EGM/ESOR/2008/BP.1
3 October 2008

ENGLISH only

United Nations
Division for the Advancement of Women
Expert Group Meeting on "Equal sharing of responsibilities between women and men, including care-giving in the context of HIV/AIDS"
United Nations Office at Geneva
6-9 October, 2008

The equal sharing of responsibilities between women and men, including care-giving in the context of HIV/AIDS

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The background paper analyses knowledge, policies and practice as they relate to equal sharing of responsibilities between women and men. It both assesses the current situation and proposes a set of future policy recommendations. The private sphere or reproductive life – care-giving, family, personal relations – is the point of departure for the analysis of inequalities in the division of responsibilities. The background paper also traces links and impacts outside the home. In explaining gender inequalities in responsibilities, emphasis is placed on ideologies and belief systems, inadequacies of policy and political will and complexities in the nature and social construction of care-giving.

This paper covers both the normative and practical causes and consequences of unequal responsibilities. Conceptually and practically responsibilities are closely associated with roles and identities. They connect the public and the private, in particular on how gender-specific roles and responsibilities are developed.

The background paper is based on a wide-ranging analysis of research and development relevant to equal sharing of responsibilities between women and men. The methodological approach involved analysis of the key research and policy documentation, including relevant web-based information, such as the online discussion organized on the topic by the Division for the Advancement of women from July 7 to August 1, 2008. The materials presented at the AIDS 2008 conference in Mexico City were also utilized.

The paper was guided by a number of key questions:

- What is the situation, nationally, regionally and globally, with regard to the distribution of responsibilities between women and men?
- Why is the situation as it is?
- What are the wider consequences of existing arrangements, in particular those relating to care-giving?
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The terms ‘unpaid work’, ‘care work’ and ‘unpaid care work’ are sometimes used interchangeably which leads to confusion (Razavi 2007a: 6). For the purposes of clarity, the present paper focuses on care-giving as a set

within and across countries in the amount of time devoted by women and men to each set of activities on a daily basis. Of the available country data (only a selection of which is presented in the table), it is obvious that cooking and cleaning are women's work in all regions. Polish and South African men report the highest time expenditure on these activities but in these countries women still do the bulk (two-thirds) of this work. Even in the highly developed countries, men's time output is never more than about a quarter of that of women (Poland apart).

The differences in the burden on women across geographic locations are also striking. Mexican women, for example, spend nearly three times as long every day on cooking and cleaning, in comparison with their counterparts across the border.

Table 1 Gender and time allocation in a selection of countries*

	Cooking and Cleaning Hours and mins per day			Care of Children hours and mins per day		
	Women	Men	m/f%	Women	Men	m/f%
Norway (2000-1)	2:14	0:52	24	0:34	0:17	50
France (1989-99)	3:04	0:48	16	0:28	0:09	32
Germany (2001 02)	2:32	0:52	22	0:26	0:10	38
Korea (2004)	2:36	0:20	9	0:55	0:15	27
Poland (2003-04)	3:13	1:02	34	0:39	0:16	41
US (2005)	1:54	0:36	23	0:48	0:24	50
Mexico (2002)	4:43	0:39	6	1:01	0:21	21
Mauritius (2003)	3:33	0:30	9	0:44	0:13	30
Nicaragua (1998)	3:31	0:31	9	1:01	0:17	17
South Africa (2000	3:06	1:00	33	0:39	0:04	10
Madagascar (2001)	2:51	0.17	7	0:31	0:08	26
Benin (1998)	2:49	0:27	11	0:45	0:05	11

Source: UN *Human Development Report 2007* (Table 32).

* The data refer to an average day of the year for the total population aged between 20 and 74.

The global pattern of gender inequality is complicated by inequalities according to region and level of development. The male/female gap in time spent on caring for children tends to be lower than that for time spent on cooking and cleaning. Men in Norway and the United States spend about half the female average outlay (time expenditure) on these activities. The cross-country variation suggests that differences in regard to childcare are linked to both culture and level of development – men from the western highly-developed countries are much closer to the female outlay as compared with Benin or South Africa where men spend no more than 4 or 5 minutes in the average day on childcare. While these data do not show any trends over time, other sources suggest that change in male behaviour is slow. In some countries, however, men's involvement in the care of their children has grown substantially over the last decade (Hook 2006). Men still 'specialize' in paid work while women not only put in longer hours overall but also 'specialize' in a combination of paid and unpaid work, with strong overlaps in the type of activity that they actually do in both spheres. In other words, women are sometimes paid for what they do and sometimes not. All of this suggests

The gender theory approach has the benefit of having application at both a micro and macro level. It draws special attention to the role of societal institutions and norms and how they reinforce or counteract gender divisions and inequalities in responsibilities. The most recent research has suggested that the national norms around equality/inequality are critical in determining the distribution of household and other labour between women and men. The sharing of domestic work reflects women's position and power in society – that is, wives in more egalitarian countries enjoy a less uneven division of housework as compared with those in less egalitarian countries (Fuwa 2004; Hook 2006; Knudsen and Waerness 2007). This, as reflected in Table 1 above, underlines the importance of national values and belief systems – culture - and how policy intersects with these.

The idea of a 'care regime' captures some of the patterns involved in how the state and society engage with care-giving. It conveys the idea of systematic, institutional patterns and political logics around care-giving and the distribution of responsibilities. These patterns not only influence who does what but are a decisive factor in whether care-giving and private work is paid or not. Scholarship suggests that all societies have a care regime – in the sense of a system of supporting (or not) the caring of people who are dependent in some way (Jenson 1997). This system may not always be formal; it need not even be an explicit concern of policy. But, whether or not it is visible, such a system exists and all the main power holders have a position on it. Jenson (1997) offers three guiding questions to identify the system that is in place: Who provides the care? Who pays for it? Where is it provided? A central feature of the care regime - in part cause, in part consequence - is the type of family structure and arrangement.

Surveying social policy provisions in Europe, Jane Lewis (1992) has suggested that countries varied systematically in the degree to which they have endorsed a traditional breadwinner role for men and a housewife/mother role for women. She identified three variants of the model – strong, moderate and weak breadwinner models (the latter more of a dual-earner family model) – and linked these variations to particular countries on the basis of their underlying social policy regime. The momentum of change, in the highly developed countries, is from a male-breadwinner family model to a dual-earner family arrangement. This, as will be illustrated below, is an incomplete process.

1.2 Other inequalities in responsibilities in personal and family life

The division of responsibilities has other resonances at inter-personal level – it both reflects and influences women's and men's relative status and power relations, in particular with regard to sexual and reproductive health and men's relative failure to take responsibility in that regard. It has been reported that most men in South Africa, for example, are not actively

women's inferior status, huge burden of responsibilities and inadequate resources enable men to exert control over them.

The conduct of men, including the use violence against women, is central. Violence is widespread on a global scale. In population-based studies worldwide, from 10 to over 50 per cent of women report physical assault by an intimate partner (UNIFEM 2005). In some countries the percentage of women reporting that their first sexual experience was forced is as high as 30 per cent (UNIFEM 2008: 128). Violence against women is deeply rooted in and condoned by gender beliefs and roles. Women suffer violence for such seemingly 'mundane' reasons as disobedience, talking back, refusing sex or not having food ready on time. Many men see violence as the only way to resolve conflict and 'control' their partners and refuse to take a personal responsibility around this. Physical violence, the threat of violence and the fear of abandonment are significant barriers for women who have to negotiate condom use, discuss fidelity with their partners, or leave a relationship that they perceive to be risky (Greig et al 2008: Peacock et al 2008). Gender-based violence, in particular violence against

There is also considerable knowledge available about how to work with and involve men.[2] UNFPA (2005) identifies three different ways of working with men:

- The approach to focus on **men as clients** aims to make reproductive health information and services more accessible and attractive to men. This includes overcoming the idea that reproductive health is a woman's concern and the fact that services are often designed for, or are, primarily used by women.
- The **men as partners** approach recognises men's influence on reproductive health options and decisions and encourages men and women to deal jointly with issues such as contraception, emergency plans for labour and delivery, voluntary HIV counselling and testing, and post-abortion counselling. This approach may go beyond reproductive health to engage men in wider issues, such as gender-based violence and

employed men. The stratification within the private sphere transfers into a structure of inequality in the public sphere (Razavi 2008).

Education is another area where women's access is affected by their home-care responsibilities and views about the appropriate roles of women and men. Almost from the very start of their lives in some countries, women are expected not to veer far from the private sphere and their responsibility in servicing family life and the personal life of men. The education of girls is seen in many parts of the world to be less urgent than that of boys. If girls do have access to schooling, the education system may confirm stereotypes rather than open up new opportunities for girls and women.

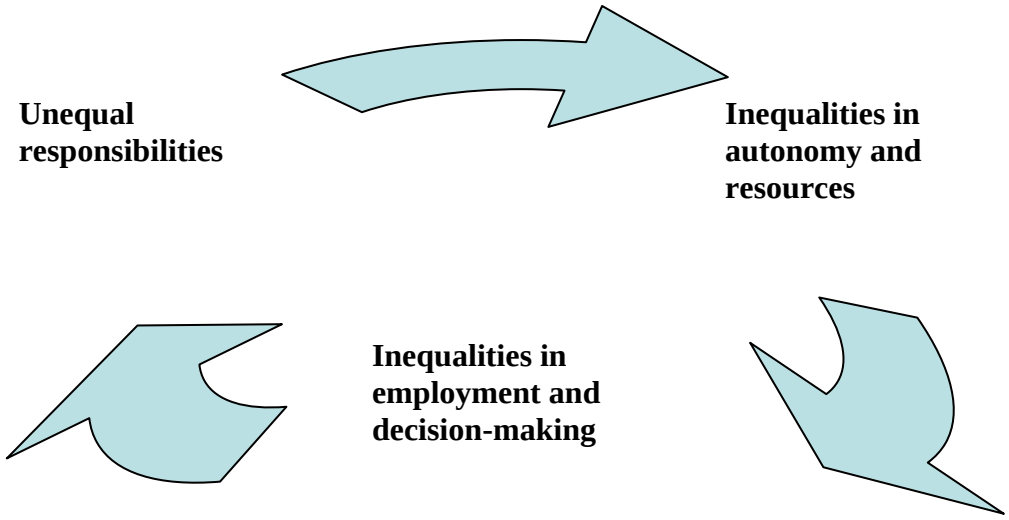
The inequalities in the sharing of responsibilities can be further linked to the realm of power, politics and decision-making. The unequal division of labour and responsibilities within households limits women's time to develop the skills necessary for participation in wider public forums and governance processes. The political realm, and the public sphere more widely, is also constructed as a male domain (similar to the process described for employment above). The figures for participation bear this out, suggesting that there is a 'volume and type of activity gap' (UNDP 2007; UNIFEM 2008). The volume gap means that women have a more limited presence in representative and public decision-making spaces and positions, compared with men. As of June 2008, for example, women's share of seats in national parliaments was only 18.4 per cent.[3] The 'type of activity gap' means that women tend to be more heavily involved in informal domains of activity or those that have less formal power, for example, in community and civil society organisations, and at local and regional rather than national or international levels, and that they are more often involved as committee member rather than chairperson. Not only does this result in public policies that are unlikely to address the needs of the care sector (paid and unpaid), it also diminishes women's abilities to advocate for these and other changes. The whole process serves to deny women agency and the possibility to direct and influence social change.

Some societies do, of course, make provision to minimize or reduce the effects of care-giving responsibilities and constraints on women's lives. Examples of such provisions include affordable and accessible child and elder care, flexible work hours, parental leaves, and assistance towards the costs of care. There are also attempts to change some institutional aspects of working life, in particular with regard to changing the timing of education and employment so that they better accommodate the schedule of a working parent. Through these kinds of policies the state and its regional and local representatives can promote gender equality. However, only a small minority of countries provide the necessary services and supports. In less developed countries, women receive little support on care-giving, although there are significant variations depending, for example, on the role played by relatives and the community at large. In most parts of the world, insufficient provision of social services, such as child and elder care, continues to restrict women's paid work, limit their economic, professional and other opportunities, and constrain their mobility.

In both developing and developed countries, paid care services have become a growing sector of the economy. It is also one that is highly gender-specific. These services mainly

[3] http://www.ipu.org/wmn-e/world.htm

employ women (as domestic workers, nannies, nurses, and care assistants). While the conditions of work vary, paid care services are susceptible to competitive pressures that generate low-pay and low-quality services—adversely affecting both care workers and the recipients of care (Razavi 2008). It is a sector that is subject to particular constraints - good quality care, whether paid or unpaid, is very labour intensive; it is difficult to increase productivity without affecting into the quality of the output; and the extent to which the costs involved can be passed on to the users of services (those requiring care or their families) is



3. The causes of unequal sharing of responsibilities

Different sets of explanatory factors are at play in the unequal sharing of responsibilities between women and men, including the following:

- The widespread existence and power of gender stereotypes;
- Inadequacies in the policy approach and lack of political will; and
- Inherent difficulties and complexities in intervening in and changing the organisation of responsibilities around care.

3.1 Gender-based norms and stereotypes

Norms, values and preferences are among the most important determinants of the unequal division of responsibilities between women and men. How these are transmitted through stereotypes is particularly important.

Stereotypes are oversimplified images of attributes that members of a particular group hold in common. Through stereotypes people learn what sorts of behaviour and dispositions are regarded within specific cultural context as appropriate for them, in contradistinction to those who are seen to be different or opposite to them. Imagery and context are central to stereotypes. Stereotypes exaggerate reality, and often utilize a binary framing. In the case of gender, for example, stereotypes posit a division of labour, responsibilities, capabilities and preferences between women and men. Differences are presented as natural - men are essentially like this and women like that, and it is proper that the responsibilities of each group be different. Many gender-related narratives are designed to be interpreted from a masculine perspective, wherein male is seen as normal or standard. A focus on stereotypes underlines that norms and values are vital in creating the existing situation and also with regard to challenging and changing it.

men who cannot be peers. Stereotypes establish a hierarchy where one sex is better than the other. To be properly understood, stereotyping has to be located in the context of power ,and should be seen as an instrument of power.

Because of the persistence of stereotypes, it is important to identify and address the factors that generate and perpetuate them. The socialisation process and the agents of opinion formation in society, such as families, schools and the media, play a key role. Since stereotypes engage primarily with culture, the media and other spheres influential in shaping culture are especially important. In a recent report, the European Parliament noted that the codes of conduct in the mass media and new information and communications technologies rarely include gender considerations.[5] Children and young people are particularly affected by stereotyping, especially as they become more open to global commerce and media.

3.2 Inadequacies in the policy response

The following offers a brief critical overview of national state responses to inequalities in care and family policy more generally.

Globally, the extent to which there has been a strong policy response to care-giving and inequalities therein varies according to level of development. There is a continuum from the least to the most developed countries. In the developing countries, care-giving is much less present as a concern for public policy. To the extent that public policy engages with care-giving, it is care as a response to medical or urgent health needs that is prioritised. Family policy is also under-developed in many countries - the implementation of policies to support families has been initiated in only 2 of 40 African countries for example (World Bank Group 2004). In the medium-developed countries, care-giving as a concern of policy is more common. Having to care for children is recognized as a constraint on women's employment, for example, and care for the elderly is increasingly coming to the attention of policy makers

These policies are known to be significant for female employment rates (Gornick and Meyers 2003; Razavi 2007b). Change has been rapid: the two-income family is now the dominant form of household in most EU member states among households with two people of working age (EUROSTAT 2002). While a direct causal line cannot be traced to services provision, there can be no doubt that services and policies by government are a key part of an enabling environment for both women and men. There are some limitations in the current approach in Europe however. Four aspects in pa

sphere. The measurement of care and its quantification vis-à-vis the formal economy has been a prime concern. Diane Elson (1999) has defined the care economy as follows: "… the work done, usually in the domestic sphere, which keeps the labour force fed and clothed, and raises the future labour force, therefore ensuring that society operates effectively". Estimates show that the value of unpaid work can be equivalent to at least half of a country's Gross Domestic Product (GDP) (ibid).

A lot of endeavour has concentrated on counting unpaid care and incorporating it into national accounts (Budlender 2004). This has focused, in particular, on measuring in particular the outputs of care (such as improved health, well-being and education), Nancy Folbre (2006) has recently suggested the need to identify the inputs to care and has developed six possible indices of care responsibility and its gender-specific distribution, incorporating financial and time outlays (Folbre 2006). These are

- individual disposable income (individual income minus taxes, minus transfers for the care of dependants);
- individual disposable time (the amount of time 'left over' for a person after they have fulfilled responsibilities for paid and unpaid work);
- gender care spending parity index (a measure of men's share of monetary outlays on dependants);
- gender direct care parity index (a measure of men's share of unpaid time outlays on direct care for dependants);
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There are also multiple costs at societal level. Direct costs include women's under-involvement in income earning and productive activities and men's unrealized contribution to the quality of family life and the rearing of children, for example. At a more indirect level, there are costs such as the relative disadvantage of women-headed households, inefficiency in resource usage and human capital development and deployment, and a perpetuation of power structures which weakens democracy. Economies do not benefit from women's full participation in the labour market, the non-market care sector is often under stress, and women themselves are handicapped in amassing the assets or bargaining power required to shift gender norms in ways that would overcome these obstacles.

Table 3 Costs of unequal responsibilities on women and society

Costs to Women	<u>Direct Costs</u> Income expenditure Energy expenditure Time expenditure <u>Indirect Costs</u> Inadequate chances of secure employment, career and income Inadequate benefits and social protection, in the short- and long-term Lack of education and training - lack of/depletion of human and othe capital Higher poverty (risk) Lack of legal status, organisation and voice
Costs to Society	<u>Direct Costs</u> Diminution of women's labour and earning power Diminution of men's contribution to care-giving and family life <u>Indirect Costs</u> Vulnerabilities of female-headed households Inefficiency in resource allocation Under-development of human capital Depletion of social capital Impairment of democratic functioning

There is no doubt that the difficulties and complexities in care-giving make it a complex field for policy and regulation. There are a number of moral issues since care is part of private and intimate relations. Public provision for care raises the risks of, or perceptions of risks of, manipulation and social engineering. The development of care-related public policy involves bringing relations that are normally treated as private into the public sphere. It involves a recasting of what are otherwise private forms of solidarity and exchange. The moral issues

involved are brought out very well in research focusing on care-giving as a disposition, orientation or attitude (Fisher and Tronto 1990; Tronto 1993). Care-giving has been said to be an ethical practice, requiring from the care-giver attentiveness, responsibility, competence and responsiveness (Tronto 1993).

The issue of whether and how to offer payment for caring-relating activities is also very difficult. It has split the women's movement, with those who argue that payment confers value and recognition to care pitted against those who argue either that this is above and beyond payment, a relational matter rather than a transaction with financial underpinnings, or that the volume of payment could never be sufficient. While there are limits to regulation and the boundary between intervention and manipulation is tenuous, care is no longer a purely private good. In the context of HIV/AIDS, care has become a major source of inequality, especially in the medium and low-developed countries.

There are other complexities involved in making provision for care. Care may entail the satisfaction of four needs:

- a need for services (to supplement or replace one's own contribution);
- a need for time (especially time free from employment or other productive activities);
- a need for financial resources (to compensate or substitute for the income and income-earning); and
- a need for capacity building (skills, information, knowledge).

Making provision for care-giving requires a broad-ranging set of measures, including, in particular, services and programmes that both assist the care-giver and substitute for her/his input. As is well known, given the current division of responsibilities, services are critical for women, and women rely on services to a greater degree than men (UNIFEM 2008).

4. Unequal sharing of care-giving responsibilities in the context of HIV/AIDS

Gender inequalities are causal in the context of HIV/AIDS. Most attention in this causal relationship has been given to infection rates – how women's lack of resources and control renders them vulnerable to infection. In this background paper, the causal links between gender and HIV/AIDS focus on care-giving and the distribution of responsibilities. Households and extended families play by far the largest role in the global response to the impact of HIV/AIDS (Loewenson 2007). Among other things, this means that the home is increasing in importance as the primary place of care for HIV/AIDS patients (Akintola 2008). It has been estimated that globally women and girls provide up to 90 per cent of the care need generated by the illness (UNAIDS/UNFPA/UNIFEM 2004). Care-giving in the context of HIV/AIDS spans the life cycle – both young girls and aging grandmothers are susceptible to the exigency of caring for an affected family member. Care givers are most likely to be family members but they may also be volunteers (who tend to have a similar profile to that of family caregivers). They are often in a non-typical relationship as a carer (as child or parent of an adult) (Campbell and Foulis 2004; Hunter 2007).

The volume of care is such that the concept of home-based care has emerged to characterize a growing phenomenon.[6] Most home-based carers are either relatives or volunteers who receive little or no training or support. Home-based care-giving in the context of HIV/AIDS is therefore carried out under adverse conditions (Campbell and Foulis 2004). While some policies and supports are being put in place, these generally remain under-developed and inadequate to the situation. Socio-economic class is also a factor, with poverty more or less universally linked to HIV/AIDS, as a risk and a consequence. In India for example, it has been said that the burden of health care is inversely related to the economic status of the

activities (such as household family management and the activities involved in securing income and/or food). This reflects the male-female pattern of care-giving in non-HIV/AIDS situations (Hook 2006).

4.2. The conditions under which care-giving is carried out

In terms of the conditions under which care is carried out, one of the most striking elements is the scarcity or absence of basic resources (such as clean water, medication, gloves and other protective materials, special food, and finance to pay for costs). Research also shows a lack of knowledge, skills and support on the part of the care giver – many care-givers are now carrying out tasks which, prior to the onset of HIV/AIDS, would have been the job of a paid health worker.

There is also a threat posed to the household economy by care-related demands. Most primary caregivers have no formal employment and caring often renders labour force participation impossible for caregivers (Akintola 2008). In many cases, the primary breadwinners in the family are the patient(s). The lack or reduction in income is accompanied by increased costs (for medicines, disinfectants and cleaning and health-related materials). Existing research, although inadequate, dispels the myth of home-based caring as relatively or absolutely costless. Financial costs, opportunity costs and physical and emotional costs have been identified (Mehta and Gupta 2006; Akintola 2008). A recent study in South Africa found that households that had experienced illness or death in the recent past were more than twice as likely to be poor as non-affected households, and were more likely to experience long-term poverty (UNAIDS/UNFPA/UNIFEM 2004). HIV has been said to be the fastest way for a family to move from relative wealth to relative poverty (Barnett and Whiteside 2003). The challenges extend beyond the financial aspects to the family system itself. Care-giving for an HIV/AIDS patient is just one aspect of the carer's life - usually the care-givers also have other roles: as parent, home keeper, breadwinner, and protector.

There is often a lack of health and other public service inputs - the health infrastructure is rudimentary in many regions suffering a high incidence of HIV/AIDS. Among other things, this can mean not just relative isolation, but that care-givers and patients have to travel long distances to access inadequate services.

Finally, the stigma and stereotypes associated with HIV/AIDS need to be considered. These are so extreme in some parts of the world that carers and other family members are forced to conceal the existence of an HIV/AIDS sufferer in the home. In some cases, stigma leads to a marginalisation, if not demonization, of women and girls (Campbell et al 2005). For example, in cases where the wife is first diagnosed she is often blamed as infecting the husband and for this and other reasons may lose the support of her own and her husband's family. Isolation is a major risk of care-givers in the context of HIV/AIDS.

4.3 The consequences of care-giving in the HIV/AIDS-related context

In terms of consequences, for individuals and families alike, HIV/AIDS influences family structure, economic and other resources, members' migration patterns and developmental life

cycles (Rotheram-Borus et al, 2005). There is much evidence to suggest that what might be called 'short-term coping strategies' are widespread not just on the part of individuals and families but also by communities, regions and states. Known family-level strategies include cutting food consumption; withdrawing children from school; sending some members of the family, especially children, from the city to the traditional tribal villages or away elsewhere to earn income (sometimes in illegal activities); and borrowing and selling vital assets (such as equipment, livestock or property) (Mehta and Gupta 2006; Urdang 2006). The extended family, where it exists or is in a position to offer support, may be called on or pressed into service. The economic survival of the family is threatened – one study has reported that families that have to cope with AIDS-related illness on average experience a two-thirds loss in household income (cited in Urdang 2006). This may be because the breadwinner becomes ill or because, as the illness proceeds, women's involvement in caring becomes so intense that it limits their capacity to do other activities. Women's income earning or food producing capacity may be endangered, with negative consequences for the household and community (Akintola 2004). Community resources may also be depleted in light of the significant demands which HIV/AIDS makes on the networks of horizontal support within communities and localities. Moreover, the vertical networks of communities to institutions, authorities and resources nationally and globally are also likely to be weaken

family obligations. These kinds of changes are not evolutionary but revolutionary – their scale and depth make them very difficult to manage.

4.4 HIV/AIDS-related policy inadequacies

The scale of the AIDS epidemic has mobilized an emergency response which has centred on major national and international interventions, funding and policy efforts. The global response to HIV/AIDS has also framed obligations in terms of human security and dignity and poverty alleviation. Health and access to treatment are now formally regarded as human rights.

The volume and targeting of services has improved significantly and information and

context, the main supports available to carers take the form of informal support and transfers, particularly from family members and neighbours. As Loewenson (2007: S86) notes, policy responses are grounded in the actions of individuals, households and extended families. In the developed countries, home-carers do not carry as much of the burden of HIV/AIDS as they do in the medium and low-development countries. This growth of home-based care has taken place in the shadow of official neglect or disinterest. Care, especially that in the home, has not been a priority – it is completely taken for granted and even regarded as inferior to formal and, in particular, medical care.

The first wave of the global response to HIV/AIDS concentrated on building awareness and emergency responses to prevention, treatment and care. The focus was on education and medication and the mobilization and expansion of medical expertise and institutional care. Loewenson (2007) suggests the need for a second wave that bridges the existing responses to more long-term structural transformation in ways that provide sustainable support to individuals, families and communities. In this context, attention must be given to increasing access to resources and making sustained support available over long periods.

The official response to HIV/AIDS has failed to explicitly recognize that women have taken the main responsibility for care-giving. There is little attention to increasing men's responsibilities in this regard in global and national responses.

5. A framework for change

A far-reaching set of reforms and innovative measures is needed to address the inequalities that pervade the distribution of responsibilities.

communities, employers, institutions and services – and aiming for a mix of provision. Care policy could dovetail with family policy and with health and other policy areas, but it should exist as a specific concern of policy in its own right.

- Care-giving should be the focus of significant investment to bring about increases in the supply of services, improve the conditions under which care-giving is carried out, and make it more equal in terms of shared responsibilities. Care-giving, therefore, has to be linked to formal resource flows.
- In the context of HIV/AIDS, there should be acknowledgement that the home carer is a central part of the state response to the epidemic requiring a range of financial, medical and social supports. Measures are needed to initiate, encourage and support community and out-reach programmes for home-based caregivers, a goal of which should be to bring about more equal sharing of responsibilities between women and men and between individuals and institutional providers.
- The quality of care needs to be a concern in its own right. Standards and benchmarks should be introduced for this purpose and monitoring should be regular and uncompromised. Benchmarks and standards should be applied to both unpaid as well as paid care-giving.
- Measures also need to be put in place to set standards around foreign/migrant care workers. This work, as well as those who undertake it, should be the subject of national and international employment protection regulation.
- Measures to count and evaluate the volume of unpaid care, its contribution to the national exchequer and its costs should be a fundamental element of the national and international policy on care-giving.
- Initiatives are needed to create alliances and bring relevant stakeholders together to plan and make provision for existing and future care-giving needs.

2. Reduce the costs for women associated with care-giving

As illustrated earlier, there are huge costs involved in care-giving, including direct losses

- The work of care-givers should be subject to the protective and quality monitoring measures.
-

gender inequality and incorporating positive images of men and boys in non-traditional activities could be relevant strategies for this purpose. Education programmes around fatherhood are especially important as are those that give men skills in care-giving activities and domestic work. Such skills should be taught to boys in schools and should have a presence also in group educational activities, community outreach and national policy initiatives. Pre-school pedagogy based on gender equality in regard to responsibilities should be put in place and apply in all childcare institutions.

- Men's responsibility for the care and upbringing of their children and other family members must be reinforced through public policy. As part of this, all policies should

opportunities for direct provision

to responsibilities to journalists' schools and other media-related training establishments.

- Training for teachers on gender equality with regard to the sharing of responsibilities should also be put in place as part of life-long learning processes. Sexual harassment, including degrading language and insults, must be addressed by schools and other learning institutions.
- There should be capacity building for educational initiatives to develop tolerance and openness to equal sharing of responsibilities between women and men and promote a culture of attitudes, behaviours and actions that endorses equal sharing.

6. Renew efforts to address violence against women

The links between violence against women need to be more explicitly identified and addresses. There is increasing understanding that men and male behaviour have to be targeted directly, for example, in prevention activities, in addition to programmes and activities that support women as victims of violence. Both women and men have to be treated as agents of change in addressing violence against women. A range of measures have to be taken, oriented to awareness raising and atti

broader gender equality agenda. In addition to individuals, structures and institutions should be targeted. A broad-based framework is needed which, within a general cognizance of multiple forms of oppression, addresses gender inequality as an underlying foundation of inequality, associated with lack of rights, lack of resources, power imbalances, lack of education and information. The state, in partnership with other national stakeholders, as well as with the international organisations and donor agencies, has a critical role to play to ensure that women gain access to the pathways that lead to empowerment (for example, through education, independent income, and access to community support networks and social services) and to recognise the unequal distribution of responsibilities as instrumental in perpetuating gender inequality.

The following issues merit emphasis and action in this regard:

- The human rights of women and girls, men and boys have to be promoted and protected. Within this general context, renewed attention needs to be given to ensuring women's access to livelihood, particularly land or property, rights and resources.
- Measures are needed to increase families' incentives to invest in girls.
- Measures are also needed to promote partnerships between women and men. Care-giving is a sphere in which women and men's interdependence could be realized and their ability to work together enhanced. In addition, some interventions need to be targeted at the entire family with a focus on challenging the traditional idea that care is only a woman's job.
- Measures are needed to underpin democracy and greater equality in general, such as the institution of legal rights (political, economic, social and cultural) and measures to monitor and increase the effectiveness of new and existing legal instruments and measures to enhance the participation of women in decision-making bodies in all sectors.
- Such measures can only be achieved by a diversity of means, including enabling legislation and policy; allocation of resources by governments (and other funders); capacity building; and political engagement and empowerment on the part of those affected.

References

Akintola, O. (2004) *A Gendered Analysis of the Burden of Care on Family and Volunteer Care-givers in Uganda and South Africa,* Durban: Health Economics and HIV/AIDS Research Division, University of KwaZulu Natal.

Akintola, O. (2008, forthcoming) 'Unpaid HIV/AIDS care in Southern Africa: Forms, contexts and implications', *Feminist Economics*,

Barnett, T. and Whiteside, A. (2003) *AIDS in the Twenty-first Century: Disease and Globalization,* South Africa: Palgrave.

Berk, S.F. (1985) *The Gender Factory*, New York: Plenum.

Budlender, D. (2004) *Why Should We Care about Unpaid Care Work?* Harare: UNIFEM.

Campbell. C. and Foulis, C.A. (2004) 'Creating contexts for effective home-based care of people living with HIV/AIDS', *Curationis*, 27, 3: 5-14.

Campbell. C., Foulis, C.A., Maimane, S. and Sibiya, Z. (2005) '"I have an evil child at my house": Stigma and HIV/AIDS management in a South African community', *American Journal of Public Health,* 95, 5: 808-15.

Connell, R.W. (2003) *The Role of Men and Boys in Achieving Gender Equality*, Paper prepared for Expert Group Meeting on "The Role of Men and Boys in Achieving Gender Equality" 21 to 24 October 2003, Brasilia, Brazil.

Daly, M. (ed) (2001) *Care Work The Quest for Security*, Geneva: ILO.

Daly, M. (2002) 'Care as a good for social policy', *Journal of Social Policy*, 31, 2: 1-20.

Daly, M. (2005) 'Changing family life in Europe: Significance for state and society', *European Societies*, 2005, 7, 3: 379-398.

Daly, M. and Lewis, J. (2000) 'The concept of social care and the analysis of contemporary welfare states', *British Journal of Sociology*, 51, 2: 281-98.

Daly, M. and Rake, K. (2003) *Gender and the Welfare State: Care, work and welfare in Europe and the US*, Cambridge: Polity Press.

Desmond, C. and Desmond, C. (2006) 'HIV/AIDS and the crisis of care for children', in *Baba: Men and Fatherhood in South Africa*, Cape Town: HSRC Press.

Elson, D., (1999) 'Gender-neutral, gender-blind, or gender-sensitive budgets? Changing the conceptual framework to include women's empowerment and the economy of care',

IPPF/UNFPA/Young Positives (2007) *Change, Choice and Power: Young Women, Livelihoods and HIV Prevention*
(available at: http://www.unfpa.org/upload/lib_pub_file/674_filename_change.pdf)

Jenson, J. (1997) 'Who cares? Gender and welfare regimes', *Social Politics*, 4, 2: 182–187.

Knijn, T. and Kremer, M. (1997). 'Gender and the caring dimension of welfare states: Toward inclusive citizenship', *Social Politics*, vol 4, no 3: 328-361.

Knudsen, K. and Waerness, K. (2008) 'National context and spouses' housework in 34 countries', *European Sociological Review*, 24, 1: 97-113.

Lewis, J. (2003) 'Gender and welfare state change', *European Societies*, 4, 4: 331-57.

Loewenson, R. (2007) 'Learning from diverse cont

Sharing of Responsibilities between Women and Men including Care-giving in the Context of HIV/AIDS.

Rotherham-Borus, M.J., Flannery, D., Rice, E. and Lester, P. (2005) 'Families living with HIV', *AIDS Care*, 17, 8: 978-87.

Shelton, B.A. and John, D. (1996) 'The division of household labor', *Annual Review of Sociology*, 22: 299-322.

Tronto, J. C. (1993) *Moral Boundaries. A Political Argument for an Ethic of Care*, London: Routledge.

United Nations (2000) *The HIV/AIDS Pandemic and its Gender Implications*, New York: United Nations.

United Nations Development Programme (UNDP) (2007) *Human Development Report*, New York: United Nations

UNAIDS/UNFPA/UNIFEM (2004) *Women and AIDS: Confronting the Crisis*, New York.

UNIFEM (2005) *Progress of the World's Women 2005*, New York: United Nations.

UNIFEM (2006) *Transforming the National AIDS Response Mainstreaming Gender Equality and Women's Human Rights into the 'Three Ones'*, New York: UNIFEM.

UNIFEM (2008) *Progress of the World's Women 2008*, New York: United Nations

UNFPA (2005) *State of World Population 2005*, New York: United Nations

UNRISD (2004) *Community Responses to HIV /AIDS: Strengthening social inclusion or carrying unfair burdens?* Report of a research workshop, Geneva, August 2-3, 2004.

Urdang, S. (2006) 'The care economy: Gender and the silent AIDS crisis in Southern Africa', *Journal of Southern African Studies*, 32, 1: 165-177.

West, C. and Zimmerman, D.H. (1987) 'Doing gender', *Gender & Society* 1, 2: 125-151.

World Bank (2004) *Early Childhood Development in Africa*, Washington: World Bank.

Yeates, N. (2004) 'Global care chains: Critical reflections and lines of enquiry', *International Feminist Journal of Politics*, 6, 3: 369-91.