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

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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.*

Table of Contents

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?
- What are the key challenges, especially from a policy perspective?
- What is the potential contribution of changes in this area to the achievement of gender equality?

The paper is organised into five sections. The first part offers an overview of key features of the division of responsibilities around labour and care at the level of the household or family, including with regard to women's control over their personal lives. In the second section, attention is given to the division of responsibilities in the more 'public' realm, *viz*, employment, governance and policy making, and to how the state and the market have responded to inequalities and care-related needs and demands. The third section considers the explanations for these inequalities, *viz.* the persistence of stereotypes and particular cultural beliefs and failures of policy, as well as the complex nature of care-giving and the difficulties of regulating it. Care-giving in the context of HIV/AIDS is the subject of the fourth section which both outlines the specificities of care in this context as well as weaknesses in the policy response. The final section reviews the prospects for change and puts forward a series of recommendations.

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 of core activities directed to meeting the care needs of dependent persons. Care-giving is defined as "…the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out." (Daly and Lewis, 2000: 285). Sometimes care-giving is unpaid and sometimes it is paid.[1] The paid/unpaid distinction is close to (but not always the same as) a formal/informal distinction. Care-giving is formal when it takes place in a formal setting (for example, an institution or service of some kind); it is informal when it is either in a non-public setting or not part of a monetary or other 'contract'. Whether care-giving is paid or not is determined by the position taken by the state. Market processes may also have a role, providing care on a commercial basis when this yields financial reward.

1. The unequal sharing of responsibilities in home-based work

This section considers the gender division of household labour – understood as the labour expended on domestic work - and provides a brief overview of responsibilities and control in reproductive life. The section works with a loose differentiation between the private and public spheres. The whole paper is underpinned by the knowledge that 'public' and 'private' are constructed rather than real terms.

1.1 Gender divisions in household labour and responsibilities

The topic of the gender division of responsibilities focuses attention on aspects of task performance, decision-making and resource allocation at the household and individual levels. Central is the degree to which, and the way in which, responsibilities and labour with regard to household and family are divided between women and men.

The division of household labour has generated a considerable degree of research interest, but less policy response. Scholarship has mainly focused on: (1) the measurement of housework and its distribution among family members, (2) consequences of the division of responsibilities and (3) explanations for the division (Shelton and John 1996). All the evidence, from time-use studies in particular, points to persistent differences and inequalities between women and men with regard to the performance of paid and unpaid work. Women spend more time than men on work overall, have fewer hours in paid work and in general have less discretionary time than men (UNIFEM 2005). There are no known countries where men do more domestic work than women and it has been estimated that women do two-thirds of all the domestic work in the world (Knudsen and Waerness 2007). Moreover, women spend more time on multiple and overlapping activities, such as care for children, older persons and ill people, cooking and cleaning, and they are more likely than men to combine paid and unpaid work (often simultaneously).

Taking a snapshot of the time devoted to two sets of activities among the total population – cooking and cleaning and child care, Table 1 shows that there is considerable variation

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[1] See Folbre (2006) and Himmelweit (2007) for more fine-grained categorisations and examples of care work.

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

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that life is fundamentally shaped by contests over the claims of individuals to resources and inequalities in responsibilities. This avenue of investigation questions the depiction of the whole area of family and private life as a sphere of co-operation and solidarity.

What are the consequences of this?

The distribution of care-giving and family labour has a long reach – it is increasingly seen as a key causal factor in determining women's advancement and gender equality more broadly. Care-giving is intensely time consuming. In the context of time as a finite resource, one clear consequence for women is time scarcity and relative time poverty. This means that their chances of participating in education, for example, are limited as are their chances of paid work. The unequal division of household and family labour and responsibilities also reduces women's access to activities and resources outside of the home, leading to income shortages or resource inadequacies more broadly. Women's control over resources and their chances of being autonomous are lessened. This has consequences at household or family level, in particular in terms of women's chances of heading households of their own. While the numbers of female-headed households are growing, such households typically run a higher risk of poverty than those headed by men.

What explains the variation within and across countries? Academic research and scholarship mainly draws from two explanatory approaches: (1) theories about relative resources, power and bargaining; and (2) gender theory. The first approach highlights the dynamics of the couple, each partner's relative resources and bargaining power in light of their individual and collective command over resources, including time. In this essentially rational choice approach, the individual commanding the larger proportion of resources, or those most highly valued (education, earnings, gender, property or assets, occupational prestige, age), utilizes such resources to negotiate his/her way out of housework (the assumption being that housework is undesirable activity). This is linked to a broader pattern of inequality in that couples with more resources (higher income, education) would, all other things being equal, spend less time on domestic activities *vis-à-vis* couples with fewer resources, usually by buying replacement services (housekeeper, cleaners, and nannies) (Hiller 1984).

These economistic explanations are very different to the second approach which envisions a system of inequality based on gender. Gender theory focuses on the extent to which diverse social structures and behaviour patterns incorporate gender equality values and convey gender dis/advantages (Ferree 1990). There are different variants of this approach. The 'social construction of gender' perspective places strong emphasis on early socialisation and intergenerational influences as explanatory factors in determining the distribution of responsibilities, among other things. Gender is viewed as continuously being constructed and utilized to further a variety of group and societal goals (West and Zimmermann 1987). In a more structuralist variant to this approach housework is perceived to be more than the invisible and unpaid labour that makes waged work possible; it is also seen as constituting a set of culturally and historically specific tasks that convey social meanings of masculinity and femininity and have particular outcomes in terms of economic value, resource distribution and power position (Berk 1985). This implies that housework produces household goods and services and also the reproduction of gender itself (Hartmann 1981).

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 involved in the reproductive health care of their partners and do not typically participate in family planning or antenatal care consultations with them. When men exercise power and control in the area of sexual and reproductive health, women's ability to protect themselves and control the number, timing and spacing of children can be limited. There are many dimensions or factors at work in this complex relationship but at its root is the fact that

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 women, is a symptom of implicit power relations and stereotypes. The tacit acceptance of domestic violence through inadequate legal/policy responses by governments and local communities is a refusal to assume responsibility.

Gender roles and imbalances in responsibilities are increasingly recognised as one of the fundamental forces driving the rapid spread of HIV and exacerbating the impact of AIDS (UNAIDS/UNFPA/UNIFEM 2004). Women's systematic lack of access to resources increases their vulnerability to the stresses of care in the context of HIV/AIDS - whether in the form of property rights that confer the assets of a deceased husband to his natal family, lack of skills and education owing to prior discrimination against female children, a lack of income-generating activities, or lack of political power to demand health and care support services. It also raises the likelihood that they themselves will contract the disease. Women who are known or suspected to be HIV positive are especially vulnerable to violence.

There is increasing evidence that abuses of the human rights of girls, especially through sexual violence and other sexual abuse committed by men, contribute directly to the disparity in infection and mortality associated with HIV/AIDS (UNIFEM 2008). Young women and girls face special risks with regard to violence and HIV/AIDS infection. They may be sought after because of the erroneous but widespread belief that sex with a virgin can cleanse a man of infection; or because they are perceived to be more likely to be free from infection. AIDS orphans, who are often forced to fend for themselves, are another segment of the population that are at particular risk because they are easy prey for sexual abuse and violence. Across the sub-Saharan African region, gender related norms all too often condone men's violence against women, grant men the power to initiate and dictate the terms of sex, and make it extremely difficult for women to protect themselves from either HIV or violence (ibid).

Against this backdrop, it is important to bear in mind that women's empowerment is a process about self (as well as 'other'). Empowerment requires self knowledge and skills (for example, analysis, organisation, and the ability to make choices), but also a belief in oneself and a sense of self–worth, understanding of the right to control one's life and a belief in one's ability to achieve this and other goals (IPPF et al 2007).

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 female genital mutilation.
- The third approach, emphasizing **men as agents of positive change** involves men more fully in promoting gender equality and social change. It offers men opportunities to reflect on their own history and experiences, to question gender attitudes and to recognize how gender inequities harm their partners and themselves.

These are generic methods with application in many areas, including to ensure a fairer distribution of responsibilities. As Greig et al (2008: S36) point out, this involves some surrender of male power.

2. The unequal sharing of responsibilities in the public sphere

Where societal norms and institutions limit women's activities to unpaid work in the household, women's chances or opportunities to access pathways to empowerment (for example, through education, independent income, employment, community support networks, social services, political engagement) are diminished. The public sphere, whether defined as employment or the domain of politics and policy, or both, rests on a male model of work and involvement. Men are assumed to be 'breadwinners' and women are seen as minor wage earners or workers who are not fully committed. The male breadwinner model is pervasive not just as an ideology but also as a set of arrangements. For example, it affects the organisation of work, occupational hierarchies, salary levels and the interaction between social policy and labour market policy. The model worker has no 'encumbrances' and workers' disposition is to give their total commitment to work. In this model, family-related responsibilities are invisible or become a perversion of normality. A direct consequence is that women's labour market participation rates are less than those of men in all parts of the world, female-male wage gaps are widespread, the responsibilities within and across jobs are often framed in gender terms and labour markets are sex-segregated. In this and other ways, the close relationship between non-waged and waged labour becomes visible: the work women undertake for wages outside the home often mirrors that which they undertake within it, just as the work that men do not undertake in the home is not considered appropriate for

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[2] See especially the papers prepared for the Expert Group Meeting on "The Role of Men and Boys in Achieving Gender Equality, which took place in Brasilia from 21 to 24 October 2003. They are available at: http://www.un.org/womenwatch/daw/egm/men-boys2003.

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

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[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 limited (ibid). In low-wage and low-cost care markets, labour turnover tends to be high, opportunities for training and retaining labour are low and regulation is minimal (Daly 2001). All of this makes those employed in the sector vulnerable.
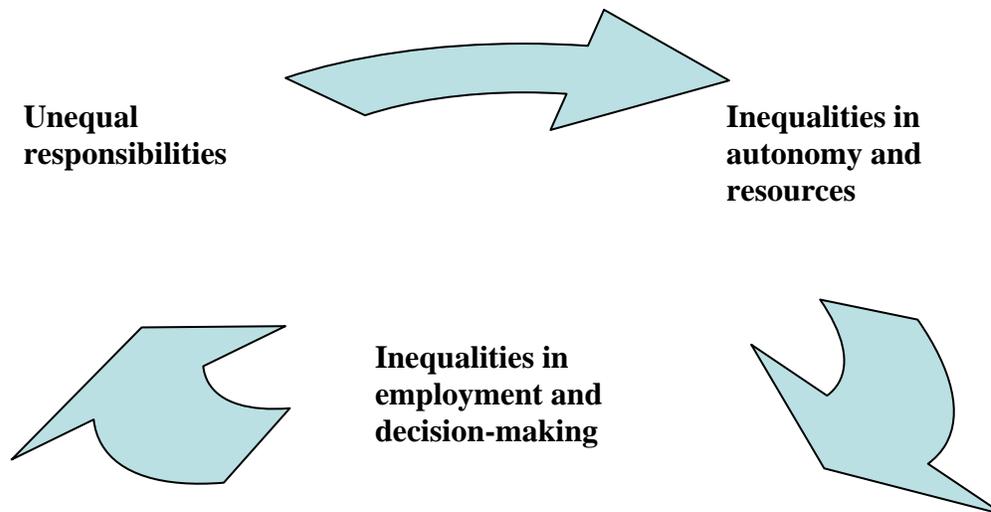
There is also the issue of volume of supply of services. In many middle- and low-income countries, commercial services of the formal kind that provide good quality care are underdeveloped and cater to a very limited market (Razavi 2008). In this situation, care-giving services tend to be individualised and informal, through domestic service for example. There is often no labour 'contract' as such, wages are very low and working conditions often poor, with few if any social rights attached to the labour contract. There have been efforts to regulate. Argentina, Chile and South Africa provide some recent examples of countries where legislative efforts to provide basic labour and social rights for domestic workers have been made, although their effective implementation would require close monitoring and sustained political pressure (ibid).

The care economy extends beyond the individual or national levels to a global system of care (Hochschild 2000).[4] The economic organization of care in an increasingly globalised world dovetails with inequalities in regional economic and social development. Care is integral to the neoliberal and post-neoliberal projects of state-society restructuring, and economic change which has reproduced rather than undone the disadvantages and inequalities associated with care-giving (Razavi 2007a: 3). The globalisation of care has occurred through various means – for example, the export and import of care (people and services) as a business or profit-making activity or the migration of individual carers across countries and regions.

There is a transnational trade in care labour which is linked to the conditions under which care is provided in particular situations and regions (Yeates 2004). One of the key ways that working women in developing countries, and high-income women in developed countries, have been able to combine market work with traditional roles is by paying others (typically poor and/or immigrant women) to take on these responsibilities (for example, as nannies and maids). There are many limits to this apparent 'solution', for example the fact that care chains shift the burden of unequal sharing of responsibilities to even more vulnerable groups of women.

The following diagram shows the causal chains involved in unequal sharing of responsibilities.

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[4] The metaphor of a continuum of care has also been used (for example, UNIFEM 2005: 32).

Unequal responsibilities → **Inequalities in autonomy and resources**

Inequalities in employment and decision-making

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.

There are three particular stereotypes that are especially relevant in the context of equal sharing of responsibilities between women and men:

- the depiction of the natural attributes and proclivities of men and women;
- the depiction of men as sexually voracious and women as asexual; and
- the location and sets of activities seen to be appropriate for women and men.

In the first regard, the view is perpetrated that women and men are naturally inclined towards different activities: biology endows them with different skills, capacities and areas of interest. Men are predisposed to be agentic (oriented to mastery and self-assertion) and thrive in competitive situations whereas women are communal (selfless and other-oriented) and prefer co-operation. This is fertile ground for the second type of stereotype which pertains to male and female sexuality – women are either asexual or docile whereas men are sexual predators, voracious and prone to perpetrating violence. In the HIV/AIDS context, the equation of masculinity with sexual conquest means that gender roles also contribute to one of the most significant factors driving the spread of HIV across sub-Saharan Africa – multiple concurrent sexual partnerships and the glorification of risk taking (Peacock et al 2008: 11). Relative to women, men are more likely to have multiple partners simultaneously, to be unfaithful to their regular sexual partner, and to purchase sex.

These and other gender stereotypes endorse expectations that men are natural leaders whereas women will gravitate towards responsibilities around personal relations and caring activities and, should they be challenged, will accede to force. These views serve to make an almost automatic link to location – the third type of stereotype identified as significant which constructs firm dividing lines between tasks and responsibilities that are seen as 'women's domain' and those depicted as appropriate to men. This leads to the 'public/private divide' - the ideal location for men is perceived to be in the public sphere where they can be entrusted with power and authority whereas the private sphere is assigned to women. Both outside and inside the home, most tasks and activities have a notional label of 'male' or 'female' attached to them. Women are identified as natural carers and caring is therefore seen as women's work.

Stereotypes serve to set and limit the spheres of operation and achievement for women and men. They reduce the choices that people have available to them and they limit rather than open up the many possibilities associated with being a woman or a man. They also limit the collective imagination and suppress critical thinking. Stereotypes are essentially about putting (and keeping) people in their place. They are therefore conservative; they function as a form of resistance to change. In particular, they make it hard for women not to be carers, or to be carers as well as have achievements in other fields.

Men too are limited by gender stereotypes. One result of stereotypical masculinity, for instance, is to portray men as deficient care-givers. Cross-cultural evidence suggests that, in many societies, masculinity is associated with a sense of invulnerability, and with men being socialised to be self-reliant, not to show their emotions, and not to seek assistance in times of need (Peacock et al 2008: 25). Stereotypes also exaggerate differences and hence lead to polarisation. Intolerant of difference, they act to reduce commonality between women and

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 as family patterns and obligations change and mobility increases. In developing countries, there is some out-of-home provision for child care or elder care but this is inconsistent and small-scale, relies heavily on informal provision and NGOs and as a result most care-giving is carried on by families and communities.

In highly-developed countries, there are two main patterns of response. While care-giving is generally recognised as something that families should not have to do without some support or substitutive services, the developed countries are divided on how involved the state should be. In countries such as the US, Australia, Japan, the public authorities limit their involvement in providing especially child-care services – thereby leaving care-giving either to families themselves, to the non-profit sector or to the market. In Europe on the other hand, the state has taken a much more active role, although there is variation in the degree to which states provide services directly and their relative generosity in supporting care (Knijn and Kremer 1997; Daly and Rake 2003; Gornick and Meyers 2003). The following discussion concentrates on developments in Europe because it is there that care-giving is most developed as a part of public policy and there are important lessons to be learned.

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[5] The report was adopted by the Parliament on September 3, 2008.

In Europe, good quality care-giving is seen as a desirable objective and there is a tradition of investing public funds in care-giving. These views have diverse roots. Public child-care, for example, is seen as a pedagogical and developmental resource for children, and quality services for elderly people come within the rubric of inter-generational solidarity. Ideals about gender equality also feed into provision along with demographic, anti-poverty and, in the latest period in particular, concerns about financial sustainability and costs to the public sector. European countries have instituted a host of benefits and services to support families. These do not always target care-giving but, in general, a supportive architecture for care-giving exists in Europe and a rights-based approach is widespread.

Table 2 lists the range of different measures and shows that they cut across many domains of policy, including social, employment, incomes, health and education policy. The table provides an overview of the range of measures in place across countries rather than a list of those in place in any particular countries. The palette of measures that policy makers have available to them include cash payments, credits for social security especially pension purposes (an attempt to mitigate the income losses associated with care-giving), tax allowances, employment leaves, services such as crèches and kindergarten for children and home-help and other services for elderly people in need of care, incentives towards job creation and private (market) provision of services. The actual mix varies from country to country. So too does the emphasis and attention given to care-giving for the elderly compared to care-giving for children. These tend to be seen and organised separately for policy purposes.

In the last ten years in Europe, policy has been framed in terms of 'reconciling work and family life'. This is an approach that has been strongly promoted by the EU and the OECD. The main goal has been to increase the numbers of women in employment (in an effort mainly to reduce costs and the 'dependency ratio'). The two-income family, where children are cared for in public or private care or educational facilities outside the home, is the guiding motto for policy. Services which substitute for the care-giving of mothers at home have been strongly supported on the policy agenda, with governments trying to find ways to provide incentives for such services to be created or expanded. Another concern has been men's closer involvement in the life of their children. Paternity leaves, whereby men get a usually short period of time off from employment when their child is born, are being introduced all over Europe. It is the Scandinavian countries that have been the leaders in this regard, introducing, as well as paternal leaves, what has been called the 'Daddy leave', whereby a proportion of the maternal leave is set aside for the father and it is lost to the family if he does not avail himself of it.

Table 2   Universe of Provision for Care

Policy Domain

Type of measure	Social	Labour Market	Education	Health	Income
Cash payments	means-tested or social insurance benefits paid to carer or care receiver; child care vouchers	severance pay for withdrawal for reasons of parenthood, motherhood		subsidies/subventions for residential care	
Credits for social security	credits to carers for pension and other social security benefits				
Taxation					allowances for care-related expenses
Leaves from employment	paid and unpaid parental, paternity and other care leaves	career breaks, time savings account, employment rights during leave	educational/ training leave for caring		
Services	public child-care, home helps, meals on wheels	Workplace childcare	creches, day care, schools, kindergarten	residential services	
Incentives towards employment creation	vouchers for domestic employment, exemptions from social security contribs for people employed as carers	reduction of working time, part-time working			tax reductions on the costs of employing domestic helpers
Incentives for market services	Subsidies towards costs of care in private provision				tax allowances for the cost of care in market-run services

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 particular will be highlighted:

- The current reforms are driven not by gender equality but more by goals of economic functioning and efficiency. It is costly to have women at home and not be employed or under-employed. The recent reforms do not recognize the difficulties faced by women, and tend to be gender neutral. They engage with women and men as workers or potential workers (Lewis 2003; Orloff 2005). This means, among other things, that the reforms are not systemic. They do not go deep enough or far enough in changing the structures and institutions that confirm and reinforce inequalities. The term 'reconciliation', the leading rubric of policy, reveals the limited nature of reform project.
- There has been little policy attention to the division of unpaid labour and responsibilities *per se*. As can be seen in Table 1, in European countries there is a (continuing) inequality in the distribution of unpaid work and these and other disparities are mirrored in an unequal distribution of paid work among women and men.
- In addition, there is too little policy attention on men. The main aspect of male behaviour that is targeted for change is the degree to which new father fathers bond with their new-born children. Measures directed at fathers – paternity leaves for example – include a strong voluntaristic aspect and are not designed to target gender inequality.
- Insufficient attention has been given to care-giving *per se* and especially to its quality. The needs of children, the elderly and those who are ill have been subsumed under the policy drive to push or pull more women into employment.

3.3. The complexities of sharing responsibilities for care-giving

The problems identified appear to indicate a tolerance for gender inequality in the division of responsibilities between women and men even in Europe. There are, however, complexities inherent in care-giving and in sharing of responsibilities of care-giving that make it a difficult area for policy and regulation. One such complexity is its relative invisibility – care-giving occurs in settings that are hidden from public view; much of it takes the form of activities that are considered 'routine'; and issues of responsibility sharing are seen as integral part of 'private' relations among individuals. This means that care-giving is given little or no economic value and has no legal status or political or other rights attached to it.

Feminist economists have taken up the challenge of the relative economic invisibility of care-giving and have illustrated the existence of a care economy which is largely a woman's

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);
- gender overall care parity index (a combination of the gender care spending parity index and the gender direct care parity index, using quality-adjusted replacement cost to assign a monetary value to the time inputs);
- the gender care empowerment index (measures men's direct unpaid care hours, relative to those of women, and men's proportional representation in paid care work occupations, relative to that of women).

If countries were to incorporate measurement of unpaid care work in national accounts, it would lead to significant progress in addressing the relative invisibility of care-giving and inequalities in responsibilities.

Just as the scale, volume and contribution of care-giving are hidden, so too are many of the costs of inequalities in associated responsibilities. It is important to explicitly identify these costs, both for individuals and societies. Figure 1 is an attempt to list these for women and societies.

While there is no doubt that care-giving also conveys rewards – personal fulfilment and high quality services for those cared for, it has huge costs for women (Razavi 2007a). The direct costs involve the expenditure of time, energy and income. Indirect costs extend over the longer-term and include such possible outcomes as lack of secure employment, career and income, reduced or no access to social protection benefits, limited access to education and training and reduced stock of human capital, high risk of poverty, and lack of legal status, organisation and voice.

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	Direct Costs Income expenditure Energy expenditure Time expenditure Indirect Costs 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	Direct Costs Diminution of women's labour and earning power Diminution of men's contribution to care-giving and family life Indirect Costs 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 household – the poorer the household or family the more likely is it to become a victim of an inefficient health care system (Mehta and Gupta 2006: 13). A range of vulnerabilities are linked to violence, substance abuse, social exclusion, fragile support networks, economic precariousness.

While care-giving in the context of HIV/AIDS shares its predominantly female character with other types of care-giving, it is specific in a number of respects: the nature of the care-giving involved; the conditions under which care is provided; and the broader context and consequences. The contrasts in the conditions faced by caregivers in the less developed countries *vis-à-vis* those in the developed countries are vast (Palattiyil and Chakrabarti 2008). The following discussion focuses on the situation of developing countries.

4.1 The nature of care-giving

The intensity and physically demanding nature of HIV/AIDS-related care is striking. Care-giving in the context of HIV/AIDS can run the entire spectrum of meeting emotional, spiritual, physical and medical needs. While there are various estimates of the amounts of time devoted to the care, qualitative studies indicate that care-givers spend between 3 to 12 hours a day caring for bedridden patients, while those caring for incontinent patients or patients suffering from diarrhoea usually need to be on stand-by 24 hours a day (Akintola 2008). Another defining aspect of care for persons living with HIV/AIDS is that it is frequently terminal. For this and other reasons, this kind of care-giving also exacts a heavy emotional toll.

There is evidence of deep gender differences in care-giving. A national survey in South Africa of how 8,500 households use their time showed that women perform eight times more care work than men (cited in Peacock et al 2008: 17). Because women are far more likely to be providing care, men are more assured of receiving care than women. Desmond and Desmond (2005) provide an analysis of parental presence when one parent has died and show that where the mother is not alive only 30 per cent of surviving fathers are present in family life, but when the father is not alive 71 per cent of surviving mothers are present. In many cases, women's chances of receiving care depend on whether they have a female relative willing to provide care for them (rather than their marital situation for example). Gender differences also influence the type of care given: the more intimate the task, the more likely it is to be carried out by a woman. When men provide care, they tend to perform instrumental

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[6] The WHO defines home-based care as " the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health, including care towards a dignified death (cited in Campbell and Foulis 2004: 6).

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 weakened, especially in light of national health systems buckling under the impact of HIV/AIDS (Loewenson 2007).

There is also the impact of the pandemic and of the unequal distribution of responsibilities in care-giving at the broader, societal level. The impact extends very broadly – even with a relatively low rate of infection within communities – and the societal impact is pervasive. In the most affected areas, the future growth and development of the whole society may be imperilled – both demographic and social renewal is threatened. Family structure is changing, with, for example, a big growth in lone parent or lone caretaker households. This development challenges the whole meaning of equal sharing, which assumes the presence of a second partner or parent. In many cases, the demographic change caused by HIV/AIDS makes already vulnerable groups even more vulnerable, for example, widows, elderly, orphans, youth in general. There is, furthermore, evidence of girls being twice as likely as boys to be kept out of school to care for sick relatives or to work to contribute to household income (ILO 2004: 2).

In addition, the epidemic has many potential and actual risks for social stability, such as the profound changes in intergenerational relations. 'Normal' intergenerational relations are disrupted, as are expectations and values about family roles (for example, that prime-aged adults will be the recipients rather than the providers of care). Child labour has become an issue, especially in the sense of the number of children who have to assume care-giving. Moreover, children's life course and development are at high risk of disruption as the effects of the epidemic penetrate the next generation. The growing numbers of AIDS orphans in some countries are just one example. The male provider role may also be endangered or destroyed. All of this results, not just in a transformation of family-related roles, but in profound changes in family structures. As Montgomery et al (2006: 2416) note, designation of 'parent' or 'child' is increasingly a social process rather than a biological fact. Parental rights and responsibilities increasingly rest with multiple individuals and the meaning of 'family' is being extended, in terms of both how wide the family extends and the content of

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 awareness are higher than they have ever been. However, control over the spread of HIV is weakened by many disempowering conditions and policy inadequacies. The intervention response has not matched the scale or scope of the epidemic. Awareness of AIDS has increased, but is not adequately backed by knowledge of actions or services. Prevention programmes reach less than one in five people who need them, with barriers to access and use of programmes arising from similar imbalances in gender equality and economic power and forms of cultural resistance that lead to risk of HIV (UNRISD 2004: 5). Strategies that focus on legal and property rights, the eradication of violence, increasing access to education and services and transforming gender roles and status have been less commonly applied. The new focus on expanding treatment access has often not paid adequate attention to strengthening the largely public sector systems used by communities, in some cases leading to projects that may have weakened these systems (Loewenson 2004: S84). In addition, the huge gaps in coverage and access to services for those most in need are not just due to lack of services but also to asymmetries of power relating to gender equality, wealth and social status, as well as the failure to recognise the significance of these asymmetries and to correct for them.

Although a social view of health is generally accepted in HIV prevention and AIDS care policy, intervention models have mainly been focused on individuals. Those acquiring HIV are typically members of families and are usually cared for within the context of family, kin and community. The end result of ineffective intervention is to privatise the response and individualize responsibility for care-giving. HIV/AIDS has to be seen as an illness that is experienced and responded to in the context of families (Rotherham-Borus et al 2005: 984). A purely health-focused policy response is therefore inadequate. There has been too little attention to the ways in which social and economic vulnerability is linked to factors such as society's views on sexuality, culture, including machismo culture; women's autonomy; gender imbalance; caste; poverty, access to education and health/medical care; the extent of protection of girl children from sexual abuse; and migration. Vulnerability derives from such factors as poverty and development, especially for women; control over resources for health; costs of medicines; access to social support; access to education and health care; and access to family and community support (UNRISD 2004: 7).

HIV/AIDS has led to traditional care-giving response in many ways – families provide the bulk of care, and within families, women and girls bear the main burden. In the present

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.

Addressing inequalities in responsibilities should be guided by the following principles:
- unequal responsibilities have deep and diverse roots (cultural, economic, social, political) and can only be undone by measures which are integrated across domains in a multi-sectoral approach;
- inequality in tasks and responsibilities is inalienably related to power differentials. Given such structural roots, measures must aim not for reform but for transformation, above all overcoming the relations of dominance and subordination that are inherent in gender inequality;
- the consequences of inequalities in care-giving and reproductive life for women and men are profound and wide-ranging;
- the diverse situations, interests and outlook of care-givers have to be acknowledged;
- inequalities in reproductive life limit the degree of control and autonomy that women have over their decisions;
- inequalities in the distribution of responsibilities in reproductive life are inextricably linked with inequalities in productive life;
- there is a need to recognize the day-to-day gender-specific realities of care-giving (for example, the constraints and relative advantages/disadvantages that women and men live with, especially in the context of HIV/AIDS) and to recognise that these are buttressed by a range of structures, practices, values and belief systems;
- inequalities in the division of responsibilities need to be made visible and measured;

- gender intersects with other factors of division, such as socio-economic class, status, religion, race/ethnicity;
- inequalities in care-giving are reproduced and exacerbated by aspects of globalisation;
- in devising and implementing remedies, there is a role for all stakeholders, including states, regional authorities, social partners, NGOs, social movements, and female and male citizens, *inter alia,* alongside the international organisations and donors;
- the role of the state with regard to public resources is crucial and provides an opportunity for action and leadership; and
- gender equality measures involving better sharing of responsibilities in the private sphere need to be connected to a general framework and existing programmes and campaigns for gender equality.

One of the convictions underlying the recommendations that follow is that fundamental changes in the treatment of care-giving – in terms of the way it is organized and the levels of support for it – will go a long way to addressing the kind of gender inequalities that have been identified in this paper. On their own, such measures are insufficient, however, and a gender-specific approach to addressing unequal responsibilities is needed as well.

The following sets of recommendations –while discussed separately - are intended to be mutually re-enforcing and to have positive cumulative effects. It is essential that each recommendation be addressed in its own right, while striving for an integrated approach overall. Flexibility is needed to allow methods and approaches to take account of culture, resources, historical specificities and location. Opportunities need to be provided for countries to learn from each other and to pool ideas and experiences

Recommendations

1. Position care-giving in policy and funding frameworks

Care-giving and equal responsibilities have been insufficiently addressed by policy makers. This is true for all countries regardless of level of development or the intensity of the HIV/AIDS crisis. There has been some attention to care-giving, in particular, under the auspices of institutional health and education provision or family policy but this area of gender equality policy is under-developed. The suggestions that follow are to bring care-giving within the purview of government and to make it count from an economic and political perspective.

The following are some recommended changes at policy level:

- Every country and relevant international organisztion should have a policy on care-giving. The goal would be to value care and to undertake measures that ensure equality of responsibilities in care-giving. Such measures should be oriented to planning for the activity of care-giving itself and the well-being and development of both care-givers and those receiving care. This would mean identifying and working with a continuum of care-givers – individual women and men, families/households,

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.

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

As illustrated earlier, there are huge costs involved in care-giving, including direct losses such as energy, time and money as well as indirect costs relating to foregone opportunities and threats around future well-being and security. These costs have particular implications for women currently carrying out the bulk of care-giving work because care-giving is under-valued and under-protected. Some of the measures suggested above are intended to raise the profile and valuation of care-giving and they should have a positive effect also on the situation of women. Investing in care-giving is also a strategy for investing in girls and women. However specific measures are also needed to reduce the costs to and burdens on women of care-giving.

The following are some suggested actions:
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- Care-giving should be linked to social security purposes. Increased social rights should be attached to care-giving so that caregivers – in addition to receiving income replacement payments for the care they provide - can get recognition for pension purposes and other benefits.

- The work of care-givers should be subject to the protective and quality monitoring measures.
- Capacity-building measures are needed to enhance female and male care-givers' access to training, education and developmental opportunities. Increasing care-givers' social assets and social capital, including their social connectedness and affiliations, should also be the subject of policy effort.
- Services should be put in place that substitute for or replace women's input to care-giving, and men's role in these services should be strengthened.
- Measures are needed to identify the spectrum of politics and policies associated with equal sharing of responsibilities and encourage and financially support empowerment activities at grassroots level, such as peer programmes, support groups, work with men and organizing/mobilizing activities. Women's agency in general, and those of care-givers in particular, should be increased by informing them about their rights and helping them to build the skills to exercise these rights. Enhancing support for women's groups should have a central place in the strategy given the effectiveness of such groups in reaching (out to) women.
- Policy makers should define specific roles and create opportunities whereby care-givers (or their representative organisations) can have an input into developing and implementing policies and programmes.
- Continued attention to the work/life balances of women and to policies that enhance women's agency and choice around their family lives.

3. Target men's involvement in care-giving

Very little change will be brought about without the active involvement and participation of men. Measures in regard to inequalities in responsibilities in the reproductive sphere need to build on the international consensus on the need to engage men and boys in improving the well-being of women and girls. Expecting men to share full responsibilities with women will require changes in beliefs and norms that men are not care-givers. Men should not be treated as an undifferentiated group in this regard. Different kinds of incentives and approaches should be used with particular groups of men. It is also important to recognize that significant male resistance exists since, individually and collectively, men benefit from the current situation. This underlines that power is a factor underlying these inequalities. Consequently, an equal sharing of responsibilities has to be constructed as a positive project for men.

The following are some suggested actions:

- The work/life balance of men needs to be a specific focus of policy and measures.
- Issues around unequal responsibilities in the workplace should be more actively addressed by measures that review and, as necessary, change the inflexibility around men's employment profiles and roles. Measures should be developed to bring about flexibility in regard to working hours, work location, career profiles and career development.
- Programmes are needed to educate men about, and to persuade them to be involved in better sharing of responsibilities. Educating men and boys about the unfairness of

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 be reviewed to ascertain whether they act to value or devalue male parenting and family roles (including roles as father, grandfather, son, brother, and uncle). More proactively, policy makers should use 'family friendly' policies to: target men specifically by ensuring that there are incentives for them to become more actively involved in their families and that these incentives are appropriate from a gender equality perspective.

- Measures should also actively focus on increasing the proportion of men involved in care-giving professions and jobs (while ensuring that this does not impact negatively on women in the sector).

- Measures are needed to develop and support the capacity of individuals and institutions working with boys around changing roles and expectations in the direction of greater sharing of responsibilities. In order for actions by men or targeting men to develop legitimate claims for equality, male initiatives should indicate how they work in partnership with women's organizations and feminist actors.

- Initiatives are needed to identify issues on which men and women could be involved together in alliances for change. As well as measures that build on the common and shared interests of women and men as caregivers and care receivers, opportunities should be created for partnerships between women and men interested in changing the gender division of labour and responsibilities.

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4. Redistribute care-giving beyond the household

Improving the distribution of care-giving and unpaid work is not just about sharing tasks and responsibilities among individuals – it is a much broader issue involving the redistribution of responsibilities and burdens among households and between the state at regional and local levels, employers, communities and families. There are four possible sets of providers of care-giving: families/households, markets, states (central and local), and not-for-profit/community organisations. Responsibility for care should be shared more broadly in society.

The following are some recommended actions:

- Increase the involvement of employers, family members (apart from the nuclear family), communities, NGOs and statutory authorities in care-giving by developing

opportunities for direct provision of care-giving or ways in which these other actors can support individual care-givers, both those who are paid and unpaid.

- 'Care-friendly policies' should be instituted widely in society (including in employment). Efforts should be made to examine ways to ensure that policies do not inadvertently reinforce gender-based divisions of labour and responsibilities.
- The social dimensions of care, its location within a context of familial and social networks, should be recognized and actively supported. This means organizing and building social and other networks to share in caring. Care providers need to be linked horizontally with their peers and vertically with higher level institutions.
- In an HIV/AIDS context, all responses need to be located within a framework of investment in, and entitlement to, essential services (including health, education and social protection services). Individual and community solidarity responses have to be bridged with formal resource flows.
- Promoting the sharing of responsibilities in the context of HIV/AIDS must take account of a variety of family types, including those with no potential for accessing the help of close male relatives. The support of female-headed households is especially important in this context.

5. Address attitudes and stereotypes

The stereotypical images of women and men perpetuate inequality in the distribution of responsibilities. An approach should be adopted that recognizes and addresses gender power relations as well as the way in which culture and stereotypes influence more equal sharing of responsibilities. Actions have to permeate all levels of society. The media and educational institutions have a vital role to play. Religious communities, community leaders, and those in positions of authority in employment constitute other important stakeholders.

In order to address these issues, the following are some recommended actions:

- Gender stereotypes in both advertising and the media should be prohibited just as racism is prohibited in national legislation in many countries.
- Public institutions, especially those associated with opinion formation (such as the media, internet and educational institutions), need to review whether they are endorsing rigid ideas around parental, family and gender roles. Codes of conduct for good practice and action plans for gender equality should include attention to the domain of equal sharing of responsibilities. These plans should address how men and women are portrayed, and the ways in which the information provided does, or does not, support gender equality, and the elimination of gender stereotypes about the distribution of responsibilities.
- Stereotypes should be replaced by images with positive messages, such as both parents being active in family life and up-bringing. Positive male and female role models around family life should be identified and promoted. The potential of art and artistic endeavour (for example, street theatre) should be utilized to the full.
- Public-service media should take a lead. Specific training should be provided on gender equality issues and the treatment of the image of women and men in relation

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 attitude change, network and alliance building, capacity building, service provision and advocacy and lobbying, in addition to law enforcement measures.

The following are some recommended actions:

- Programmes working towards developing greater responsibility among men in relation to their sexual behaviour, including a commitment to protect the health and choices of their sexual partners, should be established at international, national, and local levels. These must include a zero tolerance for all forms of male sexual violence, and be based on the principle of equality between women and men in sexual relationships. These must include a zero tolerance for all forms of male sexual violence, and be based on the principle of equality between women and men in sexual relationships.
- Sex education programmes should be put in place for boys and girls as an obligatory part of the education curricula – focusing on the social construction of sexual behaviour, and gender identities and allowing participants to explore and identify alternatives to social norms that promote risk-taking behaviour.
- Campaigns and laws are needed to ensure that men fully recognize and respect women's rights to decide if and when to have children, and that women have access to the contraception of their choice, and to safe and legal abortion.

7. Integrate the equal sharing of responsibilities into the overall promotion of gender equality

The gender-based division of responsibilities is closely associated with gender inequality more broadly. Efforts to promote sharing of equal responsibilities have therefore to be connected to the body of international legal and policy instruments and mechanisms for a

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',

Commonwealth Secretariat, *Gender Budget Initiative - Background Papers*, London: Commonwealth Secretariat.

EUROSTAT (2002) 'Women and Men Reconciling Work and Family Life', *Statistics in Focus*, Population and Social Conditions, 9/2002, Luxembourg: EUROSTAT.

Ferree, M.M. (1990) 'Beyond separate spheres: Feminism and family research', *Journal of Marriage and the Family*, 52: 866-84.

Fisher, B. and Tronto, J. (1990). 'Toward a feminist theory of caring', in Abel, E.K. and Nelson, M.K. (eds.) *Circles of Care Work and Identity in Women's Lives*, Albany: State University of New York Press.

Folbre, N. (2006) 'Measuring care: Gender, empowerment, and the care economy', *Journal of Human Development*, 7, 2: 183-99.

Fuwa, M. (2004) 'Macro-level gender inequality and the division of household labour in 22 countries', *American Sociological Review*, 69: 751-67.

Gornick, J. and Meyers, M. (2003) *Families that Work: Policies for Reconciling Parenthood and Employment*, New York: Russell Sage Foundation.

Greig, A., Peacock, D., Jewkes, R. and Msimang, S. (2008) 'Gender and AIDS: Time to act', *AIDS 2008* (suppl) 2): S35-S43.

Hartmann, H.I. (1981) 'The family as the locus of gender, class, and political struggle: The example of housework', *Signs*, 6, 3: 366-94.

Hiller, D.V. (1984) 'Power dependence and division of family work', *Sex Roles*, 10: 1003-1019.

Himmelweit, S. (2007) 'The prospects for caring: Economic theory and policy analysis', *Cambridge Journal of Economics*, 31: 581-99.

Hochschild, A. (2000) 'Global care chains and emotional surplus value', in Hutton, W. and Giddens, A. (eds.) *On The Edge: Living with Global Capitalism*, London: Jonathan Cape.

Hook, J.L. (2006) 'Care in context: Men's unpaid work in 20 countries, 1965-2003', *American Sociological Review*, 71: 639-60.

Hunter, N. (2007) *"It's Like Giving Birth to the Sick Person for the Second Time": Family Caregivers' Perspectives on Providing Care*, Working Paper No 44, School of Development Studies, University of KwaZulu-Natal.
(available at: http://sds.ukzn.ac.za)

ILO (2004) *Women, Girls, HIV/AIDS and the World of Work*, Geneva: ILO AIDSBrief.

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 contexts: Equity and inclusion in the responses to AIDS', *AIDS Care*, 19 (Supplement 1): S83-90.

Mehta, A.K. and Gupta, S. (2006) *The Impact of HIV/AIDS on Women Caregivers in Situations of Poverty: Policy Issues*, New Delhi: Indian Institute of Public Administration/UNIFEM.

Montgomery, C.M., Hosegood, V., Busza, J. and Timaeus, I. (2006) 'Men's involvement in the South African family: Engendering change in the AIDS era', *Social Science and Medicine*, 62: 2411-2419.

Orloff, A.S. (2005) *Farewell to Maternalism? State Policies and Mothers' Employment*, Chicago: Northwestern University Working Paper Series, WP-05-10.

Palattiyil, G. and Chakrabarti, M. (2008) 'Coping strategies of families in HIV/AIDS care: Some exploratory data from two developmental contexts', *AIDS Care*, 20, 7: 881-5.

Peacock, D. Redpath, J., Evans, K., Daub, A. and Greig, A. (2008) *Draft Literature Review on Men, Gender and Health in South Africa,* Sonke Gender Justice Network.

Razavi, S. (2007a) *The Political and Social Economy of Care in a Development Context: Conceptual issues, Research Questions and Policy Options*, New York: UNRISD, Gender and Development Programme Paper Number 3.

Razavi, S. (2007b) 'Does paid work enhance women's access to welfare? Evidence from selected countries', *Social Politics*, 14, 1: 58-92.

Razavi, S. (2008) *The Political and Social Economy of Care An UNRISD Comparative Research Project*, written statement submitted to Commission on the Status of Women, Fifty-second session, New York, 25 February – 7 March 2008 PANEL on The Equal

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.