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

Report of the Expert Group Meeting*

Organized by the
Division for the Advancement of Women

in collaboration with the
International Labour Organization (ILO),
Joint United Nations Programme on HIV/AIDS (UNAIDS),
United Nations Research Institute for Social Development (UNRISD)

and hosted by the
United Nations Economic Commission for Europe (UNECE)

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*The views expressed in this document are those of the experts and do not necessarily represent the views of the United Nations

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I. Introduction

1. In accordance with its multi-year programme of work for 2007-2009, the Commission on the Status of Women (CSW) will consider 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' as its priority theme during its 53rd session from 2 to 13 March 2009. To contribute to a further understanding of the issue and to assist the Commission in its deliberations, the United Nations Division for the Advancement of Women (DAW) - in collaboration with the International Labour Organization (ILO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Research Institute for Social Development (UNRISD) - convened an Expert Group Meeting (EGM) on this topic from 6 – 9 October 2008 in Geneva, Switzerland. The meeting was hosted by the United Nations Economic Commission for Europe (UNECE).

2. The Expert Group Meeting examined the issue of the equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS. It identified the causes of unequal sharing of responsibilities between women and men in the public and private spheres, and identified the consequences of unequal sharing of responsibilities. It proposed policy responses to promote the equal sharing of responsibilities between women and men.

3. This report is the outcome of the meeting. The report will be widely disseminated at the 53rd session of the Commission on the Status of Women (CSW), and highlights of the discussion at the expert group meeting will also be presented during a panel discussion on the priority theme at the 53rd session.

II. Organization of work

1. Participation

4. The Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' was attended by independent experts and observers. Three staff members and two consultants of the Division for the Advancement of Women also participated in the meeting (see Annex I).

2. Documentation

5. The documentation of the meeting consisted of:

- A background paper prepared by a consultant commissioned by the Division for the Advancement of Women;
- Ten papers prepared by experts;
- The report from an online discussion on the theme, organised by the Division for the Advancement of Women;
- Three background papers prepared by partners (ILO, UNAIDS and UNRISD); and
- Two papers prepared by observers.

6. This report and all documentation relating to the meeting (see Annex II) are available online on the website of the Division for the Advancement of Women: http://www.un.org/womenwatch/daw/egm/equalsharing/egm_equalsharing.htm

3. Programme of work

7. At its opening session on 6 October 2008, the meeting adopted the following programme of work (see Annex III):

i. Opening of the meeting;
ii. Election of officers and adoption of the programme of work;
iii. Presentation and discussion of the background papers;
iv. Presentation of papers prepared by experts;
v. Working groups on issues and recommendations;
vi. Introduction of the draft report;
vii. Adoption of the draft final report;
viii. Closing session

4. Election of officers

8. The experts elected the following officers:

Chairperson:	Indira Hirway
Co-chairperson:	Linden Lewis
Rapporteurs:	Olagoke Akintola and Valeria Esquivel

5. Opening statements

9. Ms. Ewa Ruminska-Zimny of the UNECE welcomed all participants to the Expert Group Meeting on behalf of ECE. She noted the timeliness of the topic, and briefed the participants on ECE's work on data collection in this area. Ms. Carolyn Hannan, Director of the Division for the Advancement of Women of the United Nations Department for Economic and Social Affairs, expressed appreciation to UNRISD, ILO and UNAIDS for their collaboration on the organization of the Expert Group Meeting. She thanked the UNECE for hosting the meeting and Ms. Ruminska-Zimny for her personal support.

10. In the introduction to the meeting, Ms. Hannan gave an overview of the international commitments on the equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS. She recognized the need for further development of policy recommendations at global level and for enhanced efforts to ensure full implementation at national level.

11. Ms. Hannan noted that the work carried out by women at household and community levels are important responsibilities with significant impact on development at household, community and national levels. Women in many areas face serious obstacles in the form of

limited access to property, technology, essential services, income and decision-making powers. She pointed to the persistence of stereotypes as a significant causal factor in the unequal sharing of responsibilities between women and men.

12. Ms. Hannan highlighted that the low value and status of caregiving roles within the private sphere have been transferred to the public sphere in paid care work. She noted that when women take on increased roles in the labour market, their responsibilities for caregiving and other household work are not shared more equally between women and men. Women either continue to cope with these responsibilities in addition to their work in the labour market, with increased work burdens, or these responsibilities are taken on by other women, who often work with low status, low wages, poor working conditions and different forms of exploitation. Caregiving is invisible in policy contexts.

13. Ms. Hannan noted that the HIV/AIDS pandemic has accentuated the need for increased attention to caregiving. Challenges in caregiving under normal circumstances are brought into stark relief in the context of HIV/AIDS, including the issue of resources provided, the involvement of men, and the inter-generational impacts. Stigma and discrimination against caregivers in the HIV/AIDS context is common. Policy responses to HIV/AIDS have not been adequate. Home-based care for HIV/AIDS provided by women and girls within family contexts, or in some places by volunteers, is estimated to provide the largest share of care globally.

14. A critical element in bringing about change in the sharing of responsibilities between women and men will be engaging men in the process of change. Ms. Hannan noted that more should be done to increase incentives for men, to provide adequate support to their efforts and to directly address stereotypes which work against men's involvement, such as those depicting men as deficient caregivers.

15. Ms. Hannan highlighted the challenges in policy responses to the unequal sharing of responsibilities. Policies may inadvertently strengthen existing stereotypes, perpetuate or even exacerbate inequalities and reinforce the status quo. Examples include policies on parental leave, crèches, and work-life balance which are based on the assumption that women have sole responsibilities for child-care. An adequate policy response requires measures that facilitate more long-term transformation of attitudes and institutional arrangements that perpetuate unequal sharing, and at the same time, address the immediate challenges women and girls face in the current situation of unequal sharing.

III. Background

16. Commitments on the equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS, have been made by Governments at the international level, including at the International Conference on Population and Development (1994), the Fourth World Conference on Women (1995), the World Summit for Social Development (1995), and the twenty-third special session of the General Assembly (2000), as well as in the outcomes of sessions of the Commission on the Status of Women since 1996. International human rights treaties, including the Convention on the Elimination of All Forms of

Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC) also recognize the obligations that State parties have to promote the equal sharing of responsibilities between women and men.

17. In 1994, the Programme of Action of the International Conference on Population and Development (ICPD)[1] noted that the full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and the maintenance of the household.[2] States were encouraged to make it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-bearing, breast-feeding and child-rearing with participation in the workforce.[3] Countries were also encouraged to design family health and other development interventions to take better account of the demands on women's time from the responsibilities of child-rearing, household work and income-generating activities.[4]

18. The ICPD noted that male responsibilities should be emphasized with respect to child-rearing and housework and that greater investments should be made in appropriate measures to lessen the daily burden of domestic responsibilities, the greatest share of which falls on women.[5] Countries were urged to enact laws and to implement programmes and policies which will enable employees of both sexes to organize their family and work responsibilities through flexible work-hours, parental leave, day-care facilities, maternity leave, policies that enable working mothers to breast-feed their children, health insurance and other such measures. The Programme of Action recommended that similar rights should be ensured to those working in the informal sector.[6] The equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework, should be promoted and encouraged by Governments. [7]

19. Commitments made by countries at the World Summit for Social Development, held in 1995 in Copenhagen[8] included the promotion of equal partnership between women and men in family and community life and society, the shared responsibility of men and women in the care of children and support for older family members; and men's shared responsibility and active involvement in responsible parenthood and sexual and reproductive behaviour. Governments committed to develop means of recognizing and making visible the full extent of the work of women and their contributions to the national economy, including in the unremunerated and domestic sectors.[9]

20. The Beijing Declaration emphasized that the equal sharing of responsibilities and a harmonious partnership between women and men were critical to their well-being and that of

[1] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, chapter I, resolution 1, annex.
[2] Ibid, paragraph 4.1.
[3] Ibid, paragraph 4.4.(g) and (d).
[4] Ibid 4.11.
[5] Ibid, paragraph 4.11.
[6] Ibid, paragraph. 4.13.
[7] Ibid, paragraph 4.26.
[8] A/CONF.166/9, World Summit for Social Development, 1995.
[9] Ibid, commitment 5 (g) and (n).

their families, as well as to the consolidation of democracy.[10] In the Beijing Platform for Action, the issue of unequal division of labour and responsibilities were addressed within the context of the critical areas of concern on women and poverty, education and training, health, the economy, and power and decision-making. It was noted that women bear a disproportionate burden, attempting to manage household consumption and production under conditions of increasing scarcity because of the gender division of labour and household responsibilities. Girls and young women are expected to manage both educational and domestic responsibilities, often resulting in poor scholastic performance and early drop-out from the educational system. Lack of access to productive resources and inadequate sharing of family responsibilities, combined with a lack of or insufficient services such as child care, continue to restrict employment, economic, professional and other opportunities and mobility for women; women's unremunerated (unpaid) work is undervalued and under-recorded; and the unequal division of labour and responsibilities within households limits women's potential to find the time and develop the skills required for participation in decision-making in wider public forums.

21. The Platform noted that a more equal sharing of responsibilities between women and men not only provides a better quality of life for women and their daughters but also enhances their opportunities to shape and design public policy, practice and expenditure so that their interests may be recognized and addressed.[11] The Platform called on Governments to ensure opportunities for women and men to take job-protected parental leave and to have parental benefits; to promote the equal sharing of responsibilities for the family by men and women, including through appropriate legislation, incentives and/or encouragement, and to promote the facilitation of breast-feeding for working mothers.[12]

22. The outcome document of the twenty-third special session of the General Assembly[13] noted that failure to recognize and measure in quantitative terms the unremunerated work of women, which is often not valued in national accounts, has meant that women's full contribution to social and economic development remains underestimated and undervalued. As long as there is insufficient sharing of tasks and responsibilities with men, the combination of remunerated work and caregiving will lead to the continued disproportionate burden for women in comparison to men. Governments were called on to design, implement and promote family-friendly policies and services, including affordable, accessible and quality care services for children and other dependants, parental and other leave schemes and campaigns to sensitize public opinion and other relevant actors on equal sharing of employment and family responsibilities between women and men.[14]

23. Agreed conclusions of the Commission on the Status of Women since 1996 have addressed the issue of the equal sharing of responsibilities between women and men. The 1996 agreed conclusions on child and dependant care, including sharing of work and family

[10] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II. Beijing Declaration, paragraph 15.
[11] Ibid, paragraph 185.
[12] Ibid, paragraph 179(c).
[13] General Assembly resolution S-23/3, paragraph 47.
[14] Ibid, paragraph 81(d).

responsibilities, highlighted that greater participation of men in family responsibilities, including domestic work and child and dependent care, would contribute to the welfare of children, women and men themselves.[15] The 2004 agreed conclusions on the role of men and boys in achieving gender equality recognized that joint partnership between women and girls and men and boys was essential to achieving gender equality and called for the creation and improvement of training and education programmes to enhance awareness and knowledge among men and women on their roles as parents, legal guardians and caregivers and on the importance of sharing family responsibilities.[16]

24. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC) also recognize the obligations that State parties have to promote the equal sharing of responsibility between women and men. Article 5 (a) of CEDAW, in particular, notes the need for appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to eliminating prejudices and practices which are based on the inferiority or superiority of either of the sexes or on stereotyped roles for men and women. Under article 18 of the CRC, States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. ILO Convention No. 156 (1981) addresses the situation of Workers with Family Responsibilities and provides specific guidance on the responsibility of the State to implement policies and measures to assist both men and women workers reconcile employment and family responsibilities.

25. The HIV/AIDS pandemic has implications for the equal sharing of responsibilities between women and men, particularly in the area of caregiving. The Beijing Platform for Action recognized the consequences of HIV/AIDS for women's role as mothers and caregivers and their contribution to the economic support of their families.[17] Governments were called on to support and strengthen national capacity to create and improve gender-sensitive policies and programmes on HIV/AIDS and other sexually transmitted diseases, including the provision of resources and facilities to women who find themselves the principal caregivers or economic support for those infected with HIV/AIDS or affected by the pandemic, and the survivors, particularly children and older persons.[18] The 2007 resolution of the Commission on the Status of Women on 'Women, the girl child and HIV/AIDS', expressed concern that women and girls bear the disproportionate burden to care for and support those infected and affected by HIV/AIDS[19] and encouraged Governments to increase the provision of resources and facilities to women who find themselves having to provide care and/or economic support for those infected with HIV/AIDS or affected by the pandemic.[20]

[15] Agreed conclusions of the Commission on the Status of Women on 'Child and dependant care, including sharing of work and family responsibilities' E/1996/26.
[16] Agreed conclusions of the Commission on the Status of Women on 'The role of men and boys in achieving gender equality' E/2004/11, paragraphs 3 and 6 (c).
[17] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995*, op cit, paragraph 98.
[18] Ibid, paragraph 108 (g).
[19] Report of the 51st session of the Commission on the Status of Women E/2007/27 E/CN.6/2007/9, 51/1, paragraph 3.
[20] Ibid, paragraph 31.

26. The 2002 Monterrey Consensus on Financing for Development called for investments in basic economic and social infrastructure, social services and social protection, including education, health, nutrition, shelter and social security programmes, which take special care of children and older persons and are gender sensitive and fully inclusive of the rural sector and all disadvantaged communities, are vital for enabling people, especially people living in poverty, to better adapt to and benefit from changing economic conditions and opportunities. It also noted that active labour market policies, including worker training, can help to increase employment and improve working conditions and called for strengthening of the coverage and scope of social protection needs. Economic crises also underscored the importance of effective social safety nets.[21]

27. The agreed conclusions of the Commission on the Status of Women on financing for gender equality (2008) called for the allocation of adequate resources for the elimination of all forms of discrimination against women in the workplace, including unequal access to labour market participation and wage inequalities, as well as for reconciliation of work and private life for both women and men.[22]

28. The agreed conclusions on the elimination of all forms of discrimination and violence against the girl child, adopted by the Commission in 2007, highlighted the special needs of girls, including migrant girls, employed as domestic workers and performing excessive domestic chores in their own households, and encouraged governments to develop measures to prevent their labour and economic exploitation and sexual abuse. They also encouraged governments to ensure that these girls have access to education and vocational training, health services, food, shelter and recreation.[23]

29. The agreed conclusions on the elimination of all forms of discrimination and violence against the girl child also urged Governments to identify and address the needs of girls heading households, including in the context of the HIV/AIDS pandemic, for protection, access to financial resources, and access to health care and support services, including affordable HIV/AIDS treatment. Measures should be taken to increase men's responsibility for home-based care in order to address the disproportionate burden borne by women and girls in caring for the chronically ill.[24]

IV. Sharing of responsibilities between women and men

30. The sharing of responsibilities between men and women is related to the way power is exercised in society. Men tend to be in positions of power and privilege and are therefore better placed than women to exercise control over the types of responsibilities and work they undertake. Addressing the issue of unequal sharing of responsibilities is fundamentally about

[21] Report of the International Conference on Financing for Development, Monterrey, Mexico, 18-22 March 2002 (A/CONF.198/11), chap. I, resolution 1, annex, para. 16.
[22] Agreed conclusions of the Commission on the Status of Women on 'Financing for gender equality and empowerment of women', E/2008/27-E/CN.6/2008/11, para. 21(y).
[23] Agreed conclusions of the Commission on the Status of Women on 'The elimination of all forms of discrimination and violence against the girl child', E/2007/27-E/CN.6/2007/9, para. 14.(6)(b).
[24] Ibid, para. 14.5(e).

altering the exercise of power in society**.** The unequal sharing of responsibilities is multi-dimensional, covering a wide range of decisions and activities at the household and community levels and extending to issues such as employment, education and participation in decision-making.

31. Although this report focuses on the sharing of responsibilities between women and men, it is mindful of contexts where there is limited or no possibility for sharing between women and men, for example female-headed households or same-sex families. Data on these contexts is, however, limited.

32. In the view of the Expert Group, unequal distribution of responsibilities in relation to care and social provisioning is a crucial source of gender inequality in its own right as it constitutes and affects other arenas of inequality. A departure point for identifying and addressing gender inequality is understanding how women and men are assigned responsibility for the activities that take place within homes and neighbourhoods, including the care of children and of adults, whether 'able-bodied', ill or frail.

33. This report describes the objectives of equal sharing and discusses the scope of sharing responsibilities between women and men, analyzing the causal factors and most serious consequences of inequalities in sharing of responsibilities, which are exacerbated in the HIV/AIDS context. The report provides recommendations for action.

1. CAUSES OF UNEQUAL SHARING

Patriarchy and stereotypes

34. The underlying cause of the unequal sharing of responsibilities is the entrenched nature of patriarchy, which defines the status of women, children, the disabled, marginalized men and people of different races and classes. Patriarchy is based on the presumption of the inferiority of women and the superiority of men.

35. Not all men are in positions of power and privilege, but even those men with diminished capacity for fulfilling traditional male roles, due to unemployment or other obstacles, benefit from the 'patriarchal dividend' or the unequal sharing of power. To change the unequal sharing of responsibilities it is necessary to challenge the foundation of patriarchal power at all levels. Failure to take into account the dynamics of power relations reproduces the status quo, leads to incomplete understanding of the complexity of the problem, and results in ill-informed and unworkable solutions.

36. Norms and values, transmitted through stereotypes, are among the most important determinants of the unequal division of responsibilities between women and men.[25] Stereotypes are oversimplified images of attributes that members of a group hold in common.

[25] M. Daly (2008), 'Equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS', Background paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/BP.1).

Through stereotypes people learn the type of behavior that is regarded as appropriate for women and men within specific cultural contexts.

37. Stereotypes posit a division of labour, responsibilities and capabilities between women and men. The persistence of deep-rooted stereotypes and patriarchal attitudes regarding the roles and responsibilities of women and men in the family and society are a root cause of the disadvantaged position of women in a number of areas, including in the home, the labour market and public life, and present a significant impediment to the achievement of gender equality. A focus on stereotypes illustrates that norms and values are critical in creating the existing situation as well as in challenging and changing it.

38. Gender stereotypes endorse expectations that men are natural leaders and 'ideal' breadwinners and imply that women will 'naturally' gravitate towards responsibilities around personal relations and caring activities. These views construct firm dividing lines between responsibilities and work that are seen as 'women's domain' and those depicted as appropriate to men. In this context, the ideal location for men is perceived to be in the public sphere where they can be entrusted with power and authority while the private sphere is assigned to women. Both inside and outside the home, most activities have a notional label of 'male' or 'female' attached to them. Women are identified as 'natural' caregivers and caring is therefore seen as women's work.[26] Even when not widely held, such stereotypes often have saliency because many men and women may understand them to be socially acceptable, and conform publicly to practices that they may not agree with in private. There is evidence, for example, that, in some settings, and particularly those with high HIV/AIDS prevalence, some men hide their involvement in the provision of care and support to those with HIV/AIDS because they fear they will be mocked for doing care work.[27]

Sexual/reproductive health and violence against women

39. The unequal division of responsibilities 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. 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. Research has shown that most men do not typically participate in family planning or antenatal care consultations with their partners.[28] A growing evidence base suggests, however, that well-designed interventions can change this – especially when they focus on the attitudes and behaviour of individual men and the overall structural factors that often make it difficult for men to

[26] Ibid.
[27] D. Peacock (2003), 'Promoting men's involvement in care and support activities for people living with HIV/AIDS', Paper prepared for the Expert Group Meeting on 'The role of men and boys in achieving gender equality' organized by the Division for the Advancement of Women, Brazilia, Brazil, from 21 to 24 October 2003 (EGM/Men-Boys-GE/2003/EP.5).
[28] M. Daly (2008), op cit.

participate in care work.[29] For example, in the 1970's only 27 per cent of fathers were present in childbirth in the United States, compared to 85 per cent in the 1990s.[30]

40. Violence against women is widespread on a global scale and is one serious consequence of systemic subordination of women and gender inequality. [31] Violence against women is both a cause and consequence of unequal sharing of responsibilities between women and men. In population-based studies worldwide, 10 to over 50 per cent of women report physical assault by an intimate partner.[32] In some countries the percentage of women reporting that their first sexual experience was forced is as high as 30 per cent.[33] 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. Physical violence, the threat of violence and the fear of abandonment are significant barriers for women to negotiate condom use, discuss fidelity with their partners, or leave a relationship that they perceive to be risky.[34] Women who are known or suspected to be HIV positive are sometimes targeted with violence because of their status. A ten-country study on voluntary counseling and testing and disclosure, published by the World Health Organization in 2004, reported that the proportion of women reporting violence as a reaction to disclosure ranged from 3.5 per cent to 14.6 per cent.[35]

Gender inequalities in access to resources including financial resources

41. The unequal division of household and family responsibilities and labour reduces women's access to financial resources. Having the responsibility for unaccounted and unpaid social provisioning and care reduces women's availability for paid work. As a result, women's control over resources and their chances of being autonomous are lessened. This has consequences at household or family level. For example, women's economic autonomy is important for keeping households out of poverty.

42. Under the patriarchal power structure, resources such as land, housing, and other property are owned largely by men. Although several countries have passed laws on equal inheritance, these laws are not enforced in many contexts. The limited ownership of resources reduces access to finance and credit, opportunities to pursue income generating activities and access to skills training and capacity building. It also denies women the power of decision-making with respect to the use and sale of resources and makes them economically dependent on men.

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[29] D. Peacock (2003), op cit.
[30] G. Barker (2008),'Engaging men and boys in caregiving: reflections from research, practice and policy advocacy in Latin America,' Paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/EP/1).
[31] See generally the *In-depth Study on all Forms of Violence against Women: Report of the Secretary-General* A/61/122/Add.1.
[32] UNIFEM (2005), *Progress of the World's Women,* New York.
[33] UNIFEM (2008), *Progress of the World's Women,* New York.
[34] M. Daly (2008), op cit.
[35] S. Maman and A. Medley (2004), *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes,* Geneva: World Health Organization.

Unpaid care work

43. Unpaid care work involves the direct care of persons, including children, the elderly, the sick and persons with disabilities, as well as able-bodied adults. It also involves many additional tasks such as meal preparation, cleaning of homes, clothes and utensils, and shopping, which are particularly time-consuming.[36] In many developing countries, unpaid work also involves the collection of water and firewood, food crop production and care of livestock.

44. The provision of care in both formal and informal contexts, whether paid or unpaid, tends to be disproportionately undertaken by women and girls. Time-use studies around the world show that women spend considerably more time than men in unpaid tasks related to caring and social provisioning. [37] For example, in the Republic of Korea in 1999 women workers spent an average of nearly two and a half hours per day on household tasks and family care, compared with only 25 minutes for male workers.[38] Women in Bolivia spent 35 hours in unpaid work per week compared to 9 hours for men. In contrast, men typically spend more hours in paid economic activities than women. However, when hours in paid and unpaid work are totaled in Bolivia, women tend to have longer work weeks than men and less time for leisure or sleep.[39]

45. Care work is resource-intensive and is performed on generally inflexible daily schedules. Unpaid care work imposes constraints on those who perform it, for example, limiting potential for participating in income-generating activities, taking up certain jobs or career paths, and being able to care for oneself and have leisure time.[40]

46. Despite being essential for the reproduction of the labour force and the well-being of societies, unpaid work at the household level, including caregiving, remains invisible and unmeasured by policy-makers, and its contribution to economic and social development has not been adequately recognized and valued in economic terms. As a result of the general invisibility of unpaid work in national accounting systems, there is an assumption, including among policy makers, that the supply of women's labour is unconstrained and flexible.[41]

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[36] United Nations Research Institute for Social Development (UNRISD) (2008), 'The social and political economy of care: contesting gender and class inequalities', Background paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/BP.3).

[37] International Labour Organization (ILO) (2008a), 'Equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS', Background paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/BP.2).

[38] Ibid.

[39] Ibid.

[40] V. Esquivel (2008a), 'A "macro" view on equal sharing of responsibilities between women and men', Paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/EP.8).

[41] J. Ogden et al (2004), *Expanding the Care Continuum for HIV/AIDS: Bringing Carers into Focus*, Washington, DC: Horizons Report.

47. The System of National Accounts (SNA) sets international standards for the measurement of the market economy. While SNA measures some types of unpaid work in calculations of gross domestic product (GDP), for example work in family businesses and activities such as collection of firewood and water, it does not count activities such as cooking, laundry, and cleaning, the care of children, the elderly, the sick and people with disabilities and volunteer activities, As a consequence, women's unpaid contribution to the economy remains unrecognized in data collection and is insufficiently reflected in policy development.

Paid care work

48. The gender-based division of labour and undervaluing of care work in the household has been replicated in the public sphere. Women do more unpaid care work than men, and they are also over-represented in the paid care-sector, in both developing and developed countries.[42] This sector mainly employs women as domestic workers, nannies, nurses, and care assistants.

49. The paid care sector is subject to particular constraints – good quality care, whether paid or unpaid, is very labour intensive; it is difficult to increase productivity without affecting 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.[43] In economies close to 'full employment', 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.[44] 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.[45] This makes those employed in the sector vulnerable and affects the quality of care available.

50. Hiring domestic workers has always been a common solution for many families in all parts of the world for reconciling household responsibilities with the demands of employment. Domestic work has become one of the major sources of employment for women, with, for example, 10 per cent of all new jobs created in Latin America in 2004 in domestic service.[46] Domestic workers (who are often women migrants or from minority groups) work under difficult conditions in many countries, and they do not have formal contracts and receive no social benefits, such as health insurance or pensions.[47]

51. In many middle- and low-income countries, commercial services that provide good quality care are underdeveloped and cater to a very limited market.[48] In this situation, caregiving

[42] R. Antonopoulos (2008), 'The unpaid care work-paid work connection', New York, The Bard College Levy Economics Institute, Working Paper No. 541.
[43] S. Razavi (2008), *The Political and Social Economy of Care: An UNRISD Comparative Research Project*, written statement submitted to the United Nations Commission on the Status of Women, 52nd session, New York, 25 February – 7 March 2008.
[44] Ibid.
[45] M. Daly (2001) (ed), *Care Work- The Quest for Security*, Geneva: International Labour Organization.
[46] R. Antonopoulos (2008), op cit.
[47] S. Razavi (2007), *The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options*, Geneva: UNRISD.
[48] Ibid.

services tend to be individualized and informal, through domestic service for example. There are often no labour contracts as such, wages are very low and working conditions are poor, with few, if any, social and labour rights. There have been efforts to improve the situation through regulation. 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 requires close monitoring and sustained political pressure.[49]

52. Paying other women to take on caregiving responsibilities (for example, as nannies and maids) results in care chains, which are in some cases based on transnational trade in care labour, and which shift the burden of unequal sharing of responsibilities to more vulnerable groups of women. Poor women in many parts of the world may have no other option but to leave their own children alone or in the care of older siblings, or to take them to work. In Indonesia, for example, 40 per cent of working women care for their children while working; 37 per cent rely on female relatives; and ten percent are assisted by girls.[50]

53. The care economy extends beyond the individual or national levels to a global system of care.[51] The globalization 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.[52]

2. CONSEQUENCES OF UNEQUAL SHARING

Education and training

54. The domestic responsibilities of women and girls at the household level deny them equal opportunities with men and boys for acquiring education and skills. Girls' involvement in domestic work within their own households or in domestic service contributes to their lower levels of educational enrolment and achievement. In many parts of the world, particularly in poor households, girls are more likely to drop out of school than boys. This compromises girls' education, future employment opportunities and potential for economic independence.[53] Particularly in resource-constrained societies educational outcomes dictate upward and horizontal mobility in formal labour markets. Skills' training organized by employers is not always accessible to women due to their responsibility for domestic and care work and limited mobility.[54]

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[49] Ibid.

[50] M. Daly (2008), op cit; and N.Yeates (2004), 'Global care chains: Critical reflections and lines of enquiry' *International Feminist Journal of Politics*, Vol. 6, No. 3.

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

[52] Ibid.

[53] ILO (2008a), op cit.

[54] I. Hirway (2008b), 'Equal sharing of responsibilities between women and men: some issues with reference to labour and unemployment', Paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/EP.2).

Employment

55. Inequalities in access to education and training resulting from the unequal sharing of responsibilities further reinforce inequality within the labour market. Many women are concentrated in what is typically assumed to be 'female' occupations in low productivity and low wage jobs. Unpaid work at the household level often constrains women's mobility in the labour market, horizontally and vertically, which deprives women of developmental opportunities.[55]

56. The share of women in wage and salaried work has increased during the last ten years, from 41.8 per cent in 1997 to 46.4 per cent in 2007. The share of women working as contributing family workers or own-account workers decreased from 56.1 to 51.7 per cent. Women's share as contributing family workers and own-account workers remains, however, much larger than men's, especially in the world's poorest regions.[56]

57. In 2007, 1.2 billion women around the world entered the labour market, almost 200 million or 18.4 per cent more than ten years ago. However, the number of unemployed women grew from 70.2 to 81.6 million over the same period and in 2007 women at the global level had a higher likelihood of being unemployed than men. The global female unemployment rate stood at 6.4 per cent, compared to the male rate of 5.7 per cent.[57]

58. A major consequence of the unequal sharing of responsibilities is that women enter the labour market carrying the main, if not total, responsibility for unpaid domestic and care work. This places them in a structurally disadvantaged position. The organization of employment is based on a male model of paid work. Men are presumed to be the main 'breadwinners' and women are considered minor wage earners or workers who are not able to fully commit to their employment. The male breadwinner model is pervasive as an ideology and affects the organization of paid and unpaid work, occupational hierarchies, salary levels and the interaction between social policy and labour market policy. The model worker is presumed to have no 'encumbrances' and workers are expected to give their total commitment to work. In this model, family-related responsibilities are invisible. [58]

59. Working conditions that demand long hours in paid work undermine the potential of both women and men to provide the care work required at home. This intensifies the conflict between economic and care responsibilities.[59] Long commuting time to and from work also affects the ability of women and men to balance their caregiving and work responsibilities.

60. Women are perceived to be 'ideal' caregivers and responsible for domestic and care work at the household level. The domestic responsibilities and caring responsibilities of women have multiple consequences for the status and prospects of women in the labour market.[60] This

[55] Ibid.
[56] ILO (2008a), op cit.
[57] International Labour Office (2008b), *Global Employment Trends for Women*, Geneva.
[58] M. Daly (2008), op cit.
[59] ILO (2008a), op cit.
[60] I. Hirway (2008b), op cit.

unpaid work influences the extent to which women can undertake paid work, as well as the contexts, type and duration of their employment.[61] For example, in Latin America, over half of all non-employed women aged 20 to 24 cited their unpaid household work as the main reason they did not seek paid employment.[62]

61. Women are often confined to work in the less productive and well paid sectors of economies and in status groups that carry higher economic risk and a lesser likelihood of meeting the characteristics that define decent work, including access to social protection, basic rights and a voice at work. [63] Family responsibilities are one of the reasons women turn to vulnerable and informal employment. For example, 40 per cent of mothers working informally in the slums of Guatemala City were caring for their children themselves, with lack of childcare cited as a key reason for not taking formal economy jobs where children could not accompany them.[64]

62. As a consequence of their reproductive roles, women tend to withdraw from the labour market when children are small. They find it difficult to re-enter the market when their children get older because they become "over-age" for many jobs, are out of touch with the labour market, or find that employers consider their care-related domestic responsibilities as an obstacle to their performance.[65]

Participation in public life

63. The unequal division of labour and responsibilities within households limits women's time to develop the required skills or opportunities for participation in wider public forums. The political realm, and the public sphere more widely, are also constructed as male domains. The data for formal political participation suggest that there is a 'volume and type of activity gap.'[66] The volume gap means that women have a more limited presence in public decision-making positions, compared with men. As of June 2008, for example, women's share of seats in national parliaments was only 18.4 per cent.[67] The 'type of activity gap' means that women tend to be more heavily involved in activities that have less formal power, for example, in community and civil society organizations, and at local and regional rather than national or international levels, and that they are more often involved as committee members rather than chairpersons.[68]

[61] ILO (2008a), op cit.
[62] Ibid; and United Nations Economic Commission for Latin America and the Caribbean (2007), *Social Panorama of Latin America*, Santiago, Chile.
[63] ILO (2008a), op cit.
[64] Ibid.
[65] I. Hirway (2008b), op cit.
[66] M. Daly (2008), op cit; and UNIFEM (2005), op cit.
[67] Information from the IPU website. Available at: http://www.ipu.org/wmn-e/world.htm (last accessed on 5 January 2009).
[68] M. Daly (2008), op cit.

3. POLICY RESPONSES TO ADDRESS UNEQUAL SHARING

64. Women's unequal share of unpaid work is one of the most persistent barriers to gender equality, and governments have a responsibility to address this issue in all policy initiatives to assist women and men in reconciling work and family responsibilities and to ensure equal sharing of responsibilities between women and men.

65. Insufficient policy attention has been given to caregiving for children, the sick, elderly and disabled, resulting in neglect of the needs of both care recipients and caregivers. The provision of basic services such as primary education and health services can reduce the burden of care work on families, especially in developing countries. However, developments, such as cuts on health sector spending and increased reliance on out-of-pocket payments by users, have increased the burden on care providers at the household level.

66. Public policy interventions have been undertaken to support men's and women's equal roles and responsibilities, including leave provisions, regulation of working hours and conditions, cash benefits, provision of care services and facilities. Policy responses have also included improvement in social infrastructure, such as increased access to education and health institutions, and physical infrastructure projects to reduce time burdens, including public transportation and access to energy and water. In some cases, policies that are directly targeted at women have the potential to reinforce stereotypes and inequalities with regard to care work if they are based on the assumption that women are primary caregivers and fail to recognize the care responsibilities of men.

67. The most well-known approach in addressing the equal sharing of responsibilities between women and men is the provision of leave. In addition to maternity leave provided by most States, paternity leave, or leave for the father at the time of the birth of a baby, is also increasingly provided, but it is generally very short in duration. Parental leave, with variation in eligibility, payment and duration, is a planned longer- term arrangement for care of young children, and may be taken up by either parent.[69] There are, however, limitations on the impact of these provisions in contexts where most work takes place in the informal sector.

68. Many countries have introduced policies on working arrangements in order to ensure equal division of responsibilities between women and men. These include reduction of long legal working hours, flexibility of work-time and location, and the possibility of taking part-time work. However, even where part-time options are available to both women and men, they are mainly taken up by women because of stereotypical assumptions about their roles as caregivers and their lower salaries.[70]

69. Some countries offer cash benefits in the form of family and child allowances to assist families with the costs of raising children and to support the well-being of families. Cash payments tend to strengthen the provision of care by family members and may reinforce

[69] ILO (2008a), op cit.
[70] Ibid.

perceptions of women as caregivers and exonerate other sectors from responsibility.[71] Cash transfers, often targeted at poor families, have become a common social assistance instrument in recent years. They are often conditional on families complying with certain requirements which may add to the responsibilities of women (such as school attendance, taking children to health-checks or attending workshops on nutrition).[72]

70. Reliable and affordable provision of care facilities for children, the sick and the elderly plays a key role in facilitating reconciliation of work and family life. The most commonly provided facilities are preschools and kindergartens. For children under three years of age, public financing for care facilities is less common. Governments have encouraged the private sector, non-governmental organizations and private entities to become active providers, and have made efforts to make childcare more affordable by providing subsidies to care providers or income allowances to parents.[73]

71. Investment in public infrastructure, such as water, transportation and energy, are important policy responses in developing countries, with significant impact on the care work done within households, particularly in the context of HIV/AIDS. Technological innovations, such as labour-saving technology and electrical appliances, could further reduce the burden of time and energy for women in household work and caregiving, but are often too expensive for poor households.[74]

72. Policy responses have not always been explicitly driven by the objective to reduce the unequal sharing of responsibilities between women and men, but have often been linked to other issues, such as the need to strengthen women's engagement in the labour market to increase economic efficiency. They target women and men as workers or potential full-time workers without taking into consideration other issues such as their caregiving responsibilities.[75] Policies do not go deep enough or far enough in changing the structures and institutions that reinforce gender inequalities.[76]

73. A macroeconomic perspective is critical when addressing social and individual well-being and the equal development of human capabilities because macroeconomic policy regimes greatly influence the policy space available for effecting positive social change. Different macroeconomic policy regimes - i.e. those that determine fiscal, monetary, trade and exchange rate policies- have varying effects on social and individual well-being and the development of human capabilities. The neoliberal economic regime advocates limited government spending, low inflation, free trade and capital mobility, and floating (market-determined) exchange rates. These policies have had diverse impacts, with some countries experiencing modest to high economic growth and others losing out. Changes in employment

[71] S. Razavi (2007), op. cit.
[72] UNRISD (2008), op cit.
[73] ILO (2008a), op cit.
[74] Ibid.
[75] J. Lewis (2002), 'Gender and welfare state change' *European Societies*, Vol. 4; and A. S. Orloff (2005), *Farewell to Maternalism? State Policies and Mothers' Employment*, Chicago: Northwestern University Working Paper Series.
[76] M. Daly (2008), op cit.

rates, the quality of employment, public expenditures on social welfare as well as economic insecurity often have a negative impact on women and exacerbate gender inequality.[77]

V. SHARING OF CAREGIVING IN THE CONTEXT OF HIV/AIDS

1. CAUSES OF UNEQUAL SHARING

74. Over 33 million people worldwide are living with HIV/AIDS. In low and middle-income countries, nearly 10 million are in immediate need of treatment and care yet only 3 million are receiving it. Seven million people sick with HIV/AIDS are in need of intensive and long-term care.[78]

75. Some countries have experienced cuts in spending on health care and reductions in other services that are important to those caring for the sick, including electricity, water and sanitation. Research in 2007, for example, indicated that there are five doctors per 100, 000 doctors in Lesotho, 74 in South Africa, and 222 in the United Kingdom. There is a similar discrepancy in the number of nurses, with Lesotho having 62 and South Africa 393 per 100, 000 people respectively, compared to 1,170 in the UK.[79] This illustrates the weaknesses in public health systems in many countries.

76. Patients with HIV/AIDS represent between 40-70 per cent of public health facility users in the most affected countries across Africa, in particular in Southern Africa which has the highest prevalence rates on the continent.[80] Globally, millions of adults with HIV/AIDS are dying without access to anti-retroviral drugs.[81] Few pregnant women infected with HIV/AIDS in Africa receive the antiretroviral (ARV) treatment that can prevent the transmission of the virus to their unborn child; in low and middle-income countries, 33 per cent of pregnant women infected with HIV/AIDS received such treatment in 2007.[82] Prevention of mother to child transmission is valuable, but women do not have sufficient access to treatment since most of it is aimed at the risk of reducing infections to their children during pregnancy or childbirth. In Africa ARV coverage for infected people remains low. At the end of 2007, only about 31 per cent of those who need treatment had received ARV

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[77] I. Hirway (2008a), *Restructuring of Production and Labour under Globalization: Case of Textile and Garment Industry in India*, New Delhi: ILO Regional Office; L. Beneria and S. Feldman (eds.) (1992*), Unequal Burden: Economic Crises, Persistent Poverty and Women's Work*, Colorado: Westview Press; and D. Elson and N. Cagatay (2000), 'The social content of macroeconomic policies' *World Development*, Vol. 28 No. 7.

[78] Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008a), 'Caregiving in the context of HIV/ AIDS' Background paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/BP.4).

[79] Médecins Sans Frontières (2007), *Help Wanted: Confronting the Health Care Worker Crisis to Expand Access to HIV/AIDS treatment: MSF Experience in Southern Africa*, Johannesburg, South Africa.

[80] O. Shisana et al (2002), *The Impact of HIV/AIDS on the Health Sector: National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities,* , Pretoria: HSRC Press ; and S. Shaibu (2006),'Community home-based care in a rural village: challenges and strategies' *Journal of Transcultural Nursing*, Vol. 17, No.1

[81] AVERT (Averting HIV and AIDS) website. Information available at: http://www.avert.org/aafrica.htm (last accessed on 5 January 2009).

[82] UNAIDS (2008b), *Report on the Global AIDS Epidemic*, Geneva.

treatment.[83] This imposes a heavy burden on their families, volunteer carers and public health systems.

77. Many people living with HIV/AIDS and their caregivers struggle without a formal diagnosis, which means that they do not access voluntary support services and other related programmes that could provide much needed support.[84] Gender inequality in decision-making around health means that women may not be able to fully access external support for themselves or their families because they need permission or consent from their husbands. The carers who are 'unlinked' to programmes face many challenges in providing caring without training and support including material inputs such as gloves and medication.[85] Older carers find it difficult to access medical care and the health system for themselves and their dependents. Barriers include long waiting times, transportation difficulties, unhelpful staff, and inaccessible services.[86]

78. Governments, particularly in Africa, support and even actively promote home-based care, including through volunteer organizations, in response to the capacity problems facing the public health systems, but still cannot cope with the demand for care. The home is replacing the hospital as the primary place of care for people with HIV/AIDS.[87] Households, extended families and communities play, by far, the largest role in the care of people with HIV/AIDS.[88]

79. Many home-based caregivers are family members but they may also be volunteers (who tend to have a similar profile to that of family caregivers). Cutbacks in public health and other social sector spending lead to a downsizing of health services in order to achieve cost-effectiveness. This increases the care burden of households and reinforces pre-existing norms and expectations on women's 'traditional' roles as nurturers and caregivers.[89]

80. There is unequal distribution of HIV/AIDS related care work responsibilities. Girls and women of all ages disproportionately assume caring roles, compared to boys and men. Caregiving 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. Women of reproductive age, however, predominate among caregivers. Caregivers are often in a non-typical relationship as a carer (as a child or parent of an adult).[90] It has been

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[83] UNAIDS (2008a), op cit.
[84] J. Ogden et al (2006), 'Expanding the care continuum for HIV/AIDS: bringing carers into focus', *Health Policy and Planning*, Vol. 21.
[85] Ibid.
[86] UNAIDS (2008a), op cit.
[87] O. Akintola (2008a), 'Defying all odds: coping with the challenges of volunteer caregiving for patients with AIDS in South Africa', *Journal of Advanced Nursing*, Vol. 63 No. 4.
[88] R. Loewenson (2007),'Learning from diverse contexts: Equity and inclusion in the responses to AIDS', *AIDS Care*, Vol. 19.
[89] Voluntary Services Overseas (VSO) (2003), *Gendering AIDS: Women, Men, Empowerment, Mobilization*, London. Available on the web at: http://www.vso.org.uk/Images/gendering_aids_tcm8-809.pdf (last accessed on 6 January 2009).
[90] C. Campbell and A. Foulis (2004), 'Creating contexts for effective home-based care of people living with HIV/AIDS' *Curationis*, Vol. 27; N. Hunter (2007), *It's Like Giving Birth to the Sick Person for the Second Time:*

estimated that globally women and girls provide 70 to 90 per cent of the care to people living with HIV/AIDS.[91] Most of these are poor women.

81. Older women are significantly affected because a substantial proportion of people living with HIV/AIDS move back to their communities of origin at some stage of the illness to be cared for by their parents, and older women more often than older men take responsibility for their grandchildren where the parents are ill, absent or working.[92] A combination of deaths of parents and other caregivers of productive age, and poverty and employment-driven migration, result in a shortage of adults, and much of the caring work is done by older women.[93]

82. Married women are significantly affected. Studies have shown that for married men, where care normally takes place in the home, the caregiver is most likely to be the wife.[94] Women are likely to be the caregivers in marriages where the male partner or both partners are ill, with women who are ill providing care for themselves as well as their male spouses. [95] Men may be less prepared to care for their wives, and if women in their household are ill, this leads to a need for external support from home-based care programmes.[96] Women who have lost their husbands or those in common law unions may also be denied access to family property and finances by their husbands' family,[97] leaving them with care burdens and financial responsibilities.

83. Children carry a considerable share of the care burden. As secondary providers of care supporting their parents or grandparents, they have received limited attention because of the failure of policy makers to acknowledge that children play a major role in providing care.[98] A South African study found that two thirds of carers under 18 were girls.[99]

84. Women tend to carry out responsibilities that are more 'hands-on', incur greater time expenditure and are emotionally draining. Responsibilities performed by men are usually those requiring physical strength and finances or those which can be accomplished in a shorter time, such as transportation to health facilities and managing financial and legal

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Family Caregivers' Perspectives on Providing Care, School of Development Studies, University of KwaZulu-Natal (Working paper no. 44).

[91] UNAIDS, UNFPA and UNIFEM (2004), *Women and HIV/AIDS: Confronting the Crisis,* Geneva.

[92] J.Knodel et al (2001a), 'Older people and AIDS: quantitative evidence of the impact in Thailand', *Social Science & Medicine,* Vol. 52.

[93] M. Chazan (2008), 'Seven "deadly" assumptions: unravelling the implications of HIV/AIDS among grandmothers in South Africa and beyond', *Ageing and Society,* Vol.28

[94] J. Knodel et al (2001a), op cit.

[95] O. Akintola (2008b), 'Towards equal sharing of AIDS caring responsibilities: learning from Africa' Paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/EP.5)

[96] UNAIDS (2008a), op cit.

[97] R. Strickland (2004), *To Have and to Hold: Women's Property and Inheritance Rights in the context of HIV/AIDS in sub-Saharan Africa,* Washington DC: International Center for Research on Women (ICRW).

[98] E. Robson (2000), 'Invisible carers: young people in Zimbabwe's home-based health care', *Area,* Vol. 32.

[99] M. Steinberg et al (2002), *Hitting Home: How Households Cope with the Impact of the HIV/AIDS epidemic: a Survey of Households Affected by HIV/AIDS in South Africa,* Durban:,Abt Associates Inc.

affairs. Although the male breadwinner model requires that men provide finances for their households, they may be unable to do so when they are ill, unemployed, absent or when they have absconded.[100]

85. Although a disproportionate burden of caring falls on women and girls, many men and boys also play a significant role in caring for the ill and take on other responsibilities for the sustenance of household livelihoods. However, men's contributions are rarely acknowledged and are generally downplayed by society, researchers and gender equality advocates. Men are rarely acknowledged for the role they play as secondary care providers and assisting women who are the primary care providers, providing respite and care for women carers, or providing care where women are not available, such as in the case of single male parents or gay men providing care for their male partners.[101] Men who are willing to challenge traditional gender roles by caring are often derided and ridiculed by both men and women.[102]

86. Fear of stigma and discrimination cause many to provide care in secrecy, leading to further isolation for the carer and the patient. [103] Both family and volunteer caregivers suffer similar stigmatization and discrimination to that experienced by their patients.[104] HIV/AIDS related stigma can also be found where there is limited understanding of the nature, cause and transmission of HIV. In Sukumuland in Northern Tanzania, for example, there is widespread belief that AIDS-related deaths are caused by witchcraft. Witchcraft accusations lead to intimidation and victimization of women, particularly older women, including physical attacks and murder, destruction of property, eviction from family property and ostracism. Older men are also, albeit less frequently, subject to witchcraft allegations.[105]

2. CONSEQUENCES OF UNEQUAL SHARING

Consequences for physical health

87. The physical labour of fetching water, lifting patients to help them to the toilet or to wash them, cooking, cleaning and farming, and the lack of resources to spend on their own medication, have detrimental effects on the carer's own physical health.[106] In many rural

[100] D. Philippe and R. Ntsimane (2005),'The absent fathers: Why do men not feature in stories of families affected by HIV/AIDS' in L Richter and R Morrell (eds), *Baba: Men and Fatherhood in South Africa*,Pretoria: HSRC Press.
[101] O. Akintola (2008c), 'Unpaid HIV/AIDS care in Southern Africa: forms, context, and implications', *Feminist Economics*, Vol. 14 No. 4; and H. Turner and J. Catania (1997), 'Informal caregiving to persons with AIDS in the United States: caregiver burden among central cities residents eighteen to forty-nine years old' *American Journal of Community Psychology*, Vol. 25 No. 1.
[102] C. M. Montgomery (2006), 'Men's involvement in Southern African families: engendering change in the AIDS era', *Social Science and Medicine*, Vol. 62; G Barker (2008), op cit; and O. Akintola (2006), 'Gendered home-based care in South Africa: more trouble for the troubled', *African Journal of AIDS Research*, Vol. 53.
[103] A. Moreau et al (2007), *Implementing STI/HIV Prevention and Care Interventions for Men who have Sex with Men in Dakar, Senegal*, Washington DC: Horizons Report.
[104] D. Orbach (2007), *Committed to Caring: Older Women and HIV/AIDS in Cambodia, Thailand and Vietnam*, London, HelpAge International; O. Akintola (2008b), op cit; and P. Mwinituo (2006). 'Stigma associated with Ghanaian caregivers of AIDS patients', *Western Journal of Nursing Research*, Vol. 28 no. 4.
[105] UNAIDS (2008a), op cit.
[106] C. Saengtienchai and J. Knodel (2001b), 'UNAIDS Case Study, Parents providing care to adult sons and daughters with HIV/AIDS in Thailand', *Journal of Family Issues*, Vol. 26 No. 5.

areas in the developing world, water is a scarce resource and may have to be carried from rivers, wells or public standpipes located far away from dwellings. It takes an estimated 20-80 litres of clean water to provide care every day to a person living with AIDS to wash them, clean soiled sheets and clothes, and wash dishes and prepare food.[107] Without proper training, information and supplies, there is also the risk of exposure to communicable opportunistic infections. Many carers are living with HIV/AIDS themselves and need to take care of their own health concerns. Women caregivers often ignore their own health concerns.[108] The physical and psycho-social impacts of caring on the well-being of caregivers are rarely acknowledged.

88. A significant challenge for older caregivers (both men and women) is that they are often at a time in their life when they expect to be cared for by their children, and they are not emotionally, physically or financially prepared to fully provide for their newly acquired dependents.[109] Physical ailments affect many older caregivers, including strained muscles, fatigue, arthritis, high blood pressure, diabetes, as well as hearing, vision and mobility problems.

Consequences for psychosocial wellbeing

89. The emotional stress on carers of all ages can be significant, including both women and men. Children without adult supervision, having experienced the grief of losing their parents, face the responsibility of feeding and clothing their siblings which puts them at risk of exploitation and harm. Some adults care for their partners and loved ones and, for those that do not return to health, experience the pain of watching them die.[110] Many grandparents, parents and other carers find they have little time to grieve as they have to be emotionally and physically strong to support and look after the dependent children left behind.[111]

90. The fact that many of those in caregiving roles are also themselves living with HIV/AIDS causes additional psycho-social trauma for the caregiver. The demanding nature of caring for both sick adults and children means that carers can face social isolation.[112]

Financial costs

91. Poor households that are burdened with the financial costs of caregiving move further into poverty. The increased financial costs related to caring for the sick range from costs incurred to provide immediate care (such as gloves, medicines and water) to financial outlays for medicines (prescribed, over the counter, from clinical therapists or traditional healers), user

[107] B. Ngwenya and D. Kgathi (2006), 'HIV/AIDS and access to water: A case study of home-based care in Ngamiland, Botswana', *Physics and Chemistry of the Earth*, Vol. 31.
[108] World Health Organization (2003), *Integrating Gender into HIV/AIDS Programmes: A Review Paper*, Geneva.
[109] P. Reddy (2005), *Inkala ixinge Etyeni: Trapped in a Difficult Situation: The Burden of Care on the Elderly in the Eastern Cape, South Africa*, Johannesburg: Horizons Report.
[110] UNAIDS (2008a), op cit.
[111] C. Saengtienchai and J. Knodel, (2001a) op cit.
[112] D. Orbach (2007), op cit.

fees and transportation costs for accessing health care services, and rising food and other costs.[113]

92. In Thailand, almost half of the parents who were primary caregivers of someone living with HIV/AIDS borrowed money, and many never expected to get out of debt.[114] The financial cost to older carers is exacerbated by a loss of financial support from their adult children when they become sick, particularly in communities where there is a high co-residence rate between older parents and their children.[115] Economic pressures from the burden of care can lead to sexual risk-taking by carers of all ages, increasing their susceptibility to HIV/AIDS infection by engaging in income earning activities and survival strategies, including exchanging sex on an informal transactional basis.[116] Caregivers also incur transport costs to health centers to obtain treatment for opportunistic infections, costs of anti-retroviral therapy and food costs.[117]

93. In many countries, women are less likely than men to receive a pension through the formal employment sector. Older women face age-discrimination when they are considered beyond the productive working age, impeding their income earning abilities, a situation further exacerbated for those who have lower levels of literacy and education than their male counterparts. [118]

Opportunity costs

94. Women produce between 60-80 per cent of the food in most developing countries.[119] In agrarian economies, families with a sick member must make trade-offs in the allocation of time between caring and farm work.[120] The extra responsibilities of women's HIV/AIDS related care can divert their labour from productive agricultural work, thus limiting their earning potential.

95. Households sometimes take children out of school to provide care, reduce expenditure or work on the farm. Girls are more likely to be withdrawn from school to provide care while boys are withdrawn to work on the farm or in the informal market.

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[113] Ibid.
[114] J. Knodel et al (2002), 'The impact of an adult child's death due to AIDS on older-aged parents: results from a direct interview survey', Institute for Population and Social Research, Mahidol University, Thailand, *IPSC Research Report* No 266.
[115] J. Knodel et al (2001a), op cit.
[116] UNAIDS/UNIFEM/UNFPA (2004), op cit.
[117] O. Akintola (2004a), *A Gendered Analysis of the Burden of Care on Family and Volunteer caregivers in Uganda and South Africa:* ,Durban, Health Economics and HIV/AIDS Research Division (HEARD).
[118] HelpAge International (2007), *Stronger Together: Supporting the Vital Role Played by Older People in the Fight against the HIV and AIDS Pandemic*, London.
[119] United Nations Department of Economic and Social Affairs (2005), *The World's Women: Progress in Statistics*, New York.
[120] S. Nnko et al (2000), 'Tanzania: AIDS Care -Learning from Experience', *Review of African Political Economy*, Vol. 27 No. 86; and O. Akintola (2008b), op cit.

96. Households with a sick family member have to make trade-offs between working fewer hours to spend more time caring, or working more hours to cover increased expenditures.[121] Gender inequalities in employment opportunities also impact on women's caregiving responsibilities. If one person in a working couple needs to spend time at home to care for a family member, the person with the most flexible working arrangement or lower income earning capacity – in both cases usually the woman – will be the person to sacrifice income earning opportunities for caregiving.[122]

97. HIV/AIDS caregivers who take extended leave to provide care may lose their jobs and find it difficult to return or find other jobs. Many caregivers are in vulnerable employment, especially in the informal sector, and are unable to take leave for caregiving, have to leave their jobs or lose their jobs involuntarily.[123] Women who are self-employed, for example, in petty trading, tailoring and hairdressing, also lose opportunities for earning an income.[124] Women employed in the formal sector with no flexibility in reducing their working hours have to balance their paid job and their role as primary carers in the home. One study found that one in five Kenyan health workers was also caring for an immediate family member living with HIV/AIDS.[125]

98. Women providing care in their own homes, or working as volunteers in home-based care programmes, have the additional burden of providing for the needs of their own households, including working on farms or in businesses and spending time with family and children.[126]

3. POLICY RESPONSES TO ADDRESS UNEQUAL SHARING

99. The increased care burden as a result of the HIV/AIDS pandemic has exposed the inadequacy of the health sector in many developing countries. Difficulty in accessing institutional health care often means that households, and generally women, have to take on a greater responsibility for caring for the ill or dying.[127] Research shows how women, in particular, have been disproportionately affected by fee-based care provision in countries such as Nigeria, Zimbabwe and Tanzania.[128]

100. In developed countries, governments, aided by civil society, have taken on much of the responsibility of HIV/AIDS prevention, treatment and care. They generally have well-

[121] In Swaziland 31 per cent of households diverted labour to care for the sick as a result of HIV/AIDS. See D. Budlender (2007), *A Critical Review of Selected Time Use Survey*, Geneva: UNRISD.
[122] C. Saengtienchai and J. Knodel (2001b), 'UNAIDS case study: parents providing care to adult sons and daughters with HIV/AIDS in Thailand', *Journal of Family Issues*, Vol. 26, No. 5.
[123] E. Lindsey et al (2003), 'Home-based care in Botswana: experiences of older women and young girls', *Health Care for Women International*, Vol 24, No 6; and O Akintola (2006), op cit.
[124] O. Akintola (2004b), *Home-Based Care: A Gendered Analysis of Informal Caregiving for People with HIV/AIDS in a Semi-rural South African Setting*, Durban: University of KwaZulu-Natal, PhD dissertation.
[125] H. Khan (2006), *On the Frontlines: Kenyan Health Workers Confront HIV-related Challenges at Work and Home*, Washington DC: Horizons Report.
[126] O. Akintola, (2009), 'Unpaid HIV/AIDS care, gender and poverty: exploring the links' in R. Antonopoulos and I. Hirway (eds), *Unpaid Work and the Economy: Gender, Time Use and Poverty*, forthcoming.
[127] Ibid.
[128] Ibid.

functioning health systems and the money to expand those systems to address new threats. Many developing country governments lack this capacity. [129]

101. The majority of the caring in HIV/AIDS affected societies is borne by the poor. Poor people are more likely to use public health services in developing countries[130] and the impact of HIV/AIDS is more severe among poor rural households and communities.[131] Some countries rely increasingly on a continuum of care, including public health facilities, home-based care provided by families or volunteers, households and other organizations providing support. Home-based care receives little attention and support from policy makers.

102. Home-based care and voluntary organizations have created a major shift in the primary place of care for people living with HIV/AIDS from public institutions to families, which affect the poor, and particularly poor women. Home-based care organizations include faith-based organizations, community-based organizations as well as non-governmental and non-profit organizations. Care organizations, through their volunteers, provide physical, emotional, material and financial support and assistance to affected households. This includes provision of spiritual care, basic nursing care and assistance with household work, food, access to medical treatment, clinics and hospitals, and support with accessing social grants, among others.[132]

103. Many home-based care organizations are poorly funded, receiving very little support from national governments. They have to obtain funds from international organizations which are reluctant to pay for volunteer stipends. Care organizations therefore depend almost entirely on unpaid volunteers, who are mainly women, for the care of community members. Volunteers share a similar profile with their patients and many of them are infected with HIV/AIDS or related to an infected person.[133] They are, in some cases, supported by care organizations which provide training and a range of services to family caregivers and their patients.[134]

104. There has been progress in a number of areas in increasing the participation of men and boys in caregiving within the context of HIV/AIDS. Successful projects include the Men as Partners Network, the Africare project in Goronmozi and Mutasa districts of Zimbabwe, the Horizons project among youth in Zambia, and the MenEngage Network. All of these initiatives have shown positive results but many are limited in size, impact and sustainability.[135] In Malawi, the Chitipa District AIDS Coordinating Committee requires that

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[129] D. Peacock and M. Weston (2008), 'Men and care in the context of HIV/AIDS: structure, political will and greater male involvement' Paper prepared for the Expert Group Meeting on 'The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS' organized by the Division for the Advancement of Women, Geneva, Switzerland, from 6-9 October 2008 (EGM/ESOR/2008/EP.9).
[130] O. Akintola (2009), op cit.
[131] UNAIDS (2008a), op cit.
[132] P. Blinkhoff et al (2003),*Under the Mupundu Tree: Volunteers in Home-Care for People with HIV/AIDS and TB in Zambia Copperbelt*, London: ActionAid; and L Steinitz (2003), 'When spider webs unite: the work of volunteers in providing home-based care in Namibia', *Journal of HIV/AIDS and Social Services*, Vol. 2 No 1.
[133] O. Akintola (2008c), op cit.
[134] O. Akintola (2008a), op cit.
[135] E. Esu-Williams et al (2006), 'We are no longer called club members but caregivers: Involving youth in HIV and AIDS caregiving in rural Zambia' ,*AIDS Care*, Vol. 18 No 8; and D. Peacock and M. Weston (2008), op cit.

community home-based care programmes ensure a minimum of 40 per cent male volunteers. In other countries, including Botswana, South Africa, Swaziland, Tanzania, and Uganda, national HIV policies and strategies explicitly encourage men to play a greater part in care.[136] The involvement of men in national programmes and campaigns to prevent the spread of HIV/AIDS and other STIs has helped to educate the public on the benefits of shared responsibilities.

VI. RECOMMENDATIONS OF THE EXPERT GROUP MEETING

105. The Expert Group envisions a future society where responsibilities between men and women are shared in a just and fair manner so that both women and men have equal access to opportunities to development and freedom to choose the life they want to lead. The vision also includes an enabling macro-environment that promotes economic development for the well-being of all people. Based on discussion of the nature of the problem of unequal sharing of responsibilities between men and women, including caregiving in the context of HIV/AIDS, and analysis of the causes and consequences, recommendations at different levels are presented below.

1. An economic, social and cultural strategy for care and social provisioning
2. A macro-economic approach that targets and invests in social and individual well-being and the equal development of human capabilities for women and men
3. Labour and social policies to support the equal sharing of caregiving responsibilities and eliminate inequalities in the labour market
4. Addressing the sharing of caregiving in the context of HIV/AIDS
5. Transformation of the models of the female carer and the male "ideal" worker/elimination of stereotypes
6. Transformation in attitudes and behaviour on the part of men and boys
7. Research and data collection.

1. An economic, social and cultural strategy for care and social provisioning

106. An economic, social and cultural strategy for care is needed in order to support fairness and justice in the sharing of responsibilities so that women and men can have equal human development opportunities. Such a strategy should acknowledge the societal and individual value of adequate care for all. Every country and relevant international organizations should have a policy on caregiving with the goal to value care and to undertake measures to promote equality responsibilities for caregiving. Such measures should be oriented to ensuring the well-being and development of both caregivers and those receiving care. This involves identifying and working with a continuum of caregivers – individual women and men, families/households, communities, employers, public and private institutions and services – and aiming for a mix of provisions. 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.

[136] UNAIDS (2008a), op cit; and D. Peacock and M. Weston (2008), ibid.

107. An economic, social and cultural strategy for care is needed if adequate caregiving standards are to be maintained, care workers are not to fall further behind other occupational groups in their pay and work conditions, and informal care resources are not to be depleted. Such a strategy is also necessary to support social cohesion and solidarity and encourage those currently engaged in unpaid care work to enter the labour market.

108. Policy tends to reflect the social norms and practices of a society but policy can also change those norms and practices. An economic, social and cultural strategy for caring should emphasize the societal and individual value of investing in care. This will not be achieved without public support through subsidizing caregivers, or provision through the market, not-for-profit providers or the public sector. Such a strategy will also need to give specific attention to improving the standards of care and the training and pay of care workers to ensure that market forces do not lead to downward pressure on standards of care and the wages of care workers. Unlike in other areas, raising productivity in paid care work is difficult, since lowering the ratio of care-giver to cared-for usually implies lower quality standards of care.

109. Extensive public funding for investment in caring will be needed if those doing unpaid care work are to have the possibility to enter the labour market. Furthermore, if the wages of care workers are to keep up with rising wages of those in other occupational groups, wage costs for care will rise. Public spending on care has to grow in line with the GDP to maintain the status quo, and would need to grow as a proportion of GDP if care standards are to improve, working conditions to improve, and/or coverage to grow. Public spending on caring will also have to grow if the number of people needing care increases, as in the context of HIV/AIDS, or if poverty levels increase so that more people will need financial support to meet their own or their families' care needs. It would be possible to allocate sufficient public resources to maintain the care sector in contexts where the increased need for care is linked to productivity gains in the economy, including from women's increased labour force participation. It is appropriate that the benefits of those productivity gains should be shared with those needing care by raising the proportion of GDP spent on care.

110. Capacity-building measures are needed to enhance access of both women and men to caregiving training, education and developmental opportunities. Increasing caregivers' social assets and social capital, including through strengthening their social connectedness and affiliations, should be the subject of policy effort. Equally important are efforts to consult and involve informal caregivers in decision-making processes, related to policy, budgets and programming, to enhance accountability and reduce the wastage of resources.

111. An economic, social and cultural strategy requires political will and power. The lack of such a strategy for care shifts power away from those who continue to provide care, and erodes caring norms. Without such a strategy, availability and standards of care will fall, with high cost to society as a whole and in particular to those who provide care.

112. It is important to mainstream care and the support of caregivers into overall policy-making in relevant policy areas. Policy-makers must assess the effects of government policies on the ability of people to provide care and on the provision of the support they need.

Policies can have unintended negative effects, irrespective of their objectives. For example, policies to raise employment levels will be ineffective if they do not take into account the needs of those who are out of the labour market because of care responsibilities.

Recommendations

113. Governments, civil society, international organizations and the private sector, as appropriate, should:

- Place gender equality and the empowerment of women and girls at the core of all policies and programmes;
- Ratify and fully implement the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child and the ILO Convention 156 on Workers with Family Responsibilities;
- Recognize public spending for care as a long-term societal investment which has to be accounted for as capital expenditure;
- Recognize, value and validate formal and informal provisions of care as an important activity, with long-term consequences for both individuals and society as a whole;
- Take steps to measure the volume of unpaid care work through time-use studies and value its contribution to GDP;
- Provide sufficient public resources for the provision of formal care services and the support of informal care to ensure adequate and high quality support for all, both caregivers and care recipients; and
- Incorporate the experiences of caregivers into the development and implementation of care policies.

114. In relation to the mainstreaming of care and the support of caregivers into overall policy making, Governments should:

- Evaluate all policies at the policy formation stage, regardless of their objectives, for their likely effects on care;
- Conduct care audits of existing policies to assess needs for care and develop new, or amend, existing policies on caregiving;
- Monitor the implementation of care policies at national and regional levels and include caregivers in this process;
- Encourage the private sector, civil society organizations (including trade unions) and donors to carry out care-audits of their own operations;
- Set up national and international mechanisms involving care professionals and gender equality experts to carry out analysis of care policies and publish findings regularly; and
- Take measures to ensure that public resources for care increase faster than GDP.

Indicators

115. The following indicators may be useful in measuring progress:

- Public spending on formal and informal care provisions as a percentage of GDP, per capita, for specific care provisions (such as day-care centres and nursing homes) and by means of provision (cash/services);
- Effective accessibility of care, measured as a percentage of certain age groups/need categories who use formal care;
- User/care-giver ratio to assess quality of care;
- Cost of care as a percentage of the median wage;
- Proportion of care givers at various levels of qualifications;
- Care-giver representation as a proportion of those involved in decision-making bodies related to care; and
- Number of Governments/international organizations/civil society organizations using care-audits for their own policy formation and monitoring.

2. A macroeconomic approach that targets and invests in social and individual well-being and the equal development of human capabilities for women and men

116. The Expert Group recommends that countries adopt macroeconomic policies that target human development and create decent employment, paying particular attention to how employment expansion can reduce gender inequality, enhance caregiving and improve the working conditions of caregivers. This is particularly relevant in the current context of a global recession.

Fiscal policy

117. The structure and amount of government spending is essential to guaranteeing that the macroeconomic environment is supportive of social and human development. Public spending on education and health should be treated as capital investment rather than consumption spending, since these expenditures add to long-term productive capacity. Similarly, care work should be seen as investment in human capital. Treating these expenditures as consumption leads to a bias in investment for expanding physical infrastructure rather than investment in human capabilities.

118. Financing for development often necessitates borrowing on international financial markets, and developing country governments are sometimes encouraged (even required) to prioritize debt repayment over social spending by their creditors. Such requirements ignore the essential link between effective public services and economic and social development.[137]

119. At times, privatization of public services, such as health care services, is proffered as a win-win solution to the dual challenges of public provisioning and fiscal deficits. However, such recommendations are often not sufficiently based on sound empirical assessment of the effectiveness of private provision for health and other public service delivery. While governments may save money in the short-term, the more long-term costs to unpaid

[137] Report of the Secretary-General (2008), 'Financing for gender equality and the empowerment of women', E/CN.6/2008/2.

caregivers in covering the gaps in provision left by a diminished public health care system need to be analyzed.

120. There are two additional arguments against raising public spending in the neoliberal paradigm. The first is that government borrowing will raise interest rates (as governments draw on the same capital markets as private borrowers), and "crowd out" domestic investment. This perspective overlooks the fact, however, that private capital requires the type of physical infrastructure and human capital that only public spending can produce. In that sense, government spending actually "crowds in" private investment. The second neoliberal argument against government spending is that it adds to inflationary pressures because it expands demand for goods and services. But this perspective ignores the fact that different types of spending have different inflationary impacts. Public spending on the health care sector, for instance, might alleviate inflationary pressures by addressing the supply constraints that raise prices (for example, shortages in nursing).[138]

Monetary policy and inflation-targeting

121. Inflation-targeting has dominated central bank policy across the world, which involves using monetary policy (such as raising interest rates) for the exclusive purpose of maintaining an extremely low inflation rate (typically around three per cent, regardless of level of economic development). Low inflation benefits global finance by protecting creditors against losses in the real value of their assets. However, employment creation, including expanding employment in the care sector, may put upward pressure on prices and therefore be incompatible with inflation targeting. Empirical evidence on the link between inflation and growth in a development context indicates that targeting extremely low inflation rates restricts economic expansion and public spending, both of which are necessary if care is to be adequately provided and caregiving responsibilities more equally shared.[139]

122. If national governments and central banks are committed to maintaining extremely low inflation at all costs, rather than balancing the goal of price stability with employment creation, there will be little opportunity for the types of public policies that are necessary to support social provisioning and care. It is important to note that the Expert Group does not recommend doing away with inflation targets, or imply that hyperinflation is a reasonable alternative, but rather that central banks should incorporate development goals into monetary policy-making. This is particularly relevant in times of global recession.

Trade policy

123. Trade policy, and global trade negotiations, must be assessed in terms of their impact on social provisioning. An important example is the General Agreement on Trade in Services (GATS), one of the many agreements currently being negotiated at the World Trade Organization (WTO). Part of the intention of the GATS is to make it easier for health care

[138] J. Stiglitz al (2006), *Stability with Growth: Macroeconomics, Liberalization and Development*, New York: Oxford University Press.
[139] For more on the relationship between inflation targeting and development, see *International Review of Applied Economics* (2008) Vol. 22, No. 2.

workers to travel abroad in search of higher wages – a result that will certainly increase the inequality in health care services provided in the developed versus developing countries. While it is not proposed that such migration be limited, countries that lose skilled workers should be compensated for their investment in training and education.[140]

National accounts

124. Carrying out the analyses called for above, and in the following sections, requires that national accounts be transformed so that they recognize and measure all caregiving. This should be done in two ways: (i) the System of National Accounts (SNA) should include not only home-produced goods but home-produced services, and count all forms of care as personal services; and (ii) satellite care accounts should include both paid and unpaid care work so that the contribution of care to the total economy is made visible.[141]

125. These two measures would make care visible in government policy-making and ensure that unpaid care work is not seen as a "free" resource. Unpaid care is not free, but involves costs for those who perform it, in terms of time and energy, as well as substantial opportunity costs through limiting other activities, especially income-generating activities.

Official development assistance

126. The Expert Group felt it important to raise the need for expanding and better utilizing official development assistance in support of gender equality and caregiving goals, and noted in this context that the agreed developmental assistance of 0.7 per cent of gross national income (GNI) by developed countries to developing countries has not been implemented in practice.

Recommendations

127. International financial, trade and policy institutions, such as the International Monetary Fund, the World Bank, the World Trade Organization and the United Nations can facilitate the widespread adoption of a macroeconomic approach that targets and invests in social and individual well-being and the equal development of human capabilities. More specifically, these institutions should:

- Incorporate a long-term view on investments in human capital (including for care) when addressing debt servicing in the context of lending, trade negotiations, and development assistance;

[140] World Health Organization (2006), 'International migration of health personnel: a challenge for health systems in developing countries,' Report by the Secretariat (A59/18).
[141] I. Hirway (2008a), op cit; EUROSTAT (2003), *Household Production and Consumption: Proposal for a Methodology of Household Satellite Accounts,* Luxembourg, Office for Official Publications of the European Communities; K. G. Abraham and C. Mackie (eds) (2005), *Beyond the Market: Designing Non-market Accounts for the United States*, Washington, DC: The National Academies Press; and United Nations Statistical Division (2000), *Household Accounting: Experience in Concepts and Compilation, Vol. 1 Household Sector Accounts,* New York.

- Integrate impact assessments related to gender equality and the care sector into all multilateral trade policy analysis, development and negotiations;
- Reassess the centrality of inflation-targeting versus developmental goals in global good practice standards for central banks;
- Reform SNA standards to include home-produced services, counting all forms of care as personal services; and
- Create new SNA standards for satellite care accounts.

128. It is recommended that national Governments:

- Conduct trade and policy impact analyses which include assessment of impacts on the care economy and social provisioning, and gender equality more generally;
- Adopt reformed SNA procedures to include unpaid care and other home-produced services in GDP, and create satellite accounts for the care sector;
- Allocate resources to the national bureau of statistics to collect and analyze data on the care sector;
- Expand resources for data collection on the care sector;
- Implement care-aware and gender-responsive budget analysis, including by reclassifying government spending on human capital as investment, rather than consumption; and
- Meet the agreed developmental assistance goal of 0.7 per cent of GNI to developing countries.

Indicators

129. The following indicators may be useful in measuring progress:

- Number of countries that have built satellite accounts;
- Number of countries that have revised SNA standards that account for unpaid care work;
- Number of impact assessments related to gender equality and the care sector integrated into multilateral trade policy analysis, development and negotiations;
- Number of national statistical offices that allocate resources to data collection and analysis of the care sector; and
- Number of care- and gender-sensitive budget analyses published by international financial institutions and national governments.

3. Labour and social policies to support the equal sharing of caregiving responsibilities and eliminate inequalities in the labour market

130. Gender inequalities are observed in all major labour market outcomes and women are disadvantaged in multiple ways. Women have lower workforce participation rates and higher incidence of un/under employment; they work in jobs with poor occupational diversification and are overcrowded in low end and stereotyped jobs; their participation in subsistence work and in informal work where there is little or no social protection is much higher than that of men; and when self employed, they have poor access to credit, technology and training.

Recent experience at the global level has shown that economic growth does not automatically reduce these gender inequalities in the labour market.[142]

131. Social policies that focus on care usually help families with some of the material costs of care for dependents (children, the elderly, those with special needs and people living with HIV/AIDS), but do not cover all the costs for care. These policies range from the direct provision of care services to child allowances and tax credits that help families buy-in the care or provide it themselves. Policies in different countries may produce different results according to the contexts where they are applied. The design of social policies should not take for granted women's role as primary care providers, or reinforce or reproduce gender stereotypes.

"Care-friendly" employment policies

132. Several countries have adopted policies to ensure that women and men can reconcile caregiving responsibilities with employment and achieve equality of opportunity in the labour market. The ILO has contributed significantly through encouraging and supporting national level implementation of relevant ILO Conventions and the development of appropriate national policies.

133. These policies can be broadly divided into the following categories: (a) policies to make employment conditions compatible with caregiving responsibilities, including allowing flexible schedules and/or reduced working time; allowing work from home; granting leave for periods of exceptionally high caregiving demands (such as maternity, paternity and parental leave); (b) policies to provide alternative forms of care to the existing models, including state provided or subsidized child and adult care; and requirements on employers to support employees' child and adult care responsibilities; and (c) policies to provide financial compensation for the costs of fulfilling caregiving responsibilities: financial support during maternity, paternity and parental leave and other leave taken for intense caregiving responsibilities; financial support for supplementary care; payment of allowances for the purchase of care; and various financial incentives to employers for employing those with caregiving responsibilities.[143]

134. Policy measures by governments to reconcile caregiving and paid employment and promote gender equality vary greatly. The measures chosen often depend on policy objectives, such as the promotion of higher employment levels or the retention of skilled workers in the labour market.

135. Care-friendly policies can reinforce women's traditional role as caregivers, especially if they primarily address women workers and ignore the responsibilities of men. Men's responsibility for the care and upbringing of their children and other family members should be encouraged and supported through public policy. Policy makers should use more proactively care-friendly policies to target men specifically, and ensure that there are

[142] International Labour Organization (2008c), *World of Work Report: Income Inequalities in the Age of Financial Globalization*, Geneva.
[143] I. Hirway (2008b), op cit.

incentives for them to become more actively involved in their families. For example, measures developed to bring about flexibility with regard to working hours, work location, career profiles and career development should be offered on terms which will allow men as well as women to take them up.

136. With a large gender pay gap reinforcing unequal gender equality norms, women are more likely than men to make use of care-friendly policies which should enable them to remain in the labour market through intensive care periods. However, women often take on low-pay and low-status work in order to reconcile employment with caregiving responsibilities. Making care-friendly policies mandatory would be a significant step in reducing pay inequality and in creating an incentive to couples to challenge traditional gender roles. If uptake of care-friendly policies does not result in career penalties, men will more likely to make use of them.

137. The requirement for long working hours makes it difficult for those with caregiving responsibilities to work a normal working day. Universal and mandatory policies to limit working hours would be needed to effectively reduce gender inequalities. Without this, employers tend to favour workers who can work long hours, and those who need to work shorter hours because of caregiving responsibilities (mostly women) are disadvantaged. At the same time, because men spend limited time in the home, they will fail to develop the awareness and skills that would enable them to share more equally in caregiving responsibilities.

138. The institution of maternity, paternity and parental leave, and the existence of leave for specific caregiving needs, is important in reducing gender inequalities by helping to keep both women and men employed throughout intensive care provision. However, the terms and conditions of such leave can determine whether gender inequalities are intensified or reduced. Paid leave provisions have the potential to reduce gender inequalities in income. The perception that only women are likely to take long periods of leave may lead to discrimination against women workers, and pregnant women in particular. If leave is taken for long periods by one sex only, it will exacerbate gender inequalities, both in employment and in the ability of men and women to contribute equally to the care of family members. It is therefore important to create conditions under which inequality in uptake of leave between the sexes is reduced. Leave that can only be taken by women does not fulfil that requirement - there is no equality rationale for parental leave targeted solely at women, beyond the period required for recovery from childbirth.

139. In most developing countries, many women are employed as informal workers, i.e. casual, temporary and home-based workers (home workers), or are self employed at the lower rung of the labour market. These women are often denied decent work conditions, and enjoy few maternity benefits and little childcare support or social protection. In these circumstances there is little potential that employers will adopt care-friendly policies. The most urgent need is for provision of maternity benefits for all women workers and universal childcare facilities. Public childcare facilities would also help improve the nutrition and health of children. These facilities should be free, or subsidized in such a way that parental contributions are means-dependent and affordable for all parents.

Public provision of care services

140. In contexts in which care services are non-existent or deficient in coverage, the provision of public-funded and/or publicly-provided care services is the main channel to ensure adequate and equal access to care. The transfer of some of the care work done within households to other caregivers and institutions brings about 'efficiency' gains through social provisioning and specialization, and can address unmet care needs. Public health systems which ensure necessary levels of knowledge, skills and equipment for care, benefit from economies of scale in procurement and delivery of drugs and other supplies, are better placed than families to provide care to those ill or chronically ill. Public provision can also be instrumental in enhancing the position of paid care workers.

141. Paid care workers are mostly women who, in many countries, work under poor working conditions with low pay, and no or insufficient social protection. There is a need to ensure "decent work" conditions as required under the global legal and policy frameworks, along with appropriate institutional mechanisms in the care sector. Measures should focus on increasing the proportion of men involved in caregiving professions (while ensuring that this does not impact negatively on women in the sector). There is a need to design specific programmes to provide skills training to men in care related activities.

Public regulation of the quality of care services

142. In the absence of effective regulations of quality either by consumers or the State, pressures for efficiency gains can work against the quality of the care provided. In such contexts, market provision can exacerbate existing income inequalities, which can translate into inequalities in access to care. Careful regulation of care service providers is therefore necessary. The relational aspects of good care are, however, difficult to monitor and regulate. Quality care requires workers who are well-motivated and professional. Public sector and voluntary care sector workers are less likely to have personal motivation "crowded out" by constant pressure for efficiency gains to retain profits. It is necessary to establish minimum requirements for setting up services; regular control through inspections; qualifications systems and professional training for caregivers; standards and benchmarks for regular monitoring; and career structures for care workers.

Cash support for informal caregivers

143. Cash support to informal caregivers aims to alleviate some of their burden by increasing access to resources. It is not clear, however, that the benefits of such programmes outweigh their possible non-desirable consequences. The tendency to focus on women as caregivers, based on their supposedly natural 'altruism', exacerbates women's disadvantaged position, even if the material conditions of their work are improved in the short term.[144] Cash-transfers

[144] S. Chant (2007), *Gender, Generation and Poverty: Exploring the 'Feminisation of Poverty in Africa, Asia and Latin America,* London: Edward Elgar.

should neither replace public provision of care services nor crowd out public investment in care facilities. [145]

Investment in public infrastructure

144. Investment in public infrastructure in healthcare, education, water, transportation and energy sectors eases the responsibilities typically assumed by women, such as water and fire wood collection. Such investment, which reduces women's work and time burdens, constitutes a precondition for adequate access to care in facilities and at home. Investment in care facilities should include investment in the health sector, in education and early childhood and elder-care facilities. States have a responsibility to guarantee minimum levels of provision before "marginal" transfers of responsibilities between the public sector, the market and the family can be considered, to ensure that unpaid care work does not become a "subsidy" to public sector provisioning.[146]

Recommendations

145. In order to strengthen policies to support equal sharing of responsibilities between women and men, Governments, private sector, civil society and international organizations should:

- Take measures to strengthen the implementation of ILO conventions, particularly the Convention No. 156 on Workers with Family Responsibilities;
- Ensure that all legislation, policies and programmes take into account considerations of gender equality and non-discrimination in their design and implementation;
- Ensure that both women and men have access to sufficient maternity, paternity, parental leave, and other forms of leave, with full protection and benefits;
- Create conditions under which inequality in uptake of leave between women and men is reduced;
- Develop care-friendly policies that are sufficiently attractive and well-resourced to encourage take-up by men;
- Strengthen and expand measures to support flexibility in working hours, including part-time work arrangements, on terms that encourage uptake by women and men;
- Ensure that universal and mandatory policies are in place to limit working hours;
- Review and revise or adopt gender-sensitive labour legislation and put in place measures to ensure its full implementation in terms of rights, social protection, pay and working conditions;
- Ensure the provision of formal care services that are accessible, of high standard and affordable;
- Ensure effective regulation of working conditions and wages in formal care work;
- Implement effective policies to improve the pay and conditions of the paid care workforce and encourage male entry into the profession;

[145] UNRISD (2008), op cit.
[146] R. Antonopoulos (2008), op cit.

- Monitor conditions of work and pay levels in the formal care sector by comparison with male-dominated sectors and occupations;
- Take measures to involve caregivers in the allocation and monitoring of resources targeted to care and enable them to participate in decision-making related to caregiving;
- Encourage investment in public infrastructure for care, including financial support by donors; and
- Set targets for public provision of care services and good practice standards for public regulation of the quality of care services provided by non-public sector providers.

Indicators

146. The following indicators may be useful in measuring progress:

- Number of care recipients in care facilities run by the State and non-governmental organizations;
- Proportion of men using paternity and parental leave benefits;
- Proportion of men taking flexible work-hour arrangements to care for family members;
- Number of policies specifically targeting men's involvement in child care, such as a father's quota in which fathers are given a specific individual entitlement for child care leave; and
- Proportion of women in the workplace and in previously male dominated provisions.

4. Addressing the sharing of caregiving in the context of HIV/AIDS

147. The HIV/AIDS pandemic has illustrated the need for all stakeholders to be involved in caregiving. The following actions are recommended on caregiving in the context of HIV/AIDS. Governments, private sector, civil society organizations, and donor organizations, as relevant, should:

- Mainstream HIV/AIDS care in all strategies and policies, including those on gender equality and national poverty eradication;
- Scale up the HIV/AIDS care response to strengthen public health systems and increase support to voluntary and home-based care organizations, through allocation of substantial human and financial resources, to ensure a functional continuum of care for persons living with HIV/AIDS;
- Scale up HIV/AIDS prevention using all strategies that have been shown to be effective;
- Establish adequate, accessible and functional health services to reduce transport costs and waiting time in hospitals and mitigate the financial and time burdens of AIDS care;
- Establish intermediary care facilities across countries to which government hospitals can discharge AIDS patients, in order to reduce the burden on families as well as the formal health systems;
- Provide social protection services, such as social grants, to alleviate the financial burden on poor HIV/AIDS affected households;

- Recognize home-based and informal care givers as a central part of the state response to the HIV/AIDS epidemic and allocate financial and medical resources to community-based organizations involved in care and support services;
- Integrate gender perspectives into the design and implementation of home-based care programmes and evaluate the impact of these programmes on women and men;
- Facilitate the greater involvement of men in caregiving roles, including within home-based care programmes;
- Provide resources and build capacity of organized caregiving groups to monitor and demand accountability for HIV/AIDS care responses by public institutions and agencies;
- Ensure that informal caregivers, both women and men, are linked to professional services in the public health system;
- Develop policies that validate and value caregiving and caregivers in the context of HIV/AIDS and ensure that comprehensive costing models include home-based and unpaid care;
- Ensure the rapid scale-up of, and access to, free anti-retro-viral treatment and treatment for tuberculosis which would considerably reduce the time burden associated with caring for persons with HIV/AIDS; and
- Regularly monitor the changing impact of HIV/AIDS on women and men to ensure timely development and implementation of gender-sensitive responses.

Indicators

148. The following indicators may be useful in measuring progress:

- Time spent in HIV/AIDS-related caregiving by sex, age and relationship to person living with HIV/AIDS;
- Free time spent by caregiver disaggregated by sex, age and relationship to person living with HIV/AIDS;
- Number of HIV/AIDS strategies that include the promotion of involvement of men in AIDS caregiving, including home-based care;
- Number of national HIV/AIDS policies and strategies that include allocation of resources to home-based care;
- Proportion of men involved in home-based and community-based care programmes;
- Number of intermediary care facilities established;
- Number of home-based care organizations with their main source of funding from Government;
- Number of national HIV/AIDS strategies and budgets that include care and home-based care; and
- Number of national gender equality and poverty eradication strategies that have mainstreamed HIV/AIDS care and the equal sharing of responsibilities between women and men.

5. Transformation of the models of female care-giver and male "ideal" worker/ elimination of stereotypes

149. Stereotypical images of women and men perpetuate inequality in power relations and the sharing of responsibilities. Actions to identify and address stereotypes are required at all levels of society and need to target a large number of stakeholders. The media and educational institutions have a critical role to play. Religious and community leaders, and those in positions of authority in employment and other arenas, constitute important stakeholders.

Recommendations

150. Governments and other actors, including civil society, should:

- Promote gender equality principles and the equal sharing of responsibilities between women and men with the goal to transform the stereotypical expectations that women should be caregivers and men workers in the labour market;
- Allocate adequate resources for programmes on awareness-raising for society as a whole on the existence and impact of gender stereotypes;
- Disseminate information on the involvement of high-profile men in caregiving and on their uptake of family leave opportunities;
- Develop policies and provide guidelines on eliminating gender stereotypes in advertising, the Internet and the media;
- Set up and empower "watchdog groups" to monitor and advocate against the biased portrayal of women's and men's roles in the media;
- Develop and implement campaigns to validate caregiving by both women and men, targeting a range of stakeholders;
- Promote equal sharing of responsibilities between women and men in all aspects of the education sector, including through school curricula and teacher-training;
- Create opportunities for women and men, including young parents, to learn about equal sharing of responsibilities, through training courses, seminars and publications; and
- Involve civil society organizations as full partners in the development and implementation of policies aimed at promoting equal sharing of responsibilities between women and men.

Indicators

151. The following indicators may be useful for measuring progress:

- Increase in government resource allocation and expenditure for awareness-raising campaigns and programmes on gender equality;
- Frequency of media coverage portraying women and men in non-traditional roles and activities;
- Increase in number of teacher-training programmes promoting gender equality and eliminating stereotypes;
- Increase in gender-sensitive school materials and practices;
- Number of seminars and workshops designed to promote equal sharing of responsibilities between women and men sponsored by national and local governments, and the number of attendees; and
- Number of "watchdog groups" set up by governments to monitor biased media portrayal

of women's and men's roles.

6. Transformation in attitudes and behaviour on the part of men and boys

152. While it is important to change the attitudes and behaviour of both women and men, insufficient work has been done to involve men and boys in promoting the equal sharing of responsibilities between women and men. Emphasizing men as agents of positive change increases the potential for involving them in fully promoting gender equality and social change. It is important to offer men opportunities to reflect on their own personal history and experiences, and to question stereotypical attitudes and behavior.

Recommendations

153. Governments, in partnership with civil society, including grassroots and faith-based organizations, should:

- Develop measures and policies to support the capacity of individuals and public/community and educational institutions working with children to transform stereotypical attitudes and behaviour;
- Reinforce men's responsibility for the care of their children and other family members through policies such as work-life balance and family-friendly policies, including parental leave;
- Actively focus on increasing the proportion of men involved in caregiving professions and jobs, while at the same time increasing the number of women in male-dominated professions;
- Create programmes and courses on gender equality and develop positive images of men and boys;
- Make reproductive health information and services more accessible and attractive to men; and
- Recognize men's influence on reproductive health options and decisions and encourage men and women to deal jointly with issues such as contraception, child delivery, child care, voluntary HIV counseling and testing; and engage men in wider issues, such as the prevention of gender-based violence.

Indicators

154. The following indicators may be useful for measuring progress:

- Increase in number of colleges that offer courses on gender equality, men and masculinity;
- Number of gender-sensitive family life education courses taught to children of all ages;
- Number of programmes and projects developed for community leaders, grassroots organizations and faith-based organizations to learn about equal sharing of responsibilities;

- Increase in participation of community leaders, and leaders of grassroots organizations and faith-based organizations in programmes and projects to learn about equal sharing of responsibilities;
- Number of men present at childbirth; and
- Increased number of businesses utilizing temporary special measures to increase the number of women in male-dominated professions and the number of men in female-dominated professions.

7. Research and data collection

155. Globally, there is little data available on unpaid care provided by women and men in society. Time-use surveys can provide important information on all types of paid and unpaid activities. Although most industrialized countries conduct time-use surveys at intervals of 5 – 7 years, these surveys are not common in most developing countries because of lack of awareness of their usefulness, limited resources and expertise, and the dearth of globally accepted standardized concepts and methodologies.[147] Although some work has been done by the Statistical Division and regional commissions of the United Nations, as well as by UNDP and ILO, there is a need to expand this work to enable all countries to conduct time-use surveys on a regular basis.[148] In addition, it is important to expand the analyses and utilization of the available data to better understand the unequal sharing of responsibilities by women and men.

156. A major limitation of the available statistics in most countries is that they are frequently not disaggregated by sex and age, or other factors such as education, health or income. As a result, it is not always possible to measure and monitor the different dimensions of unequal sharing of responsibilities by women and men. Although some data are available on women's participation in decision-making, such as seats held by women in national parliament and in sub-national elected bodies, there is a need to collect and analyze more comprehensive data on women's role in decision-making in different fields such as health, education, trade, finance and industry, as well as in local bodies and related decision-making bodies.

Recommendations

157. Governments, donors, international organizations and civil society should take measures to conduct periodical evaluation and monitoring of major policies and programmes aimed at equal sharing of responsibilities. With regard to time-use surveys, they should:

- Conduct time-use studies to reveal all forms of paid and unpaid work performed by women and men in society, in order to provide a comprehensive overview of the sharing of all work by women and men, including details of the extent of sharing of work within households to illustrate intra-household dynamics;
- Provide improved estimates of women and men in the workforce, including women's participation in informal and subsistence sectors;

[147] V. Esquivel et al (2008b), 'Explorations: Time-use surveys in the South', *Feminist Economics*, Vol. 14, No. 3.
[148] United Nations Statistics Division (2005), *Guide to Producing Statistics on Time Use: Measuring Paid and Unpaid Work*, New York.

- Compile satellite accounts periodically to measure the contribution of unpaid work to national well-being; and
- Measure time-stress (emanating from multi-tasking and from the large burden of social provisioning) and time-poverty.

158. Governments, donors, civil societies and international organizations should conduct research and collect data related to the sharing of responsibilities between women and men, and should:

- Document good practices in social and economic policies that have helped to transform equal sharing of responsibility by women and men, balance work and caregiving, eliminate gender stereotypes in education, and promote public awareness campaigns;
- Conduct case studies on good practices in the public and private sector and by civil society that aim to help women and men balance work and caregiving, including in the informal sector;
- Conduct quantitative research to document the distribution of different care responsibilities between women and men, and to promote understanding of the behaviour and experiences of women and men in different caring scenarios, including in the context of AIDS;
- Evaluate the success of various interventions aimed at increasing male participation in home-based and volunteer caregiving in the context of HIV/AIDS;
- Document innovative policies, programmes and projects related to HIV/AIDS, which have involved men and empowered women to participate in policy making;
- Invest in research that focuses on piloting and evaluating interventions aimed at compensating home-based and 'volunteer' caregivers in the context of HIV/AIDS, using various models such as direct payment, creation of career paths and employment, including income generating programmes;
- Invest in community-led mapping of care at the community level and scale up good practices;
- Allocate adequate resources for evaluation, research, outreach activities, and for sex- and age-disaggregated data collection, to ensure effective policy making and monitoring of progress; and
- Establish a comprehensive framework for the collection of sex-, age- and class-disaggregated data at country level on the magnitude and contribution of formal care related to HIV/AIDS, as well as gaps in provision, to inform overall policy development, strategies and budgets.

Indicators

159. The following indicators may be useful in monitoring progress:

- Existence and periodicity of national time-use surveys;
- Frequency of compilation of data for satellite accounts of unpaid work;
- Analysis and use of time-use data (a) in national human development reports, (b) in measuring gender inequalities in sharing paid and unpaid work and (c) in measuring women's participation in the care economy; and

- Number of countries compiling gender-responsive budgets which include attention to caregiving.

ANNEX I: List of Participants

EXPERTS

Mr. Olagoke Akintola (Nigeria)
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Mr. Gary Barker (USA)
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(not able to attend at last minute)

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Ms. Ritva Siemers
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Ms. Soon-Young Yoon
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DIVISION FOR THE ADVANCEMENT OF WOMEN

Ms. Carolyn Hannan
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Ms. Saras Jagwanth
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ANNEX II: List of documents

A. PAPERS BY EXPERTS

EGM/ESOR/2008/EP.1	Engaging men and boys in caregiving: reflections from research, practice and policy advocacy in Latin America **Gary Barker**
EGM/ESOR/2008/EP.2	Equal sharing of responsibilities between men and women: some issues with reference to labour and employment **Indira Hirway**
EGM/ESOR/2008/EP.3	Toward a new ontology of caring **Linden Lewis**
EGM/ESOR/2008/EP.4	Sharing of housework and childcare in contemporary Japan **Masako Ishii-Kuntz**
EGM/ESOR/2008/EP.5	Towards equal sharing of aids caring responsibilities: learning from Africa **Olagoke Akintola**
EGM/ESOR/2008/EP.6	The equal sharing of care responsibilities between women and men **Tine Rostgaard**
EGM/ESOR/2008/EP.7	Rethinking care, gender inequality and policies **Susan Himmelweit**
EGM/ESOR/2008/EP.8	A “macro” view on equal sharing of responsibilities between women and men **Valeria Renata Esquivel**
EGM/ESOR/2008/EP.9	Men, the care economy and HIV-AIDS: structure, political will and gender equality **Dean Peacock**
EGM/ESOR/2008/EP. 10	Key issues fuelling the unequal sharing of responsibilities between women and men in the context of HIV/AIDS **Esther Mwaura- Muiru**

B. PAPERS BY OBSERVERS

EGM/ESOR/2008/OP.1	Discussion Paper **The NGO Committee on UNICEF: Working Group on Girls**
EGM/ESOR/2008/OP.2	Statement **The International Alliance of Women**

C. BACKGROUND PAPERS

EGM/ESOR/2008/BP.1	The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS **Mary Daly**
EGM/ESOR/2008/BP.2	Equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS **International Labour Organization (ILO)**
EGM/ESOR/2008/BP.3	The social and political economy of care: contesting gender and class inequalities Prepared by Shahra Razavi and Silke Staab **United Nations Research Institute for Social Development (UNRISD)**
EGM/ESOR/2008/BP.4	Caregiving in the context of HIV/AIDS **Joint United Nations Programme on HIV/AIDS (UNAIDS)**

D. INFORMATION PAPERS

EGM/ESOR/2008/INF.1	Aide Memoire
EGM/ESOR/2008/INF.2	Information Note for Participants
EGM/ESOR/2008/INF.3	Proposed Programme of Work
EGM/ESOR/2008/INF.4	Provisional List of Participants
EGM/ ESOR/2008/INF.5	Participant Biographies
EGM/ ESOR/2008/INF.6	List of Documents

ANNEX III: Programme of work

Monday, 6 October 2008

Plenary Session

9:00 a.m.	Registration of participants (experts and observers)
9:30 a.m.	Opening Statements:
	Welcome from United Nations Economic Commission for Europe **Ewa Ruminska-Zimny**, Senior Social Affairs Officer, Office of the Executive Secretary, Economic Commission for Europe
	Introduction to the EGM **Carolyn Hannan**, Director, Division for the Advancement of Women, Department of Economic and Social Affairs
10:00 a.m.	Introduction of experts, election of officers, review of programme of work and information on working methods
10:30 a.m.	Presentations of background papers
	Shahra Razavi, UNRISD (EGM/ESOR/2008/BP.3) **Naomi Cassirer**, ILO (EGM/ESOR/2008/BP.2) **Judith Polsky,** UNAIDS (EGM/ESOR/2008/BP.4)
11:00 a.m.	Break
11:30 a.m.	Presentation of background paper **Mary Daly,** Consultant (EGM/ESOR/2008/BP. 1)
	Discussion
	Presentation of online discussion report **Elissa Braunstein,** Consultant
1:00 p.m.	Lunch

THEME 1: EQUAL SHARING OF RESPONSIBILITIES: CAUSES, CONSEQUENCES AND POLICY RESPONSES

2:30 p.m.	Presentations by experts and discussion

Toward a new ontology of caring
Linden Lewis (EGM/ESOR/2008/EP.3)

Rethinking care, gender inequality and policies
Susan Himmelweit (EGM/ESOR/2008/EP.7)

The equal sharing of care responsibilities between women and men
Tine Rostgaard (EGM/ESOR/2008/EP.6)

4:00 p.m. Break

4:30 p.m. Presentation by experts and discussion

Engaging men and boys in caregiving: reflections from research, practice and policy advocacy in Latin America
Gary Barker (EGM/ESOR/2008/EP.1) *[paper presented by the Division for the Advancement of Women on behalf of author]*

Sharing of housework and childcare in contemporary Japan
Masako Ishii-Kuntz (EGM/ESOR/2008/EP.4)

5. 30 p.m. Closing

Tuesday 7 October 2008

9:00 a.m. Summary of Day 1 by Rapporteur
Introduction to work by Chairperson

THEME 2: LINKAGES BETWEEN UNEQUAL SHARING OF RESPONSIBILITIES AND THE LABOUR MARKET

9:30 a.m. Presentation by experts and discussion

Equal sharing of responsibilities between men and women: some issues with reference to labour and employment
Indira Hirway (EGM/ESOR/2008/EP.2)

A "macro" view on equal sharing of responsibilities between women and men
Valeria Esquivel (EGM/ESOR/2008/EP.8)

10:30 a.m. Break

THEME 3: UNEQUAL SHARING OF CAREGIVING IN THE CONTEXT OF HIV/AIDS

11:00 a.m. Presentation by experts and discussion

	Towards equal sharing of AIDS caring responsibilities: learning from Africa **Olagoke Akintola** (EGM/ESOR/2008/EP.5) Men and the care economy in the context of HIV and AIDS: structure, political will and gender equality **Dean Peacock** (EGM/ESOR/2008/EP.9) Key issues fuelling the unequal sharing of responsibilities between women and men in the context of HIV/AIDS **Esther Mwauru-Muiru** (EGM/ESOR/2008/EP.10)
12.30 p.m.	Lunch
1:30 p.m.	Establishment of working groups by the Chairperson
2:30 p.m.	Working groups
4:00 p.m.	Break
4:30 p.m.	Working groups (cont'd)
6.00 p.m.	Closing

Wednesday, 8 October 2008

9:30 a.m.	Summary of Day 2 by Rapporteur Introduction to work by Chairperson
10:00 a.m.	Presentation by working groups and discussion
11:00 a.m.	Break
11:15 a.m.	Working groups (cont'd)
1:00 p.m.	Lunch
2:30 p.m.	Working groups continued/drafting of group reports
4:15 p.m.	Break
4:30 p.m.	Working groups continued/drafting of group report

6:00 p.m.	Plenary to discuss draft findings and recommendations from working groups

Thursday, 9 October 2008

9:00 a.m.	Group drafting of report and recommendations
10:00 a.m.	Distribution of draft report to participants
11:00 a.m.	Break
11:30 a.m.	Consolidation of revised working group inputs into draft report
12:30 p.m.	Lunch
1.30 p.m.	Presentation and discussion of final report
4:00 p.m.	Break
4:15 p.m.	Adoption of final report
5:30 p.m.	Closing