of the straightjacket imposed upon them by traditional notions of masculinity, and who are more open to reassessing their roles and responsibilities.'

Barbara Stocking, Director of Oxfam GB, in Ruxton 2004: vii

While prevailing gender norms are powerful, not all men and women choose to conform to them. In Colombia, for example, many of the women working in the flower industry expressed their dissatisfaction with the unequal distribution of labour and took steps to overcome this – such as opting to live separately from their husbands to avoid having to do their cooking, cleaning and ironing (Kabeer 2007). Likewise, in the study of care-givers in South Africa cited above (Akintola 2006), the fact that the two male care-givers continued to provide care in the face of ridicule suggests that social pressures do not inevitably determine the choices people make.

Where women migrate independently of their spouse or partner, this can prompt a renegotiation of gendered arrangements of care provision in some instances. A study of Sri Lankan female migrants found that husbands of migrant women reported much higher levels of involvement in caring activities than husbands of non-migrant working women (Save the Children 2006, in Kabeer 2007). Despite this, fathers made up only 26 per cent of primary carers, with grandmothers making up 50 per cent and other female relatives comprising the remaining 24 per cent (ibid.). In-depth studies from the Philippines have also found that men assume a more involved care-giving role in their wives' absence and report a greater appreciation for the work traditionally done by women. Only a few opted for a full-time caring role, however. Often this is because the men are themselves in full-time employment and the money they earn is sorely needed. In other cases it may have more to do with entrenched ideas about care being a women's job, or with men's unwillingness to give up their privileges and take on the low-status duties associated with women.

Nonetheless, by recognising the care that some men provide, we are able to go beyond a set of stereotyped assumptions about gender relations in which women always care and men are always resistant. Acknowledging the role that some men play in care provision can in itself be an important strategy in encouraging other men to reject the gender norms which deter their involvement in care work (Flood et al. forthcoming). It also draws attention to the fact that men are not shaped irrevocably by gender norms but can choose to act differently (Greig 2006). The question then is not whether men can change, but rather which policies and programmes best catalyse and support these changes (Peacock et al. 2008). The remainder of this section will provide examples of innovative initiatives which are encouraging women and men to challenge gender norms – focusing on gender trainings, educational activities and media campaigns; public education and curriculum design; and parental benefit and leave policies.

While the focus here is on unpaid care, initiatives are also needed to bring about a less gender segmented labour market in the care professions, for example through proactive efforts to recruit male

care workers – and not only into management positions (see the SRC for an example of an initiative by Oxfam GB to challenge gender stereotyping in a marginalised community in the UK by recruiting male care-givers).

4.1.3 Gender trainings, community education programmes and campaigns

Programs H and M in Brazil – questioning accepted gender norms

Promoting critical discussion of traditional gender norms and roles is precisely what the Brazilian-based Program H Alliance set out to do. Program H ('H' for *homens*, 'men' in Portuguese, and *hombres*, 'men' in Spanish) was initiated in 1999 by the Brazilian-based NGO, Instituto Promundo, and partner organisations, in collaboration with young men from low-income communities in Brazil and Mexico. The programme works in group educational settings and at the community level to promote reflection on the costs of 'traditional masculinity'. A training manual series and educational video have been developed, including a manual on fatherhood and care-giving (see the SRC for more information). Questioning the assumption that men are not concerned with care-giving, the manual focuses on how young men themselves define care-giving and the place it has, and should have, in their daily lives.

To assess changes in attitudes resulting from project activities, Program H has developed a Gender-equitable Men Scale (GEM) consisting of 24 attitude statements. In Brazil and India, young men were asked to respond to the statement 'giving the kids a bath and feeding the kids are the mother's responsibility'. In urban areas, 91 per cent of men initially supported the statement – falling to 84 per cent after participation in programme activities. In rural areas, 79 per cent of men agreed at first – falling to 66 per cent after the training.

Instituto Promundo and partners have recently developed Program M, a complementary initiative to promote young women's empowerment. As part of this initiative, 30 young women and men from low-income communities in Brazil came together to design a radio-based soap opera called *Entre Nos* ('Between Us')¹⁴. It addresses a range of issues related to women's empowerment and gender equality, including parenthood and shared care-giving, first sexual experiences and unplanned pregnancy. It is played on community radio stations and in a range of settings where young people spend time – community centres, schools, beauty salons, snack bars, and at large community events. Following the airing of the episodes, peer educators facilitate discussion groups with youth to reflect on the storyline and its connections to their own lives and relationships. And attitudes are starting to change:

'Many people... questioned: 'Why can a man do this and I can't?' 'Why do women get beaten so much?' ... 'Why don't men take care of the house?' I think that the group was able to...make people think...put in their heads 'Look, this is our reality but does it have to keep being this way?'

Samuel, a male peer educator, from personal communication with Christine Ricardo

¹⁴ This example is based on personal communication with Christine Ricardo from Instituto Promundo.

See section 5.1 of this report for a case study of Sonke Gender Justice's PhotoVoice Project in South Africa, which is also encouraging men to reflect on their roles and responsibilities – in particular in relation to caring for children affected by HIV and AIDS.

4.1.4 Public education and curriculum design

The school system can be another powerful entry point for promoting equitable gender relations and a diversity of male and female roles. Conversely, it can also be a dominant source of gender bias and stereotyping. For example, there are numerous examples of gender stereotyping in school textbooks. Women and girls tend to be represented in a limited range of subordinate, nurturing roles – as wives and mothers or doing low-income and unskilled employment (UN Millennium Project 2005a; Leach 2003; ADEA-WGHE 2006). Men and boys, on the other hand, are rarely depicted in the home or carrying out domestic activities; instead, they are portrayed doing 'productive' work in the public sphere. This fails to reflect the diversity of male and female roles and limits the kinds of futures girls are able to imagine for themselves (Kabeer 2005).

Instead, textbooks should promote the multiple roles of women and men. Women and girls should be represented in non-traditional employment and leadership roles in the public domain alongside more traditional images of motherhood and care-giving; men should be depicted sharing care-giving responsibilities in a family context as well as working in the public sphere. Both CEDAW and the BPfA commit governments to taking measures to eliminate stereotypical representations of women and men within the education system, and to challenge the gender division of labour (see the box below). Gender equality and human rights activists should mobilise around these existing commitments to put pressure on signatory governments to take action. This is especially important in the light of the narrowness of the indicators developed for monitoring progress towards the official MDG3 target of eliminating gender disparity in education¹⁵, and the omission of any clear indicator¹⁵ to measure progress in reducing gendered stereotypes in the content of educational materials (Elsoufi 2004).

CEDAW

Article 10

State Parties shall take all appropriate measures to ensure:

(c) The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods. UNDAW 2008,

see <http://www.un.org/womenwatch/daw/cedaw/index.html>

¹⁵ The official target was to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The official indicators are: the ratio of girls to boys in primary, secondary and tertiary education; and the ratio of literate women to men, aged 15–24.

BPfA**Paragraph 179**

Governments should:

e. Develop policies, inter alia, in education to change attitudes that reinforce the division of labour based on gender in order to promote the concept of shared family responsibility for work in the home, particularly in relation to children and elder care;

UNDAW 2008, see <http://www.un.org/womenwatch/daw/beijing/platform/>

Several tools and checklists have been developed to assist with reducing gender bias in learning materials. The box below presents guidance from two manuals on eliminating gender bias in textbooks.

Encouraging positive representations of diverse gender roles in educational materials

- Deliberately portray women and girls in a wide range of positive roles.
- Apply a role-reversal to portray males and females in atypical roles (e.g. a boy cooking, a woman driving a car).
- Increase the portrayal of women in the public sphere – in economic and political roles as well as social, and in leadership roles (e.g. Member of Parliament, director of a company etc.).
- Place greater emphasis on female intellectual and professional capacities.
- Increase the portrayal of men in the private domain, in a family capacity, and sharing domestic duties.

Adapted from Sifuniso et al. 2000, in Leach 2003: 120–1

- Avoid stereotyped family scenes such as the woman cooking and the man reading a newspaper, the boy playing football while the girl mends clothes or fetches water. Instead show the man playing with the children or working in the kitchen, the woman reading the newspaper or playing with the children; show the girl playing football and the boy mending clothes; or show both parents playing, reading, sharing domestic and childcare responsibilities, both the girl and the boy mending clothes etc.
- Avoid stereotyped pictures of occupations and activities: show a female pilot or engineer, or a male nurse or nursery or primary teacher; avoid girls playing only with dolls, and boys with bricks or cars.

Adapted from UNESCO 1997: Section 8, in Leach 2003: 120–1

Revision of textbooks does not necessarily mean they will be used in a gender-sensitive way, however – pointing to the need for teachers to receive ongoing gender awareness training.

4.1.5 Parental benefits and leave

Policy and legislative measures offer an alternative avenue for encouraging shared parenting and gender-equitable relationships. This is recognised explicitly in the BPfA, which commits governments to:

‘Ensure, through legislation, incentives and/or encouragement, opportunities for women and men to take job-protected parental leave and to have parental benefits; promote the equal sharing of responsibilities for the family by men and women, including through appropriate legislation, incentives and/or encouragement, and also promote the facilitation of breast-feeding for working mothers.’

BPfA 1995, paragraph 179d, cited at UNDAW 2008

The Scandinavian countries are particularly progressive in this respect. In Iceland, no distinction is made between paternity and maternity leave, but a nine-month paid leave after childbirth at 80 per cent of salary is granted instead (ILO 2007). This leave is split into three equal parts between the mother (whose share is non-transferable), the father (whose share is non-transferable) and the couple (which can be taken by either the mother or the father). There have been some encouraging changes as a result: in three years the average number of days taken by fathers in Iceland after the birth of a child increased from 39 to 83 (ibid.). In Sweden, a couple that has a baby is entitled to a total of 480 days of paid leave, the cost being shared between the employer and the state. At least 60 of the 480 days are forfeited if they are not taken by the second parent. In 2002, men accounted for 15 per cent of the parental allowance, an increase from 12 per cent two years earlier. While the burden is still unequal, there is more sharing than in other countries, where all the leave is typically taken by the mother (Björk 2004). However, evidence from Scandinavia suggests that parental leave policies intended to increase men’s involvement in family life are often compromised if men think that their own career progression will be damaged if they take paternity leave (Esplen and Greig 2008). More attention is needed for gender awareness work at the management level to help address this – see the slide below, which is from a campaign based in a corporation in Brazil, developed as part of the Program H initiative described above – urging men (and senior management) to allow men more flexible time.



'In your work and in your life, what kind of man are you?'

While this degree of government support may not always be possible in lower-income countries with limited state resources, positive examples from Brazil suggest this need not be the case. In Brazil, several states offer one month of paid paternity leave at the time of birth for government officials. There is also a national law being debated in dialogue with civil society representatives which would grant all fathers 30 days of paid paternity leave upon the birth of a child (or adoption) (Flood et al. forthcoming). Initiatives like this promote the idea that men have something positive to contribute to their families, which can be influential in terms of breaking down gender stereotypes and encouraging men to take a more active role in providing care. However, the impact of providing maternity or paternity benefits is often limited in lower- and middle-income countries by the fact that the bulk of the labour force is informally employed and will, therefore, have no access to the benefits.

4.1.6 Gaps in existing work and priorities for the future

The pioneering work of organisations like the Brazilian NGO, Instituto Promundo, clearly show that yes, men can change. On the whole, however, beyond innovative work on fatherhood, some of those working on masculinities and gender equality have been slow to talk about domestic and care work, including

issues such as who does the housework or cares for elderly, sick or disabled people. It is important that these issues are incorporated into gender training programmes aimed at men and boys alongside the more common focus on safer sex and anti-violence.

Gender transformative work must also go beyond small-scale interventions, which are often of limited duration and targeted at bringing about changes in individual attitudes and behaviour through workshops and trainings. While such initiatives are very important, interventions which challenge the social, economic and political institutions that sustain gender inequalities are also needed. One approach is to build the capacity of men and boys to take a stance for greater gender equality in alliance with women's rights and social justice activists. Examples might include advocating for better protection of the labour rights of domestic workers, or calling for greater public responsibility for care for people living with HIV.

This section has explored some of the practical approaches for challenging the gender norms which shape what is regarded as women's work and men's work, in order to instigate a shift in the gender distribution of care work. The next section will focus on strategies for better *valuing* unpaid care – a crucial step in terms of convincing decision-makers to take care more seriously when making policies and allocating budgets.

4.2 Re-conceptualising unpaid care as valuable and productive

'Women have challenged conventional views [of economics] and proposed new visions of economic life in which women's activities *count*, in several senses: counted in statistics, *accounted* for in representations of how economies work and *taken into account* when policy is made.'

Elson 2000: 21, emphasis added

The unpaid care work performed disproportionately by women is typically taken for granted by governments, economists and society at large, as discussed in section 3.1.3. This section will consider what is needed in order to *re-conceptualise* unpaid care as valuable and productive.

Several strategies are needed. The first is to measure the huge amount of care work performed and the extent of the gender imbalance in the distribution of this work. By measuring the amount and gender distribution of care work, gender equality advocates can access the 'hard' evidence often needed to convince government to view care as a serious policy issue (Moser 2007). A second step is to assign a monetary value to unpaid care work. This is important to challenge perceptions that this work is unproductive and does not contribute to the wealth of society. It also makes evident the fact that care work does not come without financial costs, and that some policy prescriptions show gains only because they do not incorporate all of these costs, including the costs of unpaid care¹⁶. This valuation could encourage

¹⁶ For example, health care sector reforms may reveal savings by reducing the number of days patients spend in hospital, without contemplating the time and labour costs for the families, particularly for women and girls.

decision-makers – particularly those with economics backgrounds – to take unpaid care more seriously, and to ensure that public investment serves the needs of those engaged in unpaid care, as well as those involved in marketed production.

Thirdly, concerted lobbying is needed by civil society organisations, including gender and women-focused women’s organisations, to put pressure on Ministries of Finance to push for changes in the SNA rules. The SNA rules are not set in stone. Indeed, it was only in 1993, and after intensive lobbying by some developing countries and those concerned about non-recognition of women’s work, that unpaid production of goods (for example, subsistence agriculture) was included. Given the central importance accorded to the GDP measure by bodies such as the World Bank and International Monetary Fund, as well as by private investors, the inclusion of unpaid care work in calculations of GDP would serve as a constant reminder to the top policymakers that unpaid care work exists – and in large quantities – and that it contributes to the wealth of society. Until the SNA rules change, the only option available to countries is to compile ‘satellite accounts’ to measure and quantify the value of the output of unpaid work in the care economy (Elson 1999). Some countries now have these satellite accounts, including Australia, Canada, Switzerland and the United Kingdom (Razavi 2007a). The problem with this approach is that policymakers are less likely to take parallel satellite accounts seriously than if unpaid care work were included in the main national accounts (see the SRC for more information on satellite accounts).

4.2.1 Measuring care

There is no obvious money measure for unpaid care work, because of its non-financial nature. Nor is there an obvious measure of what is produced, because unpaid care work produces intangible services (Budlender 2004a). The best option is to find out whether people have done any unpaid care work and how many hours they worked.

Time-use surveys are the most common way of measuring this. These surveys ask women and men how much time they spend on different activities during a typical 24-hour day, particularly in relation to unpaid care activities. Sometimes this is done by completing a time diary which records what activities a person did in a given day. Sometimes it is done by asking people how much time they spent, or typically spend, on each of a number of specified activities during a day or week.

Time-use surveys, therefore, show who bears the burden of different types of care at the household level, and how individual women and men combine care work with other activities, including paid work and leisure. They have been less effective at capturing unpaid care work that occurs in intermittent bursts (rather than discrete activities which have a defined beginning and end), or care work which overlaps with other activities, such as looking after a child whilst also cleaning the house or tending a market stall (Razavi 2007a). But this is a design issue rather than an inherent weakness of time-use surveys (see Budlender 2007d for a discussion of how time-use surveys could be better designed to capture unpaid care work).

Convincing government to conduct a time-use survey

Civil society actors cannot easily conduct a national time-use survey themselves, given the level of statistical expertise and specific time-use expertise required, and the costs involved. Ideally, a time-use survey should be carried out by a national statistical agency, since they have the capacity and legitimacy to conduct surveys of the size required for reliable results, and can build time-use surveys into their regular survey cycle.

Civil society can play a key role in encouraging and assisting the national statistical agency to conduct a time-use survey. In Tanzania, for example, the Tanzania Gender Networking Programme (TGNP), a well-known NGO, organised workshops for government officials from the Ministry of Finance, the Planning Commission and the National Bureau of Statistics, on the importance of accounting for unpaid care work when developing policies and budgets. It explained how time-use data could be used in the macro-economic modelling that informs the government's budgeting and policy. It also conducted small-scale research to reveal the time spent by members of AIDS-affected households on care work. After several years of research and advocacy, TGNP's efforts resulted in a decision by Tanzania's National Bureau of Statistics to add a time-use module to the 2006 Integrated Labour Force Survey (Budlender 2007d). TGNP provided the necessary technical assistance, including around training and monitoring.

Using time-use data to effect policy change

Although time-use surveys are too new in most developing countries to expect real impact at this stage, there are examples of where time-use data have led to positive policy changes in developed countries (see the box below).

Time-use data leading to policy change in Australia

In Australia, time-use surveys carried out by the government in 1987, 1992 and 1997 helped to make policymakers aware of the need to account for unpaid care work. Policy changes introduced as a result included subsidised childcare services and job training schemes to encourage women's take up of paid employment. The government also provided incentives such as tax relief and parenting allowances so that parents (mainly mothers) of young children could stay at home and look after them. These measures were relatively successful. Where the government was less successful was in influencing behaviour in the home and family: each new time-use survey showed that women in Australia continue to do the bulk of unpaid care work.

Adapted from Budlender 2004a: 52

Having time-use data does not automatically lead to policy change, however; data must be used in advocacy if they are to be influential. However, existing time-use data have not been used as much as they could be, particularly by women's organisations – in part because they often lack the quantitative

skills needed to analyse the data. According to a statistician of the Australian National Bureau of Statistics:

'In some areas, such as gender equity, information collected in time use surveys in Australia has had a direct bearing on public policy. In other respects, time use data are more or less untapped resources which have the potential to inform social and economic policy. To a large extent, time use data appears to be the province of statistical agencies and specialist researchers. Our task is to communicate the informative power of the data to a wider audience of policy makers.'

Webster 1999: 1, in *ibid.*

It is down to government statistical agencies, particularly gender statistics units, and others with strong quantitative skills to build the capacity of civil society organisations and policymakers to analyse the data so that they can be *used* – both to advocate for care as a serious policy issue, and to better inform social and economic policies.

Measuring care work in other ways

Time-use surveys measure the time spent by individuals on unpaid care work and other activities. Other sources of data can be used to get a sense of the 'size' of other types of care work. For example, as part of a United Nations Research Institute for Social Development (UNRISD) research project on the Political and Social Economy of Care¹⁷, researchers collected data on:

- The amount of money spent by government on salaries in care-related government sectors such as education, welfare and health. This gave a measure of paid care work inside government which could be compared with the amount of unpaid care work done by society at large. This revealed the extent to which governments in different countries were providing care rather than placing the burden on ordinary citizens, particularly women.
- The amount of money earned in the economy as a whole by people in care-related occupations. This gave a measure of the remuneration of care work across both public and private sectors.

4.2.2 Assigning a monetary value for unpaid care work

Once time-use data are available, it is possible to estimate a monetary value for unpaid care work. This is usually done by assigning an hourly 'wage' to the time spent on care. There are two main approaches to deciding on the appropriate wage. The first approach is to ask how much the person who does unpaid care work would earn if they did paid work instead. The second is to ask how much the person doing the unpaid care work would need to pay someone else to do the work for them. In both cases, information on wage levels is taken from other surveys, such as labour force surveys which most countries conduct (see Budlender 2004a for a critique of these approaches).

¹⁷ The research, based on case studies of Argentina, India, Republic of Korea, Nicaragua, South Africa, Tanzania, Switzerland and Spain is exploring how – in these eight very different countries – care is provided by the state, private sector, 'community' and in the home.

The UNRISD research project mentioned above provided estimates of the ‘size’ of unpaid care work compared to a country’s GDP using the second approach¹⁸. The calculations showed that in South Africa the value of all unpaid care work carried out was equivalent to 15 per cent of total GDP, while in India it was equivalent to 39 per cent. These comparisons emphasise that the contribution of unpaid care work to the economy is significant and should not be ignored when making policy and drawing up budgets, nor when calculating GDP.

Once economists have a monetary value for unpaid care work, they can experiment with building the care economy into the macro-economic models that governments use to inform budgets and policy. There is limited experience of this sort of modelling to date, but there is evidence of the potential of such models for highlighting gender implications of different policy decisions (see, for example, Fontana 2002).

Sections 4.1 and 4.2 have considered the social and economic dimensions of care, respectively. However, for holistic solutions to be developed, a more unified approach is needed – based on greater dialogue between those working on the economic aspects of care, and those seeking to bring about fundamental changes in attitudes and behaviour.

4.3 Social policy options

Gender advocates have proposed a range of policy measures to better guarantee the rights and inclusion of those who perform unpaid care. This section will discuss these different options, considering their advantages and disadvantages from a gender equality and pro-poor perspective, and will provide examples and ideas for action. Some policies are designed to ensure that carers are not penalised because of their unpaid care responsibilities – primarily by providing financial compensation to offset the costs incurred in providing unpaid care. Others focus on expanding the choices available to women by ‘freeing’ them from the responsibility to provide ongoing care for dependents – either by providing alternative, public sources of care, or by encouraging men to assume greater responsibility for care (as discussed in section 4.1.3). Policy options to protect the rights of paid care workers are discussed later in section 5.2.

4.3.1 Lessening the burden of unpaid care

‘We need boreholes because we rely on unsafe water from streams and unprotected wells. It is a critical problem because most of these streams and wells dry out during the dry season. We have to travel long distances searching for water.’

A participant in a discussion group of poor men and women in Malawi,
in Narayan et al. 2000: 72

¹⁸ Argentina is excluded from the comparison because the time-use survey covered only the City of Buenos Aires.

There are various ways in which the burden of unpaid care can be lessened. While these do not change *who* does the work, they can help to reduce the disadvantages endured by primary carers because of their responsibilities for care. Moreover, if the work is less burdensome and time-consuming, those who are currently resistant to assisting with domestic tasks might be more prepared to assist. In South Africa, for example, the 2000 time-use survey found that men were more likely to be involved in the collection of fuel and water where these were relatively near to the dwelling than when they were far away (Budlender et al. 2001).

Provision of electricity, and water in or near the home, are some of the most important ways in which the burden of care work can be reduced in poorer countries where such infrastructure is not in place, particularly in remote areas. Easier access to fuel and water lessens the time women and children must spend collecting these resources and makes it quicker to complete tasks such as cooking and cleaning. In addition, adequate safe water and fuel contributes to the health of family members and reduces the time care-givers spend looking after sick people. The Millennium Project Taskforce on Water and Sanitation also notes that mothers with improved domestic water services are better able to care for their children, in part because they devote less time to fetching water and seeking privacy for defecation, which in turn contributes to reducing child mortality rates (UN Millennium Project 2005b). In addition, access to fuel and water in the home facilitates home-based income-earning activities such as hairdressing and cooking, making it easier for those responsible for unpaid care to combine paid work with their unpaid care responsibilities.

4.3.2 Cash payments

'One of the conundrums facing the design of family/child benefits is how to support families yet without enforcing a uniform model of the family which naturalizes motherhood as women's lifetime vocation (often in contradiction to their daily reality of having to balance care with some form of paid work) while excluding men from the domain of care.'

Razavi 2007b: 391

Over the years, there have been calls for the state to provide some kind of cash payment for women in the form of mother's stipends or wages for housework. From a gender equality perspective there are difficulties with this approach since it tends to confirm women as natural care providers. A care-givers' allowance or citizens' wage can be more gender neutral, being open to women and men in a variety of household and caring arrangements (Razavi 2007a).

Child and family support allowances (universal benefits going to all households with children) are particularly common in developed countries, where grants are available to primary carers. They are also common in Latin America, where they are typically given to care-givers of poor children (Sedlacek et al. 2000). The grants are seen as a contribution to the costs of bringing up children rather than as compensation for care; but to the extent that children generate a need for care, the grant reaches those

with an extra care burden and can help to offset the financial costs incurred by unpaid carers due to loss of income. However, for this to happen, mechanisms are needed to ensure that grants reach the primary carer rather than going to the head of the household, who may or may not be the primary carer. A common criticism of family and child allowances is that they only cover a small amount of the cost of bringing up children (Folbre 1994).

The last decade has also seen a growing emphasis among international donors on cash transfers as a way of investing in children's capabilities (Razavi 2007a). Unlike child and family support allowances, which are universal, cash transfers are selective – targeted at poor families. Cash transfers are often accompanied by conditionalities requiring 'good' behaviour on the part of care-givers; for example, receipt of cash or vouchers may be conditional on the child attending school or being fully immunised. This tends to penalise those who are already disadvantaged, since it is precisely the poorest children who are likely to face obstacles accessing health and education services. Cash transfers also do little to improve the quality of public health and education services, especially in poor and remote areas. When considered from a gender equality perspective, there are other disadvantages:

- the payment is often at a low level and allows for few social security or employment rights;
- cash transfers tend to strengthen the provision of care by family members – most often mothers – absolving the state of responsibility;
- although cash payments can help to valorise the care work women do, they also reinforce gender stereotypes of women as natural carers (see the example in the box below).

Razavi 2007a

Oportunidades – a conditional cash transfer programme in Mexico

The most well-known and extensively evaluated conditional cash transfer programme is the Oportunidades programme (formerly Progresa) in Mexico. Oportunidades aims to reduce poverty by providing mothers with cash transfers. But these payments come with conditions: mothers must agree to fulfil certain duties, including taking children for regular health checks, meeting targets for ensuring their children's school attendance, attending health workshops, and giving up time to work in the community on activities such as clearing rubbish.

Oportunidades has been widely praised for improving school attendance, putting the importance of girls' education on the policy agenda, and improving women's self-esteem (see Eldis 2006 for evaluations of the programme). However, it has also been criticised for adding to women's responsibilities and reinforcing the traditional division of labour. Rather than seeking to incorporate men into the programme, any actions to improve the well-being of children are simply assumed to be 'part of the mothering role'. There is also little in the design of the programme to enhance women's economic security, or to provide childcare provision for women who might want or need it because they work or study. The programme, therefore, depends for its very success on women fulfilling their traditional social roles and responsibilities.

Adapted from Molyneux 2007a: 23–30

This example illustrates how the provisions offered by governments or donors, and the conditions attached to the receipt of these provisions, can serve to reinforce particular models of the family, and of gender roles and relations, and delegitimise others (Razavi 2007a). On the other hand, provisions can be designed in ways that are more gender neutral. In South Africa, for example, the State Maintenance Grant for women was replaced in 1996 with the Child Support Grant (CSG) which is open to the primary carer – male or female – on behalf of the child. While in practice it continues to be the biological mother who generally claims the grant (Kabeer 2008), the move has been seen by some as an important symbolic shift away from the male breadwinner/female care-giver model of the household towards an appreciation of the diversity of family and care arrangements in South Africa (Razavi 2007a). However, in the absence of a comprehensive public education campaign, many male care-givers are unaware that they are entitled to the grant. Some feminists have also been critical of the change, arguing that whereas the State Maintenance Grant had provided some mothers with an income of their own, the CSG earmarks all the money for the child (Kabeer 2008). However, unlike the Oportunidades programme, receipt of the grant is not conditional on the carer attending nutrition and hygiene classes or carrying out unpaid work in the community – so not further compounding work burdens.

4.3.3 Pensions

Many countries have some sort of pension system which is meant to cover the financial needs of elderly people when they are no longer able to earn. However, where pensions are tied to contributions made while employed, there is an immediate bias against women, as they are less likely than men to have been in formal employment. The interrupted character of many women's working lives – as a result of having to take time off from formal work to care for dependents – means that even where they are covered by contributory pension schemes they lose out relative to men because of their lower contributions over their lifetime (ibid.).

The privatisation of pension provision, particularly in Latin America and Eastern and Central Europe, has exacerbated these existing gender inequalities (see Razavi 2007b). This is because the amount of benefits an individual receives in privatised systems is determined by their individual record of earnings. In state systems, by contrast, the disadvantages experienced by women are usually mitigated by generous minimum pensions, by re-distribution towards low-income groups, and by credits that are sometimes given for years spent caring for children (ibid.). State old age pensions which are not linked to employment are most gender equitable, and are also more equitable in class terms – although they still rely on women and men being in formal employment. One example is the South African Old Age Pension system, a non-contributory scheme financed from general state revenue rather than individual contributions (see ibid.). However, where employment-related pensions exist, they can be expanded – as in the Argentinian case described below – to cover those in informal employment, or even those doing unpaid work in the home.

Pensions for 'housewives' in Latin America

Some countries in Latin America have implemented innovative mechanisms to ensure that women who are responsible for unpaid care work in the home have an assured income in old age. In Argentina in the early 2000s, the pension rules were changed to allow those (including unpaid carers) who do not contribute to social security schemes because they are not formally employed, to register and contribute to the pension fund. When these contributors reach retirement age, they will receive a pension equal to 80 per cent of the minimum wage. Other Latin American countries have made similar provisions. In Ecuador, housewives (typically defined as women 'not in the labour market') have been entitled to pensions since 1964. In Venezuela, the 1999 constitution establishes that 'the State shall recognize work in the home as an economic activity that creates value added and produces wealth and social well-being. Housewives are entitled to social security under the law'. In all three countries, housewives' pensions are partly financed by individual contributions from the unpaid carer, but the main resources come from a fund which is maintained by contributions from other workers and public funding.

Based on Giménez 2005

4.3.4 Tax credits or benefits

In more developed countries, the tax system may compensate those with care responsibilities. Typically this takes the form of a tax credit or benefit, where a household or individual who is responsible for the care of a child pays less tax. Sometimes similar credits or benefits are available for those who care for elderly, sick or disabled people. In Norway, for example, in 1992, care credits were introduced to compensate for the paid work time lost by individuals who cared for family members, including children under seven years of age and elderly, ill and disabled persons, if the work prevented the carer from doing paid work (Budlender 2004a).

4.3.5 Public care services

International legal and policy commitments with respect to the provision of public care services

CEDAW

States Parties must take all appropriate measures to 'encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities'.

CEDAW, Article 11

BPfA

'Governments, NGOs and the private sector should provide affordable support services, such as high-quality, flexible and affordable child-care services, that take into account the needs of working men and women.'

BPfA, paragraph 173

The restrictions that unpaid care work impose in terms of time and mobility can also be reduced through providing alternative sources of care for periods of the day, such as crèches for young children and daycare centres for elderly, ill and disabled people. Good pre-school education facilities, and accessible, well-functioning public health services requiring no out-of-pocket payment, are also important in terms of freeing the usually female primary care-givers to engage in other activities such as income generation, study or leisure. In Brazil, for example, mobilisation by mothers' groups, neighbourhood networks and parish priests resulted in a significant expansion of pre-school nurseries (Sorj 2001, in Razavi 2007a). Renewed policy interest over the last decade in 'investing in children' – in developed countries in particular, but also in many developing countries – could provide further opportunities for the expansion of pre-school education and a shift in education policies towards the provision of services for younger children (Razavi 2007a). Such provisions are imperative if women are to be genuinely empowered by economic opportunities.

The expansion of public services has several advantages from a gender equality perspective. Importantly, it reflects an acknowledgement of women's significant economic contributions and of the need to support their dual responsibilities for income generation and care work (Kabeer 2008). It also expands the employment options available to working women, particularly those from low-income households (Kabeer 2008; Razavi 2007a).

Care workers in the expanded facilities may not fare so well, however – often being expected to provide quality care for large numbers of people for very low pay. In Brazil, for example, a planned community-based childcare and education programme relied for its success on the unpaid or low-paid work of women without professional training. Advocates inside the country were successful in countering these proposals, which they argued were 'low cost' for government but instead imposed the cost on the women who did the care work for very low pay (Rosemberg 2006).

Elderly care insurance¹⁹

An important example of innovation in the public provision of care is to be found in the Republic of Korea (South Korea). In the past, the South Korean state had been heavily reliant on the family to meet welfare needs. This began to shift after the Asian economic crisis of the 1990s, when – in a context of growing

¹⁹ This case study is based on the draft research report by An and Peng 2008, the first in the series of UNRISD papers on the care economy in Korea, and on personal communication with Ito Peng who is co-leading the research.

poverty and rising numbers of single-parent families – women sought to take up new employment opportunities created by the deregulation of the labour market and the subsequent growth of non-standard (part-time and temporary) forms of employment. However, many women were constrained from taking up these opportunities by the lack of public childcare facilities. Meanwhile, falling fertility rates and the projected ageing of the Korean population were creating concerns about increasing care needs and longer-term reductions in labour supply and economic growth.

In response to these challenges, and partly as a result of feminist advocacy, from 2001–2, strong social policy initiatives were passed in South Korea, focusing on issues of employment and work/family harmonisation for single mothers and other working mothers. These included the National Child Care Plan, which commits the government to substantially increasing childcare facilities and government subsidies for childcare over the next ten years, and the Elderly Care Insurance, which was introduced in 2008. The Elderly Care Insurance entitles all citizens over the age of 65 to public care services according to the severity of their needs. It claims to cover a huge range of care services for elderly people, including help with domestic work and delivery of prepared meals, as well as full institutional care in nursing homes where necessary²⁰.

There was an active debate in South Korea as to whether recipients should be entitled to cash benefits or public services. The consensus was to follow Japan's example and limit elderly care insurance to service provision. This was partly due to concerns by feminist advocates that elderly people may not use cash benefits to purchase care services and could continue to rely on their wives, daughters or daughters-in-law to meet their care needs, as happened in Germany. However, the new childcare policies were motivated as much by the need to raise the country's total fertility rate to promote economic growth as by the need to promote equality by reducing women's burden of care. Like childcare, elderly care is seen as a new source of economic growth and job creation due to the need to train new care workers. What is more, it is seen as a socially and politically acceptable policy initiative.

Childcare facilities

In other cases, crèches or daycare centres are provided by civil society organisations. One example is the Self-Employed Women's Association (SEWA) in India, which has a crèche programme providing childcare support to its members – mainly women working in the informal sector. A survey of one of the crèche programmes found that while previously the women had only been able to work irregularly and part time, now they were able to work more regularly and generate higher incomes (Kabeer 2008). Seventy-five per cent of the mothers also reported that their older children were now attending school because they no longer had to care for younger siblings (Chatterjee and Macwan, in *ibid.*).

Another voluntary organisation, Mobile Crèches, has been working since 1969 to meet the childcare needs of informal women workers in the construction industry in India. It has around 369 day care centres located on construction sites and in slums in rural and urban areas of India, and reaches out to

²⁰ To be eligible for the elderly care services, citizens have to pay about 30 per cent co-payment during their working lives. People on very low incomes are exempted from insurance payment.

approximately 200,000 children across the country. The organisation approaches builders in potential construction sites about opening a crèche. Those who agree provide suitable accommodation, electricity and water. Mobile Crèches also provides employment opportunities to young women with a basic education, as well as skills training and basic advice on care-giving. It also has a more formal training programme for young women and men who would like a career in childcare. By creating opportunities for men to work in childcare – and in the caring professions more broadly – and by encouraging male employees to bring their children to work, initiatives to provide care services can prompt a shift in traditional patterns of responsibility for care-giving within the family.

This section has explored the different policy provisions available with respect to unpaid care, and has provided examples of policy initiatives already taking place in this regard. Steps to promote the participation of carers in the design, implementation and evaluation of social protection policies are key in terms of ensuring that policies are responsive to the specific needs and priorities of care-givers. Public care facilities such as childcare and elderly care services must be in place to free carers to participate.

For these policy options to be put into practice, however, major shifts are needed in how governments allocate their spending, so that care services are seen as a priority and are invested in appropriately. This is particularly true with regard to the provision of subsidised, high-quality public care services – an approach which carries heavy financial implications for state budgets but which is arguably the most positive policy option from a gender equality perspective.

5. ADDRESSING EMERGING CARE ISSUES

The challenges of meeting care needs in ways that are equitable, sustainable and effective are considerable across all societies. Yet – as discussed above – these challenges are particularly acute in contexts where the need for care is escalating due to HIV and AIDS or ageing populations. At the same time, as the global market for paid care grows, there is increasing advocacy pressure for major legal reforms and policies to better protect the rights and well-being of those who carry out paid care work. This section will explore strategies for responding to these concerns, looking first at the context of HIV and AIDS, and secondly at that of paid care work. In the case of care provision for elderly people, the range of appropriate social policy responses are similar to those related to care work more broadly and have been discussed in section 4.3 above – such as pensions and elderly care insurance.

5.1 HIV and AIDS

5.1.1 Mainstreaming gender and care into HIV and AIDS work

Care issues should be a central component of HIV and AIDS policies and programmes and must be addressed in gender-sensitive ways. The Joint United Nations Programme on HIV and AIDS (UNAIDS) has developed a checklist to provide HIV and AIDS educators and policymakers with a tool to assess the gender sensitivity of their programmes and policies, and of their own organisations. Gender issues in relation to care provision are fully integrated into the checklist (see examples in the box below).

UNAIDS Gender Sensitivity Checklist

Programme/policy development

Does your programme/policy...

- Occur at a time and place that is convenient to all participants, especially women and girls?
- Provide childcare for participants during programme activities?

Programme/policy implementation

Does your programme/policy...

- Encourage discussion about socially assigned gender roles affecting women, men, adolescents, and elderly people?
- Encourage men and boys to help with domestic tasks as women's lives are impacted by HIV? (Greater assistance with domestic tasks may be needed if a mother, sister or wife becomes ill, if she has to care for infected loved ones, if she has to begin to generate the family income etc.)
- Encourage men to become more involved in the care of their families?

Organisational structure

Does your organisation...

- Support the needs of employees, both women and men, with families? (For example, provide childcare facilities, allow employees to work flexible schedules, provide leave to care for loved ones etc.)

Adapted from Bunch 2003: 2–4

Gender-sensitive indicators must also be developed to monitor progress towards desired outcomes and impacts. One example might be the proportion of men trained as home-based care workers. Similar mainstreaming tools and checklists are needed to support practitioners to integrate care issues into their work in other key development sectors beyond HIV. This is a priority in terms of supporting the mainstreaming of care issues across all development interventions.

5.1.2 Supporting home-based carers to advocate for their rights

There are a growing number of care providers working for small-scale home-based care projects set up by networks of people living with HIV and AIDS or other civil society organisations. As discussed in section 3.2, most of these care providers work without pay, or for very little pay, and have little access to basic equipment such as gloves. To respond effectively to their needs, it is imperative that governments, donors and NGOs recognise the expertise of care-givers themselves, and ensure that community and home-based care organisations and networks are involved in the design, implementation and monitoring of HIV programmes at community and national levels (Global Coalition on Women and AIDS undated).

Political and financial backing is also needed to support home-based care-givers to articulate their priorities to decision-makers and advocate for their rights. One exciting initiative in this regard is the Home-Based Care Alliance in Africa which is aiming to shift resources and decision-making into the hands of grassroots women. Through peer learning and exchange, care-givers are identifying their own solutions to the challenges they face. And with support from the Huairou Commission²¹ and its member networks, they are developing their capacity to communicate their specific concerns and priorities to those who make the decisions on policies and resources related to HIV and AIDS. The process has been successfully piloted in Kenya and Uganda, and is currently underway in Cameroon, Nigeria and Rwanda.

Through peer exchanges and workshops, grassroots care-givers have come together to articulate the challenges they face and call for action (see the box below).

²¹ The Huairou Commission is a global coalition of networks, institutions and professionals that link grassroots women's community development organisations.

What do care-givers want? Huairou Commission members call on governments, donors and development professionals to:

- recognise care-givers as valued stakeholders by giving them a formal place in decision-making bodies at local, national, regional and international levels;
- earmark and monitor a fixed minimum percentage of all HIV and AIDS funding to go directly to support community-led responses to AIDS, particularly those being driven by women;
- support peer learning and networking among home-based care-givers to facilitate the transfer of knowledge, strategies, lessons learned and good practices;
- establish an official role for home-based care-givers as monitors and evaluators of national and international AIDS programmes;
- establish data and documentation banks outlining existing community programmes and successes so donors can locate these experts and mobilise and allocate their resources accordingly;
- provide funding to support grassroots women's organising in order to build constituencies and sustain long-term movement-building.

Adapted from the Huairou Commission Policy Brief undated

For a full list of policy recommendations see: <http://www.huairou.org/campaigns/aids/policy.html>

In addition to promoting advocacy and political participation, Huairou Commission member organisations provide practical training and support to care providers. For instance, at the request of its members in Kenya, GROOTS Kenya organised several 'training of trainers' workshops on home-based care in 12 regions of Kenya (Huairou Commission website).

5.1.3 Capacity building for older women carers²²

As discussed in section 3.2, the task of caring for AIDS patients and for orphans and other vulnerable children often falls on elderly women. Although numerous commitments have been made at the international level to take steps to understand and address the needs of older women carers in contexts of HIV and AIDS (see the SRC for more information), targeted assistance is still largely lacking in practice.

In Vietnam, for example, elderly people affected by HIV and AIDS are not recognised in national policies, nor do they receive any specific government support. In response, since 2005, the Vietnam Women's Union, in collaboration with HelpAge International and other local partners, has supported the establishment and capacity building of self-help groups for older people infected and affected by HIV. Each group is made up of at least 70 per cent older people, 70 per cent women, and 70 per cent people living with or affected by HIV and AIDS. Their activities include providing training on HIV prevention and caring for people living with HIV and AIDS, promoting self-care, raising community awareness about the impacts of HIV and AIDS on older people and of the important contributions older carers make, and

²² This example is adapted from Orbach 2007: 30–1.

providing livelihoods training and microcredit loans. The project also builds the capacity of club members to lobby the government for increased resources and services. Outcomes have included reduced HIV and AIDS-related discrimination within communities and families and increased awareness of the important role of older people in providing care for people affected by HIV and AIDS, as well as better livelihood options for older women carers due to increased access to credit.

5.1.4 Strengthening men's commitment to providing care²³

Studies often suggest that men are generally unwilling to provide care for people with AIDS-related illnesses, except in cases where women are unavailable (Akintola 2006), or where there is a tangible incentive involved such as payment or increased social status (unpublished interviews conducted by Elaine Mercer, BRIDGE, Zimbabwe 2007). However, the role that men and boys play in providing care in contexts of HIV has been poorly documented and may be under-recognised (Ogden et al. 2004). Moreover, high HIV and AIDS-related mortality in some countries has left many men with little choice but to take on a more active role in caring for their sick partners and meeting the care needs of AIDS-affected children (Desmond and Desmond in Flood et al. forthcoming).

Sonke Gender Justice (Sonke) is using innovative approaches to strengthen men's capacity and commitment to care for children, including orphans, affected by HIV and AIDS in rural South Africa. One aspect of Sonke's work is a PhotoVoice Project which trains children to use photography and writing to tell their own stories – about what being a girl or boy means to them; about how gender beliefs and practices in their communities affect their day-to-day lives; and about the roles men play in their lives, especially in contexts heavily affected by HIV and AIDS (Sonke 2008)

Extracts from the children's photojournals

'Before you cook first you are forced to fetch water in the river. At home they say it's a job of girls to fetch water. When I carry water I feel bad because at home there is no tap but other families have taps. I feel bad because when I fetch water it is heavy and I have a headache.'

Sonke 2008: 17

'This child [in the photo] washes her sister. She takes care of her sister...while their mother is in Johannesburg to find money for food. I feel sorry for this child, [be]cause she is also a child and she can't take good care of her sister because she also need[s] someone old to take [care] of her.'

Ibid.: 24

'This is a [photo of a] man ironing for his wife. He is doing gender equality. I love [a] man like this.'

Ibid.: 20

²³ This case study is adapted from Sonke 2008.

Rigid gender roles, inadequate health services and poor access to clean running water are just some of the common concerns emerging from the children's photojournals. To promote awareness of these problems, the photojournals are being used to create educational materials such as posters and stickers which are being exhibited in schools and local municipal offices, and in government offices at the provincial and national level. The exhibits will be interactive – next to each poster will be a question written by Sonke but derived from the content of the child's writing, posing a challenge to the men/fathers/parents in the community. Sonke is also using the materials in workshops and community education initiatives with men – with fathers, teachers, traditional leaders, government officials and NGO staff – to encourage reflection on the children's stories. Why do men feature in so few of the children's pictures, for example? What does this say about men's involvement in providing care for children, especially in contexts where high HIV prevalence has left many children orphaned and many women shouldering the burden of caring for children and chronically ill people? With support from workshop facilitators, the men are encouraged to commit to actions to share responsibility for caring for those who are sick, and for children affected by the pandemic.

Boys are also encouraged to reflect on the images and narratives to strengthen their understanding of the reality of girls' lives – including the gendered nature of care and domestic work such as collecting water and fuel, and the impact this has on girls. They too are supported to commit to actions to share care responsibilities typically assumed by girls. In the words of one boy: 'I used to say girls should wash dishes, cook, sweep the floor, and clean the house, but now I know that we are equal' (Sonke 2008: 10).

5.2 Protecting the rights of domestic workers

5.2.1 Providing protection for domestic workers under national labour laws

Many governments regard domestic work as being beyond the scope of regulation, so denying domestic workers the labour protections extended to other workers – rights to decent working conditions and minimum wages, to basic benefits and protections such as health insurance, and to freedom of association (HRW 2006). Hong Kong is one exception, guaranteeing domestic workers (including migrants) the right to a minimum wage, a weekly day of rest, maternity leave and public holidays. In part this is because domestic workers in Hong Kong are among the best organised. Encouragingly, gender advocates have had other successes in lobbying governments to pass legislation protecting the rights of domestic workers in countries such as Argentina, Chile and South Africa (see the box below). Combined with the freedom to form associations and trade unions, domestic workers in these countries have greater awareness of their rights, an ability to negotiate better working conditions, and access to legal avenues for reporting labour exploitation (HRW website).

Increased protection for domestic workers in South Africa

In South Africa, domestic work is the most common single occupation for women (Statistics South Africa 2007). After the ending of apartheid in 1994, basic labour protections were extended to domestic workers, and in 2002 they became entitled to minimum wages and conditions. At the same time, the rules of the Unemployment Insurance Fund were changed to cover domestic workers alongside all other employees. The Fund provides for payment of a proportion of the wage to workers when they are on maternity leave or, for a limited period, if they become unemployed. These reforms were widely advertised through a campaign that included frequent radio broadcasts and advertising on public transport.

Comparison of data from labour force surveys just before the minimum wages and conditions came into effect and two years after shows marked improvements. The percentage of workers who reported they had written contracts increased from seven per cent to 24 per cent; the percentage whose employers contributed to a pension fund increased from two per cent to eight per cent; and the percentage earning less than 500 rand per month decreased from 61 per cent to 35 per cent. The fact that many workers are still not enjoying their rights points to the need for stronger enforcement by the Department of Labour.

(Based on Budlender 2005)

5.2.2 Ensuring the rights of care workers abroad

The Philippines Government was one of the first to extend greater government protections to its citizens employed abroad as domestic workers (HRW 2006). The protections include a standard contract ensuring a weekly day of rest, as well as regulations requiring employers to cover most of the costs relating to recruitment and placement. The Philippines Department of Labor and Employment also provides skills and welfare programmes in the destination countries, as well as monitoring the welfare services provided by private recruitment agencies and regulating foreign placement agencies (Government of Philippines 2005). In addition, the government accredits NGOs to provide pre-departure orientation seminars for workers to inform them about their rights, entitlements and obligations, and the available services in their destination countries. Programmes to help workers re-integrate into Filipino society on their return from working overseas are also in place. To encourage gender-sensitive treatment of female migrants, the government has increased the number of women officers working with overseas migrants both in the Philippines and in the destination countries.

5.2.3 Supporting domestic workers to organise for their rights

Organising is one of the most important ways for workers to take action to challenge discrimination, and to advance and defend their rights and interests. Organising can enable domestic workers with few assets to pool their resources, thereby increasing their economic power; it can help them to access services and social protection provisions; and it can facilitate their representation in local, national, and international

policymaking forums (Chen et al. 2005). However, the fact that care workers often work in private homes, isolated from co-workers, makes it more difficult for them to organise themselves into unions and stand up for their rights. Unlike those who work in larger workplaces, each worker faces a separate employer, so there is not the same strength in unity when negotiating. Long working hours can also reduce the time available for social and political activities. In addition, the personalised nature of employer–employee relations in the case of domestic workers makes it more difficult for workers to state their demands firmly. Further difficulties can result for migrant domestic workers who may have an uncertain legal status, making them reluctant to demonstrate for fear of deportation (ibid.). The organisation of domestic and other care workers thus needs to have multiple foci, including informing care workers of the rights they already have, fighting for increased rights, and targeting both government and employers.

Despite these obstacles, domestic workers – including migrants – have been organising to demand their rights, often with support from NGOs. Most action has been driven by grassroots organisations in countries of origin, which have put pressure on governments to take more responsibility for their workers abroad (Sidiqqi 2003, in Kabeer 2008) (see the SRC for examples).

6. REFLECTIONS AND RECOMMENDATIONS

All women and men have the right to determine their own life paths, and to be respected and supported in the choices they make. Taking this as its basic premise, this report has argued that initiatives to address the issue of care from an equality perspective require a dual focus. On the one hand, action is needed to radically 'de-feminise' care-giving – challenging assumptions that care work is the domain of women and not men. This can help create the foundations for a more equal sharing of care responsibilities between women and men.

The report has explored various ways of achieving this – educational workshops and media campaigns to promote critical reflection on the costs of rigid gender roles; initiatives to eliminate gender stereotyping in the school curriculum; policies to expand paternity leave entitlements; and social protection measures designed to recognise the diversity of family and care arrangements rather than assuming that women are or should be the primary carers. Such strategies can help free women from the obligation to provide care, enabling their more active presence in the public sphere. They can also make it more legitimate for men to provide care.

Being able to choose – for example, to take up full-time paid work outside the home, to study or to participate in politics, often in addition to heavy care responsibilities – requires that the necessary policies and services are in place. The provision of subsidised, accessible and high-quality public care services is fundamental in this regard. Although this approach carries heavy financial implications for state budgets, it is arguably the most positive policy option from a gender equality perspective, particularly in terms of giving unpaid care-givers greater choice in seeking employment (Razavi 2007a; Kabeer 2008). Without access to these basic services, important efforts to bring about women's economic empowerment will be persistently undermined – since working a 'double day' or a 'second shift' is unlikely to be experienced as empowering.

On the other hand, in recognition of the large amounts of unpaid care that women in particular provide – whether through choice, necessity or both – this report has argued that it is essential that care-givers are supported in the work they do, and valued for the crucial contributions they are making. Policies and interventions are needed which support unpaid care-givers to undertake their work without undermining their rights – to education, decent work, health and well-being, and participation in the public sphere. A number of different policy options have been considered. Some focus on reducing the burden of unpaid care work through, for example, the provision of electricity and water, or the expansion of public care services. Others seek to mitigate the disadvantages experienced by carers as a result of their unpaid care responsibilities; for instance, by providing cash transfers to offset the costs incurred in providing care.

In light of the often inferior pay and working conditions which characterise paid care work, this report has also grappled with the question of how to better protect the rights of paid care workers. It has argued that, as a minimum requirement, governments must guarantee care workers the same basic labour protections available to other workers, including the right to a fair wage, a weekly day of rest, public holidays, health

insurance, maternity leave and the right to organise. Where positive laws and policies exist, these must be communicated to care workers so they are aware of their rights and can mobilise to claim them. At the same time, and in line with the imperative to de-feminise care-giving, dedicated efforts are needed to recruit more men into the caring professions – in turn requiring that policymakers move beyond negative stereotyped representations of men as lazy, irresponsible and incapable of providing care.

Political commitment and dedicated resources are a prerequisite if these innovative approaches are to be translated into action; at present, both remain sorely lacking. As this report has shown, there are many reasons why care issues should be a priority. Care work has a major impact on people's day-to-day lives and on the strategic choices available to them, particularly for the poorest people. It is also a fundamental obstacle to gender equality – generating insecurity through restricting women's options for decent work; limiting voice by creating obstacles to full and meaningful participation in the public sphere; and undermining women's rights and well-being when undertaken without adequate recognition, respect and support. Challenging the persistent invisibility of care on national and international development agendas is, therefore, an essential step towards realising the goal of gender equality. This calls for strong commitment from gender and human rights advocates – to make a compelling case for the importance of care, to get the issues heard, and to generate sustained pressure for action. It also calls for greater solidarity among those working on the full range of care issues, to build a broad and diverse alliance of organisations and individuals fighting for change.

6.1 Recommendations

The following four recommendations are key and overarching – being relevant for *all* actors, to take up in their own ways. More targeted recommendations are provided below these.

6.1.1 Key overarching recommendations

1. **Care work must be recognised as a core development issue** which needs to be accounted for and addressed in *all* development interventions, across all sectors, in gender-sensitive ways. Tools and checklists should be developed to support policymakers and practitioners to mainstream care issues into their work – particularly in the fields of education, political participation, economic participation, social protection, and migration.
2. **Development policies and programmes must challenge stereotyped assumptions about gender roles** – for example, that care work is the domain of women and not men. Policies and programmes should be designed in ways which expand women's opportunities and choices – particularly in relation to waged work – rather than restricting them only to traditional gender roles tied to motherhood and the domestic domain. Policies should also involve men in ways that break down gender stereotyping and open up possibilities for men and boys to take on a more active caring role.

3. **Initiatives to promote women's economic participation and empowerment must include an analysis of the interrelationship between paid work and care work**, as well as comprehensive measures to redress the double burden of paid and unpaid work shouldered by many working women.
4. **Greater solidarity is needed among those working on the full range of care issues** – gender, HIV and AIDS, ageing, disability, health and so on – from across diverse disciplines and perspectives. In particular, opportunities for greater dialogue and collaboration among those working on the economic and social aspects of care are key for holistic solutions to be developed.

6.1.2 Recommendations for donors

1. Gender advisors in donor agencies should work within their own agencies, and with relevant ministers in partner governments, to ensure that government and donor policies and programmes challenge stereotyped assumptions about gender roles, particularly in relation to care, and move beyond the conventional two-parent model to also recognise single-parent families and same-sex partners.
2. Donors should raise the need for gender-sensitive social protection provisions in policy dialogues with partner governments, and ensure that funding mechanisms are in place to strengthen public care services such as crèches and elderly care provision, and health and education systems.
3. Donors should fund qualitative and quantitative research, advocacy and lobbying initiatives relating to care work, particularly activities initiated by grassroots women's organisations, networks, and national NGOs. Funding is also needed to build the capacity of government to conduct time-use surveys in gender-sensitive ways, particularly in countries without strong statistical agencies.
4. Donors should fund capacity building of grassroots care-givers, women's organisations and networks, and organisations and networks of people living with HIV and AIDS, to enable care-givers to advocate for their rights and represent themselves in local, national and international decision-making forums.
5. Donors should support the creation and/or strengthening of local, national and regional home-based care alliances of care-providers for people living with HIV and AIDS, to allow care providers to share knowledge, skills, strategies, lessons learned and resources, and to provide spaces for mutual support and organising.

6.1.3 Recommendations for government

1. National statistical agencies should carry out time-use surveys – which must be sex-disaggregated – and build them into their regular survey cycle, using consistent methodologies and ensuring that the data are analysed and used to inform social and economic policy.

2. National statistical agencies, particularly gender statistics units, and others with strong quantitative skills, should help to build the capacity of government policymakers and civil society representatives, particularly women's organisations, to analyse and use time-use data effectively in advocacy and policymaking.
3. In line with CEDAW, BPfA and other legal and policy commitments to gender equality, governments should take measures to challenge and eliminate stereotypical representations of women and men, including within the education system. This should include the revision of textbooks to reduce gender stereotyping in the school curriculum – particularly in relation to care and domestic activities – as well as ongoing gender awareness training for teachers.
4. Gender advisors within government should work with relevant ministers to ensure that social and economic policies and programmes challenge stereotyped assumptions about gender roles – for example, that care work is the domain of women and not men – and move beyond the conventional two-parent model to also recognise single-parent families and same-sex partners.
5. Governments should carry out gender-sensitive participatory development processes – including participatory poverty and needs assessments, budget processes and service delivery processes – to ensure that women's and men's differing needs and priorities are taken into account in the design of policies and services, and in the allocation of budgets.
6. Governments should increase investments in social welfare services and expand the provision of public care services – including childcare, elderly care, care for people with chronic illnesses and disabilities, and education and health services. In particular, more attention needs to be given to ensuring that public care services are in place to support disabled people and those who care for them.
7. Governments should expand the provision of social protection measures available for care-givers such as unconditional cash transfers, social pensions, disability grants and tax credits, and ensure that information on assistance is made widely available.
8. Governments should ensure that the rights of paid care workers – including migrants – are protected, by guaranteeing care workers the same protection under national labour laws as other workers, including the right to a minimum wage, a weekly day of rest, public holidays, health insurance, maternity leave and other social protection measures, and the right to organise. Efforts are also needed to recruit more men into the caring professions.
9. Gender-sensitive care provision should be an integral and budgeted aspect of HIV and AIDS policies and programmes. Greater provision should be made to support community and home-based care providers, including: access to accurate information on HIV prevention, treatment, care and support;

access to training and basic equipment such as needles and protective gloves; and resources for capacity building.

10. Governments must ensure that community and home-based care organisations and networks, and organisations and individuals working with care-givers – including women and girls living with HIV and AIDS – are involved in the design, implementation and monitoring of HIV programmes at community and national levels.

6.1.4 Recommendations for gender trainers and community educators

1. Gender trainers and community educators should ensure that trainings and workshops include critical reflection on care-giving and domestic roles and responsibilities, including in relation to who does the housework or provides care for young children and elderly, ill or disabled adults. Training activities targeted at men and boys should be carried out in consultation and collaboration with women's organisations, and in combination with empowerment programmes aimed at women and girls. This enables greater dialogue to take place between men and women and reduces the risk of men imposing changes (even when well-meant) from their position of power.
2. Gender training programmes should include raising awareness on structural injustices and capacity building for activists. This is important to promote women's and men's wider mobilisation around social justice and gender equality issues, including in relation to care – such as labour rights for domestic workers or greater public responsibility for care for people living with HIV and AIDS.
3. Community educators and gender trainers should work in collaboration with civil society organisations and government to carry out community- and national-level media campaigns aimed at engaging women and men, including youth, in critical reflection on rigid gender roles – especially in relation to responsibilities for housework and care for children and elderly, ill or disabled family and community members. Campaigns should be developed in partnership with women, men, girls and boys from local communities.

6.1.5 Recommendations for civil society

1. Gender equality and human rights activists and advocates should hold decision-makers accountable for existing national and international legal and policy commitments to gender equality, particularly commitments which relate directly to care work, including through using the CEDAW shadow reporting process (see the SRC for information on the relevant commitments). In particular, activists should lobby for the expansion of public care services, including better childcare and disabled and elderly care facilities.
2. Gender equality and human rights advocates should ensure that paid care workers, including migrants, are aware of their entitlements and obligations – for example, through providing pre-

departure orientation seminars for migrant domestic workers. Support should also be given to domestic and migrant care workers to help them mobilise for their rights – targeting government and employers.

3. Gender advocates with an internal mainstreaming remit in NGOs and international NGOs (INGOs) should work in collaboration with those responsible for designing social and economic policies and programmes, particularly in relation to employment and social protection, to ensure that policies and programmes do not reinforce gender roles or stereotypes.
4. They should also work in collaboration with those responsible for designing and implementing HIV and AIDS policies and programmes, to ensure that care provision is a key component of HIV and AIDS programming and that the gender dimensions are mainstreamed throughout.
5. Community members – especially women and girls, youth, elderly people, and people living with HIV and AIDS – should be involved in the design, implementation and monitoring of HIV and AIDS policies and interventions.

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