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Key policy initiatives on equal sharing of responsibilities between women and men, including in the context of HIV/AIDS

Written statement*

Submitted by

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* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

Sharing Care More Equally in an Unequal World

This paper asks three related questions. First why is care (both paid and unpaid) important and who bears the costs of providing it? Second, what kind of policies and programmes are needed to sustain this work (assuming that it is important to society) but help share the burdens more equally within society? Third, what kinds of policies and programmes are particularly effective in developing country contexts? For the sake of clarity and without going into much detail, I provide a few words below on how care is understood in the context of the present paper, before responding to the questions posed above.

Care is commonly thought of as the activities that take place within homes and neighbourhoods, and are primarily structured by relationships of kinship and community: care of children, and repairing the wear-and-tear on adults whether able-bodied, ill or frail. But unpaid care work (UCW) involves many additional tasks such as meal preparation, cleaning and shopping which are particularly time-consuming in many poorer countries where access to appropriate infrastructure (such as piped water), technology (such as domestic appliances) and ready-made items (of food, clothing) is limited. Moreover, it is not only households that produce care on an unpaid basis. Care is provided through a variety of social relations and institutions, including *markets*, *states*, and the *not-for-profit sector*. The “care diamond” conceptualizes these institutions in a stylized fashion. However, the boundaries between different pillars of the care diamond are neither clear-cut nor static. States, for example, very often subsidise and regulate provision through markets and not-for-profit providers, and when public services are retrenched the provision of care by households very often increases to replace the shortfall. The point of the care diamond is to emphasize the multiplicity of sites where care is produced and the decisions taken by society to privilege some forms of provision over others, with these decisions having implications for who accesses adequate care and who bears the burden.

Why is care important?

Some analysts emphasize the significance of care for economic dynamism and growth, whether in terms of its contribution to “human capital” or as part of social investment. Children need to be fed, clothed, educated, socialized and their emotional needs also taken care of, if they are to be productive workers and good citizens. Others see care in much larger terms, as part of the fabric of society and integral to social development. All human beings are dependent (interdependent) and need care as they go through life, but during some periods—infancy and childhood, when we are physically or psychologically weak, and frailty in old age—we need particularly intense doses of caring. Many would argue that how a society treats the issue of dependency and care (when young, old and ill) is a much better indicator of the quality of life of the members of that society than its Gross Domestic Product.

While responsibility for unpaid care has its rewards (both for the person who performs these tasks and for society more broadly), it also has numerous costs. These costs come in different forms, such as weaker labour market attachment (foregone jobs, shorter work hours, lower wages), weaker claims to social security, and less time for education, leisure, self-care or political activities. In other words, while care is a good thing, it is also burdensome. As Diane Elson (2005) puts it, “The fact that much unpaid work, especially unpaid care work, is done for love does not mean that we *always* love doing it” (p.2). Yet at the same time, the fact that “unpaid work is frequently burdensome, does not mean that the best policy is to reduce it to zero” (ibid.).

So let us now consider how *unequally* the burden of care is divided in society, before turning to policies that can redistribute the burden.

The problem of multiple inequalities and why redistributing care responsibilities between women and men cannot be enough

How much care families and households provide (on an unpaid basis most often) can be measured through the metric of time. The main source of data is from time use surveys. These surveys differ from standard labour force surveys in that they typically ask respondents to report on *all* activities done in a specified period. They tell us how much time is spent by the surveyed population on: a) *non-productive activities*: sleep, leisure, studies, and self-care; b) *employment-related work*, which in developing countries includes both market work and subsistence activities such as subsistence agriculture and gathering fuel and water and c) *unpaid care work* which includes unpaid housework and person-care (Budlender 2008).

We know from time use surveys in the more developed market economies that the time that family members allocate to unpaid care activities is significant and that it does not disappear as countries develop. Time use surveys are now being increasingly carried out in developing countries too. The UNRISD project on the Political and Social Economy of Care analysed the time use data for Argentina/Buenos Aires, India, Nicaragua, South Africa, Republic of Korea and Tanzania. The findings for these six countries (analysed in Budlender 2008) suggest that the mean time spent by women on unpaid care work is more than twice the mean time spent by men. In some countries women spend nearly ten times as much time on UCW than men. As expected, men tend to spend more time on paid work than women do, but the gender gap in paid work is smaller than the gender gap in unpaid care work.

When all types of work are combined, therefore, women in all six countries allocate more time to work than men—which means less time for leisure, education, political participation and self-care. A similar pattern is found among most high-income countries (with the exception of several Nordic countries). In general therefore, we can talk of “time poverty” being more prevalent among women than men. But this statement relates to averages (or means), calculated across the population. But there are significant differences among both women and, to a lesser extent, men (since men tend to do very little UCW and it tends to stay consistently low regardless of other factors). For example, having younger children in the household tends to increase the amount of unpaid care work done, especially by women. In some countries we can see very clearly that the amount of unpaid care work tends to *decrease* as income goes up. This could be explained by several factors, including the poorer infrastructure (piped water, electricity) and technology available to poor households, the fact that the poor live in larger households and have more children, and their weaker ability to purchase care (by employing domestic workers and nannies).

It seems rather misleading therefore to talk about “time-poverty” as a blanket term without looking at the economic situation of the household. Good care depends upon adequate resources: material goods, time, and skills (Tronto 1993). It is one thing to be time-poor and income-rich (Manhattan professionals prior to the financial crisis), another thing to be time-poor and income-poor (Indian time use survey would seem to suggest that this is indeed the case for many low-income women and men in the country), and yet quite another to be time-rich and income-poor because for political-economy reasons the development path that is taken cannot generate sufficient paid employment opportunities—a severe problem in the labour reserve economies of southern Africa, where capital no longer needs the labour that it pulled from rural households over so many generations (O’Laughlin 1998). Think of South Africa for example where unemployment rates of around 30 per cent can be considered the norm (30.7 per cent for ALL women and 36% for African women; 21.2 per cent for ALL men and 25% for African men).

We need a care lens to look at the process of capital accumulation and what happens in the process of development, rather than assuming *a priori* that development/growth will lead to an improvement in care-giving and human welfare.

Looking at economic policies through a care lens would mean asking what happens to care-giving and wellbeing in the process of development: does capital accumulation—a necessity for developing countries—facilitate care-giving and enhance human well-being? Or does it come at their expense? The process of development has often meant diversifying the productive base by nurturing manufacturing industries, typically by increasing outputs of items produced for pay by women. There is a lot of evidence that suggests that capital accumulation that relies on increases in women's paid work to produce exports is not matched by compensating reduction in the amount of unpaid care work that women and girls have to do to meet their social obligations. As Diane Elson (2005) argues, it is very likely that in these contexts the outcome has been an extension of total time spent by women on paid and unpaid work, as well as a reduction in the quality of the output produced by unpaid work, especially through a “squeeze on time for care”.

Policies to support care-giving *and* share the burden more equally

Policy responses to care responsibilities must focus on the reduction and elimination of economic and social disadvantages that women face due to their disproportionate involvement in unpaid care activities, reduce the burden or drudgery of care-giving, and redistribute this burden within the household *and across society* more equally while at the same time ensuring that those who need care (be it young children, those who are ill, or frail elderly persons) are able to access good quality care in a dignified manner. This is a difficult balance to achieve.

Given the inequalities across socio-economic groups, it is particularly important to have policies in place that can help redistribute the costs/burdens of care-giving more evenly throughout society, through the provision of publicly funded or subsidised forms of care, income redistribution towards low-income large families, and structural changes (more and better jobs, especially for women) that make it easier for women to re-negotiate their care responsibilities with the fathers of their children (whether present or absent), and their brothers (in providing care for their elderly parents).

As is noted in the report of the Secretary-General, under Conclusions and Recommendations, “Increased sharing of responsibilities between women and men will not, however, be adequate to address the persistent challenges of caregiving in society. The HIV/AIDS pandemic has illustrated the need for the increased involvement in care work of all stakeholders - States, private sector, civil society and households. Policy-makers must recognize that care-work is a critical societal function, contributing to the reproduction of society and to economic development. A multi-sectoral approach, including increased investment in quality public services, is needed to reduce the care burden on households.” (Report of the SG, *The equal sharing of responsibilities between women and men, including care-giving in the context of HIV/AIDS*, E/CN.6/2009/2, paragraph 76).

Five specific areas stand out for policy action (there are more extensively elaborated in Razavi and Staab 2008):

1. Investment in appropriate infrastructure

The provision of easily accessible drinking water, sanitation and electricity will reduce the time needed for fetching fuel and water – a task that becomes particularly burdensome when caring for a patient with HIV/AIDS. This is a key priority for many low-income countries.

2. Provision of social and care services

Reliable and affordable social care services should be a top priority in all countries. State-led care service provision can have a triple pay-off by: (1) providing good quality care to care-recipients; (2) creating decent service-employment for women (and men), (3) enhancing women's choices to engage in paid employment. If *women* are to benefit from new care services arrangements, however, they need to be designed in ways that adapt to women worker's needs in terms of proximity, opening hours, and costs.

Basic social services such as primary education and health are seamlessly connected to the unpaid care work carried out within households. Decent primary schools and public health services can reduce the care burden that is placed on family members. Public health systems have to be strengthened in countries where under-funding of public services has weakened their ability to attend to the population's health needs. Likewise, primary educational facilities have to be adequately funded and designed in ways that alleviate the unpaid care burden of household members while fulfilling their primary purpose. This would include school hours that are in tune with parents' working hours (a recommendation that is applicable to many higher income countries as well) and the provision of meals during school-hours.

3. Recognition of unpaid care work in social security

Leave entitlements (including parental leave) constitute a classical social security response to care responsibilities. They provide both time and money to workers with care responsibilities. As the payments for leaves are usually financed through social insurance to which the employee must have contributed for a minimum number of years in order to benefit, their relevance for many lower-income developing countries, where labour relations are largely informal, is limited. Extending maternal leave to fathers and providing incentives for men to make use of leave provisions, as undertaken in several developed countries, is nevertheless desirable from a gender equality standpoint, and can constitute an important area of state action in many middle-income developing countries. While parental leaves are a way of supporting family care of young children, long absences from the labour market may also complicate re-entry.

4. Social assistance

Cash-transfer schemes targeted at "vulnerable" groups have become a popular social assistance instrument in recent years in many developing countries, framed as a measure for reducing poverty and enhancing children's capabilities. These transfers are often meant to facilitate the care work of mothers by allowing them to purchase essential inputs (such as food or school materials).

Despite their positive effect on poverty, more attention needs to be paid to the socially divisive affects of "targeting" as well as its administrative costs. There are also concerns about the financial sustainability of such programmes, especially when they are dependent on donor funding. From a gender perspective these programmes also run the risk of strengthening the provision of care as something that only mothers should do, thereby exonerating other sectors from responsibility. This last problem could be avoided if payment for care is done in a more gender-neutral form (as in the case of the South African Child Support Grant which is given to the primary carer, rather than mothers *per se*). More importantly, however, cash transfer programmes should also aim to bring *women* back in as agents, instead of using them as a policy conduit for the next generation. This can be done by using the programme to bring women together to discuss their own priorities, and to provide services such as job training, and information on labour market entry. The Argentine (*Jefas y Jefes de Hogar Desocupados*) and the Chilean Heads of Household programmes (*Mujeres Jefas de Hogar*) provide useful examples of programmes that have combined cash transfers

with access to labour training, facilitating women's participation in paid employment as a more sustainable route out of poverty.

5. Decent wages and working conditions for paid care workers

Although wages and working conditions of care workers vary across employment categories and skill levels, many care workers receive lower wages than workers with comparable skill levels in non-care related occupations. In developing countries, care workers often face particularly precarious conditions. There is an urgent need to provide adequate working conditions and rewards (including decent wages and social security coverage) to front-line care workers, whether nurses, teachers, carers in crèches and homes for the elderly, domestic workers or “volunteers” in Home-Based Care programmes. Usually, the public sector is more likely to provide access to formal, secure and relatively well-paid employment for care workers, and well organized groups of care workers in regulated sectors tend to face better conditions than domestic workers. This is the case of professional nurses in South Africa and teachers (including pre-school teachers) in Argentina, when compared to domestic workers, for example. These two countries have also made important attempts to formalise domestic employment through minimum wages and other legal requirements (the right to a written contract, paid leave, severance pay, dismissal notice, the employers' obligation to enrol workers in unemployment, health and pension plans, etc.), that seem to have improved workers' employment conditions and status.

Finally, as the Secretary-General's report notes, there is a need for the “increased involvement in care work of all stakeholders - States, private sector, civil society and households”. Governments can in theory orchestrate care diamonds with a “mix” of public and private provision that is not exclusionary, that provides accessible services for everyone, and that provides good working conditions for care workers. **But this requires states with both fiscal and regulatory capacities—to regulate non-state care providers and to underwrite some of the cost of service provision for low-income users.** It also requires a willingness to invest in basic public health and education services and appropriate infrastructure as the bedrock of social provisioning to help reduce the unpaid care burden placed on families and households. However, the reason why governments very often get into these so-called “private-public” partnerships is to save costs (especially staff costs). So both researchers and activists need to be particularly vigilant about the terms and conditions of work that these “public-private” mixes offer to their workforce (the nurses, orderlies, domestic workers, Home-Based Care workers, and other care workers who tend to be women).

Pluralism in the provisioning of social and care services can have un-equalizing, if not exclusionary, outcomes in contexts where the state fails to play this leadership role. In historically more unequal societies pluralism in welfare and care provision easily slips into fragmentation as gaps are filled by providers that offer services of varying quality which cater and are accessible to different segments of the population. In such contexts private provision (of health, pensions, care services) for the better-off may be underwritten by state subsidies while meagre resources are channelled into poor quality public or “community” services (health, education, care) for the majority who may be asked to make “in-kind” or “under-the-table” contributions.

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