WE-CARE MALAWI PROGRAMME REPORT

Linking unpaid care work and mobile value-added services in Malawi

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WE-CARE
WOMEN'S
ECONOMIC
EMPOWERMENT
AND CARE

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ACRONYMS AND ABBREVIATIONS

BMJ	British Medical Journal
CABI	Centre for Agriculture and Bioscience International
CADECOM	Catholic Development Commission in Malawi
CI	Confidence interval
CSO	Civil society organization
FGD	Focus group discussion
GAIN	Global Alliance for Improved Nutrition
GBV	Gender-based violence
GCP	Global content partner
GSM	Global System for Mobile Communications (a trademark)
GSMA	GSM Association
H0	Null hypothesis
HA	Alternative hypothesis
HCS	Household Care Survey
HNI	Human Network International
ICT	Information and communications technology
IFPRI	International Food Policy Research Institute
ILRI	International Livestock Research Institute
IVR	Interactive voice response
LCP	Local content partner
mAgri	Mobile Agriculture
mHealth	Mobile Health
MNO	Mobile network operator
mNutrition	Mobile Nutrition Programme
RCA	Rapid Care Analysis
RCT	Randomized Control Trial
SMS	Short Message Service
TA	Traditional authority
WE-Care	Women's Economic Empowerment and Care

EXECUTIVE SUMMARY

Around 75 percent of the world's total unpaid care work, including housework, water and firewood collection and caring for people such as children and the elderly, is performed by women. To fulfil women's rights and to move towards greater substantive equality between women and men, there is a need to tackle the inequalities created by unpaid care workloads that are heavy and unequal. Based on this belief, Oxfam GB, with support from the William and Flora Hewlett Foundation, has implemented the Women's Economic Empowerment and Care (WE-Care) programme, which aims to build evidence for influencing change on care work in six countries across Africa, Asia and Latin America.

In Malawi, the programme implemented three different research methodologies that included qualitative and quantitative methods, as well as participatory research to generate a strong evidence base for awareness raising and policy advocacy at the national and global levels. The programme was designed to be closely interlinked with the GSM Association's mNutrition programme, which is a three-year multi-country programme, for which Oxfam is the lead partner in Malawi for content development. The WE-Care programme in Malawi also focused on the use of information and communications technologies (ICTs) for data gathering, analysis and implementation of a Randomized Control Trial (RCT).

The first activity that took place was the Rapid Care Analysis (RCA), which was conducted at the end of 2014 in two different provinces, Lilongwe and Chitipa. This is a participatory action research methodology for the rapid assessment of unpaid household work and the care of people in the communities where Oxfam is supporting programmes. Findings from the RCAs highlighted that, on average, women in Malawi undertake considerably more unpaid care work than men. This is particularly the case among younger populations. Findings from the RCAs also pointed to an association between inequality of unpaid care and different social harms (violence against women, marital discord, adverse effects on health, limited mobility and even threat to life). RCAs and focus group discussions (FGDs) proved to be an effective way to help men recognize the unequal distribution of care work between men and women, and the need to reduce and redistribute this work.

The Household Care Survey (HCS) built on the findings from the RCAs and used an ICT-enabled data-gathering tool, which was developed in parallel with the implementation of the RCAs. The HCS proved to be a successful quantitative methodology to gather insights on the main factors influencing unpaid care work at the household level. The HCS was conducted in April 2015 and gathered data from 594 households participating in Oxfam's livelihoods programmes in Lilongwe and Mchinji. The HCS identified that younger women, particularly those with children under six years old, dedicate more time to unpaid care work. Women who have received at least primary-level education and women with savings dedicate more time to unpaid care work than women without education and without savings. Additionally, group membership and access to public water sources reduce women's primary care hours.

The findings from the HCS informed the development of an RCT, which took place between January and March 2016. The data collected during the HCS was also used for the RCT baseline and to identify participants in the RCT. Of the 594 households interviewed during the HCS, 160 were selected to take part in the RCT, of which 80 participants were randomly assigned to the treatment group and 80 to the control group. The RCT aimed to understand the impact that access to mNutrition (mAgri and mHealth) services has on the allocation of time to unpaid care work. Participants in the treatment group received a total of 24 SMS messages on their mobile phones in the three categories of health, agriculture and food preparation, while those in the control group received a total of 12 messages containing interesting facts and seasonal greetings. The RCT endline (follow-up) survey took place in March 2016, soon after the finalization of the trial, and used a similar methodology and questionnaire to the HCS/RCT baseline.

The short period of time in which the RCT took place must be taken into account when analysing the results, as these might have varied if the study had been conducted over a longer period. The results from the RCT indicate that if all three types of message are delivered simultaneously to the target population of the programme, participants might tend to prioritize the application of those messages directly related to income-generating activities during the first two months of receiving the information, to the detriment of messages directly linked to health and food practices. This increase in the time allocated to productive work also resulted in a reduction of sleep hours and time dedicated to personal care, as well as a higher perception of the occurrence of domestic violence by participants in the treatment group. Three main recommendations emerged out of these findings for the mNutrition programme:

- Parallel messages and interventions that unlock part of the time dedicated to unpaid care work should be promoted. This would ease the pressing need for message prioritization and provide more flexibility for behavioural change, without resulting in a reduction of time dedicated to sleep and personal care. This would also help to ensure customer usage and retention over the mid- to long term, as users would have more time flexibility to change their behaviours according to the information received.
- mAgri advice should always be accompanied by other messages, such as food preparation advice, that are more directly related in the short term to improved nutrition than those that the current mAgri service is offering. This could be done by involving content specialists in the design of the service. This would help to balance the increased calorie consumption derived from the additional time dedicated to farm work.
- Alternative channels and interventions should promote spaces for knowledge sharing and information uptake, particularly with friends, community members and other members of savings or farmers' groups. This will increase the likelihood of promoting behavioural change.

This research proves the importance of recognizing, reducing and redistributing the unequal burden of unpaid care work in order to move towards greater substantive equality between women and men in Malawi. The findings also highlight the need for government, the private sector and development practitioners to recognize and evaluate ways in which addressing unpaid care work can help them achieve their organizational and development goals. Understanding the distribution of unpaid care work is a necessary prerequisite for all programmes, products and services that have women as their primary target population.

Development projects can benefit from a greater integration of unpaid care work in their theories of change, leading to more comprehensive approaches to women's empowerment and improved impact on gender equality. Civil society organizations (CSOs) also have a role to play in identifying the most problematic care work activities in the communities where they operate. They can help increase recognition of the unequal distribution of unpaid care work at the community and household levels, promote stakeholder dialogues and even develop interventions that can help reduce problematic and inefficient care work activities.

Private companies have an important role to play in the promotion of products and services that help reduce the amount of time dedicated to inefficient care work activities or reduce the intensity and lack of time flexibility of certain activities. Private sector actors should also consider unpaid care work as a core barrier to the uptake and retention of female customers, particularly in rural areas.

The Government of Malawi should enforce international labour standards so that employers provide employees with enough time to care and a minimum living wage to help them finance care-giving. It could also perform a critical role by providing quality accessible public services and comprehensive social protection systems to help reduce the amount of time dedicated to unpaid care work at the household level. Additionally, particular government-provided services, such as agriculture extension or healthcare, should take into account the impact of the unequal distribution of unpaid care work in the discouragement of behavioural change in women.

National stakeholder dialogues between government, the private sector, academia and CSOs are critical to maximize the transformational impact and sustainability of these interventions. These conversations will play a crucial role in raising awareness on the importance of addressing unpaid care work for the development agenda of Malawi, and the alignment of individual organizational priorities and approaches.

Overall, the WE-Care programme in Malawi has successfully applied three different research methodologies to gather context-specific evidence about the existing distribution of unpaid care work at the household and community levels. It has also harnessed the use of new communications technologies for the implementation of the programme and has engaged with in-country stakeholders for the replication of care research methodologies and the sharing of findings at the national level.

1. INTRODUCTION AND BACKGROUND

1.1 Introduction

The eradication of poverty and injustice depends on women's equal enjoyment of their human rights. Oxfam has invested significantly in women's economic leadership, and believes that economic empowerment requires parallel progress in women's political, social and personal empowerment. Women's control over their own time and labour is increasingly recognized as a precondition for this, as confirmed by a recent (2013) report by the UN Special Rapporteur on Human Rights and by the UN Women report, *Progress of the World's Women 2015–2016*.[1]

Around 75 percent of the world's total unpaid care work is performed by women, including housework, water and firewood collection and caring for people such as children and the elderly. Unpaid care work is necessary for all societies to function, has tremendous social value and is a source of fulfilment for many; therefore, reducing the amount of care provided to people is not a solution. What must change are the inequalities in who pays for and who provides care. To fulfil women's rights and to move towards greater substantive equality between women and men, there is a need to tackle the inequalities created by heavy and unequal unpaid care workloads.

Based on this belief, and with the support of the William and Flora Hewlett Foundation, Oxfam has implemented a three-year programme on Women's Economic Empowerment and Unpaid Care Work (WE-Care) to generate evidence and influence change in six countries across Africa, Asia and Latin America (Colombia, Ethiopia, Malawi, the Philippines, Uganda and Zimbabwe). This report summarizes the rationale for the WE-Care programme in Malawi, describes its key activities and research methodologies, and highlights the main findings from each activity.

1.2 Oxfam's WE-Care Programme

1.2.1 Defining unpaid care work and simultaneous activities

Unpaid care work (also called household work, domestic labour or family work): Unpaid care work refers to the provision of services for family and community members outside of the market, where concern for the well-being of the care recipients is likely to affect the quality of the service provided.[2]

Simultaneous activities: The care of persons is often performed at the same time as other activities. For example, someone might be supervising cooking while gardening or supervising children, washing clothes or attending to customers in a family shop. In the analysis of unpaid care work, it is important to record simultaneous activities accurately, because otherwise the amount of unpaid care work that is being done can be underestimated. According to Floro (1995), 'Engaging in simultaneous activities (using time more intensively by doing two or more things at the same time) provides households with more unpaid work at the cost of higher work intensity for those who provide it.'[3]

1.2.2 Introduction to the programme

Oxfam GB, with support from the Hewlett Foundation, has implemented the WE-Care programme, which aims to build evidence for influencing change on care work. The first phase of the programme ran from October 2014 to March 2016 (inclusive) and developed new research methodologies to gather context-specific evidence about care activities, created tools accessible to local organizations, used mixed methods and harnessed new communications technologies for the implementation of the programme. Oxfam aims to leverage this evidence on care through existing development initiatives and policy advocacy, and to monitor outcomes of change strategies and advocacy.

1.2.3 Care change strategies

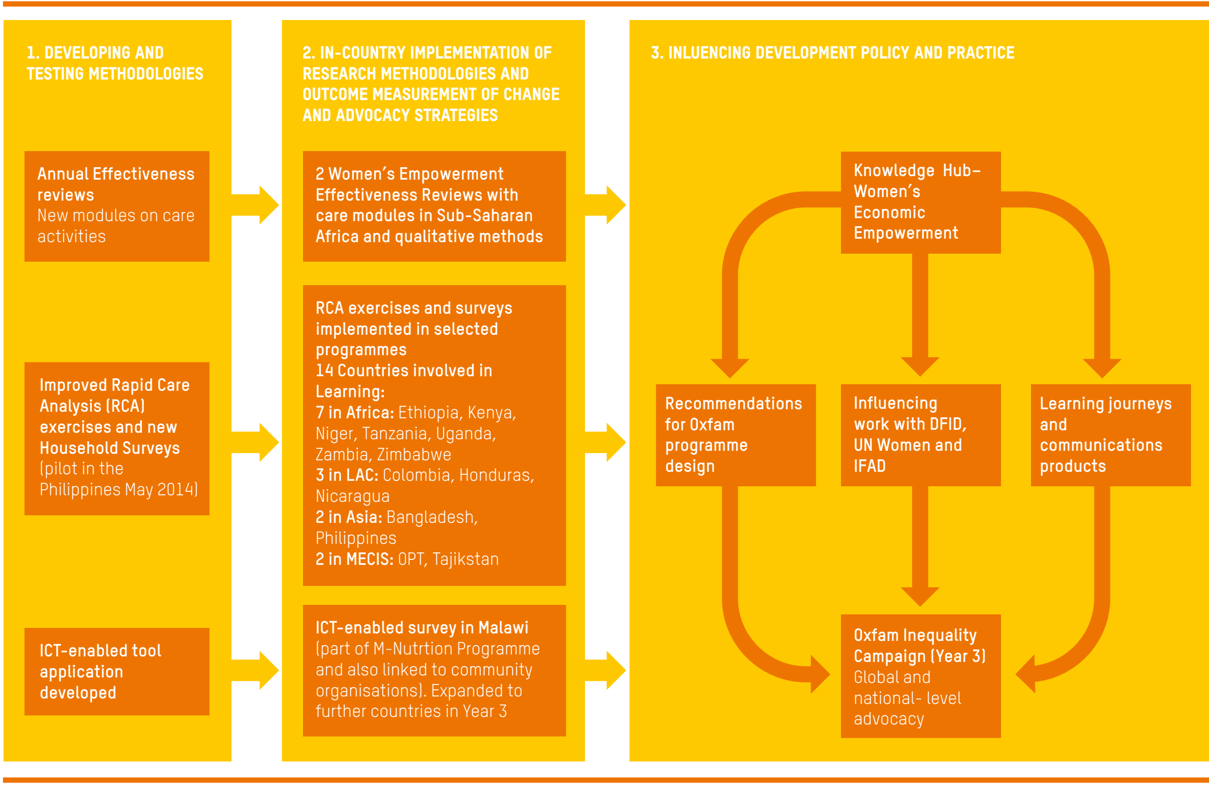
Oxfam believes that there are four different strategies that can be used to rebalance the unequal distribution of unpaid care work. These are often called the '4 Rs' of care work:[4]

[1] UN Women. Progress of the World's Women 2015–2016. Transforming Economies, Realizing Rights. http://bit.ly/29yf6J6
[2] Folbre (2006).
[3] Floro (1995).
[4] Elson (2008)

- **Recognition** of care work: the need for all members of society to recognize the unequal distribution of care work.
- **Reduction** of difficult and inefficient tasks: the need to identify labour-saving equipment and technologies that allow the reduction of lengthy and inefficient care work activities.
- **Redistribution** of care responsibilities more equitably: the need to redistribute responsibilities from women to men and from families to the state/employers.
- **Representation** of carers in decision making at all levels of society.

1.2.4 Components of the WE-Care programme

Figure 1.1 Components of the WE-Care programme



1.2.5 Key cross-country findings of the programme

The programme implemented different research methodologies in each of the six WE-Care countries for evidence generation. This research helped Oxfam to identify key findings related to unpaid care work in each of the country contexts, and also to identify high-level findings consistent across all six countries where the WE-Care programme was implemented. These are some of the most relevant cross-country findings to date:

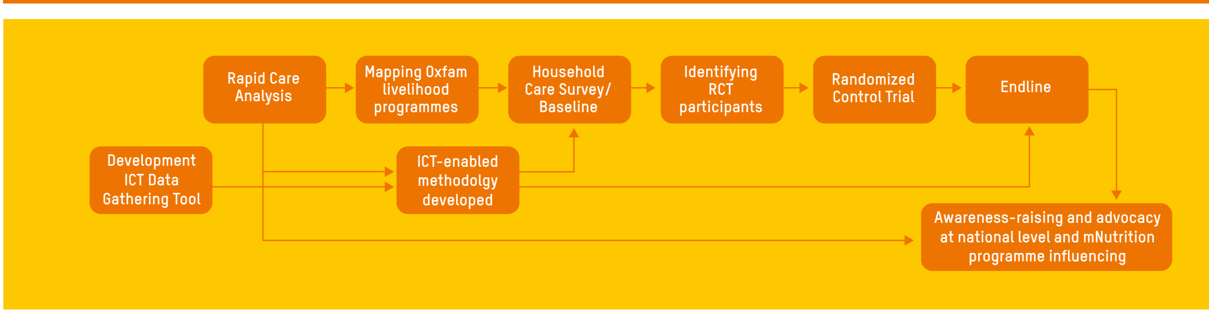
- On average, poor and rural women in our surveys are found to work long hours on care work. For example, in Household Care Surveys (HCS) across five countries in 2015, women reported on average doing 5.5 hours a day of care work, and over 13 hours a day with care responsibility.
- All the research so far shows that women undertake considerably more unpaid care work than men. For example, the HCS shows that overall in five countries women in our sample on average spent 5.42 hours per day on care as a primary activity and 13.82 hours per day on any care activity. The corresponding numbers for men were 0.99 hours and 4.31 hours.
- Women have longer hours of total work (productive/paid work and care work combined) than men.
- Women's unpaid care hours vary by age; younger adult women spend more hours than older women on unpaid care work.
- Women's unpaid care hours increase with the number of children in the household aged under six.
- Participatory research (RCAs) points to an association between inequality of unpaid care and different types of social harm (violence against women, marital discord, adverse effects on health, limited mobility and even threat to life).
- Women in livelihoods programmes dedicate more time to productive work and less time to care work as a primary activity, have higher overall workloads and on average have less leisure time and less sleep.

1.2.6 The WE-Care programme in Malawi

The WE-Care programme in Malawi took a unique approach compared with the other five countries. It implemented three different research methodologies (Rapid Care Analysis, Household Care Survey and Randomized Control Trial) that included qualitative and quantitative methods, as well as participatory research, to generate a strong evidence base for awareness raising and policy advocacy at the national and global levels. The programme was designed to be closely interlinked with the mNutrition programme, a three-year multi-country programme in which Oxfam is the lead partner in Malawi for content development. The WE-Care programme in Malawi also focused on the use of information and communications technologies (ICTs) for data gathering, analysis and implementation of the RCT intervention.

As shown in Figure 1.2, the different research methodologies were applied sequentially, and all fed into the awareness raising and advocacy activities of the WE-Care programme.

Figure 1.2: Activities of the WE-Care programme in Malawi



The first activity that took place was the Rapid Care Analysis (RCA), which was conducted at the end of 2014 in two different provinces, Lilongwe and Chitipa. This is a participatory action research methodology for the rapid assessment of unpaid household work and the care of people in the communities where Oxfam is supporting programmes. It aims to assess how women's involvement in care work may impact on their participation in development projects. It is also used to identify how wider programmes can ensure adequate care for vulnerable people.

The Household Care Survey (HCS) built on the findings from the RCAs and used an ICT-enabled data-gathering tool developed in parallel with the implementation of the RCAs. The HCS aimed to learn about what happens in households in communities where a range of 'care change strategies' could be implemented and to build understanding about pathways of positive change for more equitable care provision. The HCS was conducted in April 2015 and gathered data from 594 households participating in Oxfam's livelihoods programmes in Lilongwe and Mchinji.

The findings from the HCS then informed the development of the protocol of a Randomized Control Trial (RCT), which took place between January and March 2016. The data collected during the HCS were also used as a baseline and to identify participants for the RCT. Of the 594 households interviewed during the HCS, 160 were selected to take part in the RCT, of which 80 participants were randomly assigned to the treatment group and 80 to the control group. The primary research question of the RCT was: 'Is the daily allocation of time to non-paid care work different between women smallholder farmers who are members of farmers' clubs in Lilongwe and Mchinji and who access mNutrition mobile-enabled services (health and agriculture) through a mobile phone in their household and women smallholder farmers who are also members of farmers' clubs in the same regions who do not access mNutrition mobile-enabled services?'

The RCT endline (follow-up) survey took place in March 2016, soon after the finalization of the trial. The methodology and questionnaire used were similar to the ones used for the baseline, except for some additional questions to evaluate the impact of the study. The analysis of the findings was presented to the RCT steering committee and at a national stakeholder workshop on 31 March 2016, where 20 participants from the Government of Malawi, civil society organizations (CSOs), academia and the private sector were present. These findings will also be used to influence the redesign and implementation of the mNutrition programme in Malawi and the other 12 countries where it is being implemented.

1.2.7 Linking WE-Care and mNutrition

The mobile nutrition (mNutrition) programme aims to make a positive impact in terms of improved nutrition, food security and livelihoods for people living in poverty, especially women, through the increased scale and sustainability of mobile-based, nutrition-sensitive information services on health (mHealth) and agriculture (mAgri). The programme is an initiative of the UK's Department for International Development (DFID), in partnership with the GSM Association (GSMA), and is being implemented in 13 countries: nine in Africa (Ghana, Malawi, Mozambique, Nigeria, Tanzania, Kenya, Rwanda, Uganda and Zambia) and four in South Asia (Bangladesh, Pakistan, Sri Lanka and Myanmar). In 2014 the GSMA appointed a consortium formed by CAB International (CABI), the Global Alliance for Improved Nutrition (GAIN), the International Livestock Research Institute (ILRI), Oxfam and the British Medical Journal (BMJ), to lead the development of content in each implementing country. These five global content partners (GCPs) recruited local content partners (LCPs) in each country to create content, ensuring that it is aligned with national nutrition priorities. The LCPs are a vital part of content development for their local knowledge and expertise (such as languages) and their relationships with key stakeholders, and for longer-term sustainability of content development beyond the life of mNutrition. The GCPs and LCPs also assist the GSMA in working closely with local stakeholders to develop relevant mNutrition services.

The link between nutrition and women's empowerment is widely studied and acknowledged. The mNutrition programme's specific focus on improving nutritional levels in low- and middle-income countries, particularly those of women and children, makes women's empowerment an inseparable dimension of the programme. ICTs in general, and mobile phones in particular, can be powerful tools to advance women's empowerment and are currently used in making education accessible to girls, fighting against gender-based violence (GBV) and promoting women's leadership and female participation in decision making, amongst others.

It is widely recognized that, in order to change people's behaviour, multiple interventions need to be implemented for effective results, and the use of ICTs has the potential to support national governmental and non-governmental initiatives, particularly in the most remote areas. In unlocking the potential of ICT-enabled services for enhancing people's lives in low- and middle-income countries, the GSMA acknowledges the need to overcome gender barriers that prevent women from benefiting from mobile-enabled services. Among these barriers are affordability, relevant content, cultural and educational barriers and disparities in literacy. The GSMA has been implementing actions to bridge this gender gap through its mWomen programme, which includes research, allocation of grants to initiatives that reach women, replication of good experiences, evaluations and consistent dissemination of these experiences and learning. This corresponds with the efforts of the international nutrition community to focus on gender and nutrition, such as those of the UN family, the European Union and the International Food Policy Research Institute (IFPRI). Additionally, the Scaling Up Nutrition (SUN) movement, established in 2010 and an mNutrition partner in many countries, includes the gender dimension and women's empowerment as one of its six key strategic themes.

However, women's time is also a critical factor that can prevent them from accessing and using these services and information. In relation to nutrition, women's time is significant as development interventions, in particular agricultural interventions, may result in women diverting their time away from feeding their children and preparing food or, most commonly, not having the time to adopt new approaches. Therefore, new technologies support good nutrition when they are developed with consideration for the local context and when the implications they have for the time use of all household members, particularly women, are monitored.

If mobile services are to contribute to women's empowerment, the content development and service delivery processes need to address barriers, including time poverty, and must reinforce women's increased access to and control over resources and decision-making structures. Besides identified barriers to ownership and usage of mobile phones by women, time, poverty and social norms must be seen as barriers to women's uptake of messages and behaviour change.

Based on these principles, Oxfam designed the WE-Care programme to interlink with the implementation of the mNutrition programme in Malawi. As shown in Figure 1.3, WE-Care aimed to generate evidence on the current distribution of unpaid care work for women in the country, its role in the promotion of behavioural change and the usage of mNutrition services, with the aim of improving the design and implementation of the mNutrition programme.

Figure 1.3: Linkages between the WE-Care programme and mNutrition in Malawi

mNutrition

Stakeholder consultation landscape

Landscape validated

Draft content framework

SUN taskforce meeting

Stakeholder consultation content framework

Content framework validated

Selection LCP

Content Creation

Content aggregation in platform

Launch of services

Re-design content and services

Ongoing services

Rapid Care Analysis

Mapping Oxfam livelihood programmes

Household Care Survey/ Baseline

Identifying RCT participants

Randomized Control Trial

Endline

Development ICT Data Gathering Tool

ICT-enabled methodolgy developed

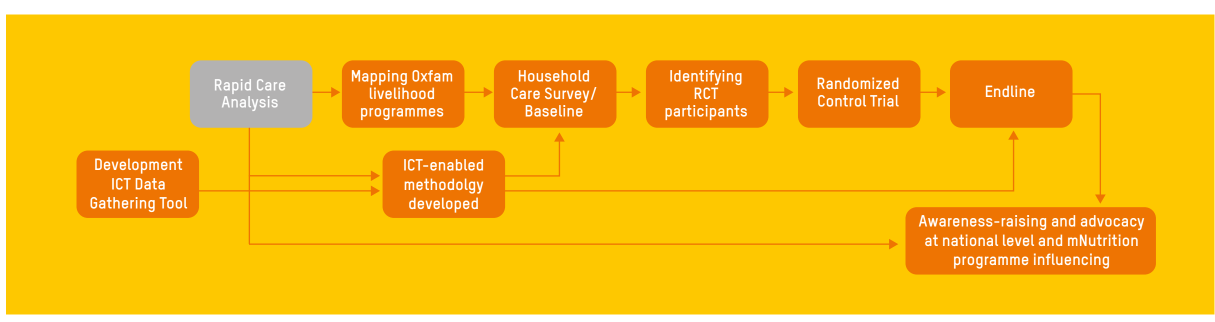
Awareness-raising and advocacy at national level and mNutrition programme influencing

WE-Care

2. RAPID CARE ANALYSIS

2.1 RCA methodology

Figure 2.1: Design of the RCA



The WE-Care programme conducted three different RCAs in Malawi, two of them in Lilongwe and one in Chitipa. The RCAs had an average of 16 participants per session, consisting of 60 percent women and 40 percent men. One of the RCAs in Lilongwe had a higher representation of younger people than the other, while the RCA in Chitipa brought together people of a wider age range. The sessions were conducted by facilitators fluent in the Chichewa language and with a command of the local socioeconomic context. There were three facilitators – one male and two female – and one documentation facilitator.

The RCAs entailed a set of exercises for the rapid assessment of unpaid household work and the care of people in the immediate communities. The RCA exercise had four objectives, namely to:

- Provide women and men with a space to explore the issue of care together and to collaboratively develop practical solutions or 'care strategies';
- Recognize care work, identify the most problematic care activities and develop proposals to reduce and redistribute care work. This included the following four steps: 1) exploring relationships of care in the community; 2) identifying unpaid and paid work activities performed by women and men; 3) identifying gendered patterns in care work, changes in care patterns and 'most problematic' care activities; and 4) discussing available services and infrastructure and options to reduce and redistribute care work;
- Be quick to use and easy to integrate into existing exercises for programme design and/or monitoring. The RCA exercises further aimed at assisting in the assessment of how women's involvement in care work might impact on their participation in development projects; and
- Identify how wider programmes, such as this initiative, can ensure adequate care for vulnerable people.

2.2 RCA findings

Experience with RCA sessions showed that both ordinary members of the community and community leaders recognized that women did more unpaid care work than men. They attributed this to the roles that women are ascribed by society. Community members linked women's unpaid care work, such as washing clothes, cooking, fetching firewood and collecting water, with their role as mothers, which involves caring for children and having to deal with most of the family welfare requirements that necessitate caring. This perception was particularly acute among younger men and women, but less strong among elder populations. Pregnancy and young babies, particularly new-borns, impose an additional time and mobility constraint on women, which prevents them from engaging more in income-generating activities.

> *Woman: 'Looking after children can be a burden because we postpone doing other things like going to the field in order to prepare them for school. But sometimes, during farming season, women neglect the children as they want to concentrate on farming activities.'*

Additionally, younger men prefer women not to get involved in income-generating activities. The following views were expressed by participants:

> Man: *'The way it is in the society, we [men] are the household heads and therefore the breadwinners, so it doesn't make sense for women to be busy doing income-generating activities when a man is around. I wouldn't feel comfortable for my wife to be doing income-generating activities, I am the financial controller.'*

> Woman: *'Men don't like it when women are involved in income-generating activities; it gives an impression that the man has failed to provide for his family. That is the reason why most women don't do any income-generating activities like businesses.'*

The physical limitations of elder men limit their engagement in farm activities and free up part of their time, which is sometimes used to relieve the burden of care work for women. However, elder men engage in certain care activities only when there is no one else to carry them out.

> Woman: *'Elderly people only cook when they don't have someone to cook for them or when no one is around.'*

At the beginning of the RCA sessions, men considered care work as not being a big burden of work. The view held by men is traditionally focused on commercial and income-generating activities, which they commonly see as the best way to secure the welfare of their households. This perception is representative of the value placed by communities on unpaid care work, particularly from the angle of not making an economic contribution to the welfare of the household.

After going through the individual one-day recall exercise, both men and women recognized that care work was labour-intensive and was mostly left to women. This exercise encouraged lively discussions between men and women in each of the RCAs and led to an increased recognition of the unequal distribution of care work and its negative impact on women's time poverty. Women observed that, in addition to care work, they do unpaid work like gardening for household food security. Participants expressed the following views:

> Man: *'Traditionally, it is women who are supposed to be providing care work, so it is not a surprise that they have more hours on care work than men. It is just how it is supposed to be.'*

> Man: *'We have learned a lot from this exercise. We took for granted the work that women do, but now we will begin to share responsibilities at home so that we free up some time for the women.'*

> Community leader: *'At first when we were just starting the exercise, I thought to myself, why we are discussing care work? This is surely a waste of time, but as we went on with the exercise, seeing the results that were coming out, it became interesting. I didn't know that men spent so much time sleeping and on other non-work in this community. We will definitely change after seeing this and put our time to better use, helping the women.'*

> Community leader: *'This exercise has been very helpful, it has helped us realize how much work women do and how much it affects their participation in community work as well as income-generating activities. As you can see, it is very difficult to convince men in this area to take up some of the care work; however, it is now up to me as a chief to talk to my people about this. I will use the different community meetings to raise awareness for the men to be involved in care activities as well.'*

2.3 Who does what work?

During the RCAs, facilitators discussed with attendees six types of work category.

Table 2.1: Work categories and symbols

Symbol	Work category
	Work to produce products for sale. This includes farming crops for market (cash crops) and other business activities (including home-based businesses).
	Paid labour and paid services. This includes waged work on farms and other waged work.
	Unpaid care work. This includes the direct care of persons, housework that facilitates the care of persons and the collection of water or wood for fuel.
	Unpaid work producing products for home consumption or for the family. This includes gardening, rearing animals, making furniture and subsistence agriculture.
	Unpaid community work. This includes attendance at committees and community work related to health, education, natural resources and religious or cultural events.
	Non-work. This includes personal care (bathing, resting), sleep, entertainment and recreation.

Participants were then asked to recall the hours spent on each of the six work categories on a normal (non-festive) day. They were asked to do this exercise considering both main and simultaneous activities. Each participant then calculated their weekly average for each activity, taking into account that on Sundays time allocation tends to differ from a normal day. The totals were then captured in different tables for men and women.

The total weekly hours obtained were then divided by the number of attendees (women and men separated) to obtain the weekly average for men and women. In all RCA sessions, women reported more unpaid care work than men as both their main and simultaneous activity.

These averages were then captured in a table reflecting work hours for both men and women. In this way attendees could see the unequal distribution of work between genders, without seeing themselves exposed in front of the community. The results are shown in Tables 2.2–2.4.

Table 2.2: Lilongwe – older group

Activity	Women		Men	
	8 hours	3 hours (simultaneous)	33 hours	3 hours (simultaneous)
	13 hours	0 hours (simultaneous)	11 hours	3 hours (simultaneous)
	38 hours	35 hours (simultaneous)	15 hours	8 hours (simultaneous)
	28 hours	2 hours (simultaneous)	21 hours	2 hours (simultaneous)
	0 hours	0 hours (simultaneous)	4 hours	4 hours (simultaneous)
	54 hours	5 hours (simultaneous)	81 hours	13 hours (simultaneous)

Table 2.3: Lilongwe – younger group

Activity	Women		Men	
	8 hours	0 hours (simultaneous)	39 hours	18 hours (simultaneous)
	9 hours	0 hours (simultaneous)	8 hours	1 hour (simultaneous)
	49 hours	35 hours (simultaneous)	6 hours	2 hours (simultaneous)
	18 hours	2 hours (simultaneous)	12 hours	5 hours (simultaneous)
	3 hours	0 hours (simultaneous)	5 hours	4 hours (simultaneous)
	72 hours	7 hours (simultaneous)	94 hours	42 hours (simultaneous)

Table 2.4: Chitipa – mixed ages group

Activity	Women		Men	
	8.3 hours	3 hours (simultaneous)	24 hours	4 hours (simultaneous)
	0 hours	0 hours (simultaneous)	0 hours	0 hours (simultaneous)
	64 hours	34 hours (simultaneous)	10.5 hours	16 hours (simultaneous)
	16.7 hours	2 hours (simultaneous)	15.6 hours	2 hours (simultaneous)
	1 hour	0 hours (simultaneous)	0 hours	0 hours (simultaneous)
	66.3 hours	30 hours (simultaneous)	99.7 hours	13 hours (simultaneous)

These tables illustrate how the unequal distribution of care work is more acute among younger populations (women: 49 hours per week (h/w) main and 35 h/w simultaneous vs men: 6 h/w main and 2 h/w simultaneous) than older ones (women: 38 h/w main and 35 h/w simultaneous vs men: 15 h/w main and 8 h/w simultaneous). On average, these findings also highlight the critical role played by women in unpaid productive work (women: 23 h/w main and 2 h/w simultaneous vs men: 16.5 h/w main and 3.5 h/w simultaneous). The combination of these activities results in a more unequal distribution of non-work activities between genders (women: 66.5 h/w main and 37 h/w simultaneous vs men: 27 h/w main and 8.5 h/w simultaneous).

The unequal distribution of care work between genders constrains women in Lilongwe and Chitipa from engaging in political participation and income-generating activities, limiting their decision-making power and control over assets at the household level. Moreover, it prevents women from fully enjoying basic needs/rights like sleeping or personal care, and has a direct negative impact on their well-being.

2.4 Gender and age distribution for care work

In order to establish how gender and age influenced care work, the RCA session deliberately moved away from other types of work and focused only on care work. Using the age distribution matrix (Table 2.5), facilitators asked the group to discuss how much time women, men, girls, boys, older women and older men spent on each activity on average.

The RCAs reported most care work as being done by adult women of reproductive age, followed by girls. The least work was done by men and elder men. As shown in Table 2.5, most care activities are carried out by women and girls:

Table 2.5: Age distribution care work matrix

	Category					
Sub-category						
Fetching water	● ● ●	●	● ●	●	● ● ●	
Cooking	● ● ●	●	● ● ●	●	●	
Going to the market to buy food and clothes	● ● ●	●	● ● ●	● ●		
Looking after the children	● ●		● ●	● ●	● ●	
Cleaning the house	● ● ●	●	● ●	●		
Cleaning outside the house	● ●	●	● ●	● ●		
Collecting firewood	● ● ●		● ● ●			
Washing clothes	● ●		● ●	●		
Breastfeeding	● ● ●					

Key: Three dots: more than 10 hours per week; two dots: 5–10 hours a week; one dot: less than five hours per week; no dots: never

The table has been ordered based on the number of hours required for all age groups, resulting in a ranking of the most problematic and time-consuming care activities. As can be observed from the table, the top four care activities are fetching water, cooking, buying food and clothes from the market and looking after children.

2.5 Age implications of who does more care work

Participants in the RCA sessions pointed out that older people tend to do less care work because of their advanced age. Women aged 30–40 do most of the care work, not only because they have the strength and ability, but also because they do not want to be seen to be failing in their core role of looking after their own families. This expectation on the part of other household members is what drives adult woman to work much more than anybody else.

Young women with small children also do more unpaid care work than elderly women. This is because their children are too young to lend a hand in the care work, small children demand more attention in terms of feeding, washing, protection and treatment and young women are likely to have more school-going children.

2.6 Negative and positive norms and perceptions in care work

The moderators facilitated discussions in which RCA participants were probed on social norms that are known to either hinder or enhance care work at household and community levels. From the RCA sessions it became clear that the practice of men leaving care work to their womenfolk has much to do with attitude, tradition and society's perception of care work.

Man: 'There are some households that have embraced the sharing of household care work between men and women. However, society brands men who cook as being under the woman's spell [love potion] or not being man enough.'

Woman: 'I consider this as gender-based violence. Why should it only be a woman doing so much work? Where is the love in a marriage?'

The culturally entrenched position is that it is not socially acceptable for men to perform certain care activities as defined in this study. Some men indicated their concern about what their neighbours or their women would think of them if they took on care work such as cooking or washing clothes.

2.7 Seasonal changes in care work

The RCA used a seasonal calendar to map how the top four care activities are affected by the time of year. The rainy season was identified as the key factor that increased or decreased the amount of time needed to perform each of the care activities.

- Fetching water becomes particularly difficult between August and November due to water scarcity.
- Cooking becomes particularly challenging during the rainy season (December–February), as it is more difficult to find dry wood to start the cooking fire.
- Buying food and clothes from the market requires extra time during the rainy season, as the roads flood or become muddy.
- Taking care of children also becomes more difficult during the rainy season. Children play in the mud, increasing the time needed for washing clothes and the likelihood of having sick children at home.

Table 2.6 shows a 12-month calendar and maps the times when each of the top four care work activities are more intense.

Table 2.6: Seasonal changes in care work

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec

Fetching water | Cooking | Going to the market | Looking after the children

Woman: 'Looking after children becomes more demanding during the rainy season because kids like playing in the mud. Hence you have to give more attention to them to make sure that they don't hurt themselves, and also the washing becomes more intensive. Sicknesses like diarrhoea become more problematic during this season.'

2.8 Most problematic care work

To determine which care activities are most problematic and to guide the development of solutions to address those issues, the RCA sessions prompted discussions among men and women to list the top four most problematic care activities in the matrix. For each problematic care activity, the group assigned dots to assess a) how much it is a time burden; b) how much it affects mobility; c) how much it affects health; and d) how risky it is to perform the task.

Fetching water was identified as the most problematic activity, as it restricts women's mobility and is time-consuming. It can also be risky as on occasion people encounter wild animals while carrying water.

Cooking is also a problematic activity as it is extremely time-consuming and has an adverse impact on health, due to the use of firewood for cooking. Surprisingly, attendees agreed that it does not have a negative impact on mobility, as women have flexibility on when to cook, depending on other activities.

Looking after the children is the most time-consuming activity, and carrying them was identified as having a negative impact on health. Buying food and clothes from the market was identified as being relatively less problematic than the other activities but still constraining of women's mobility. Table 2.7 summarizes the discussion.

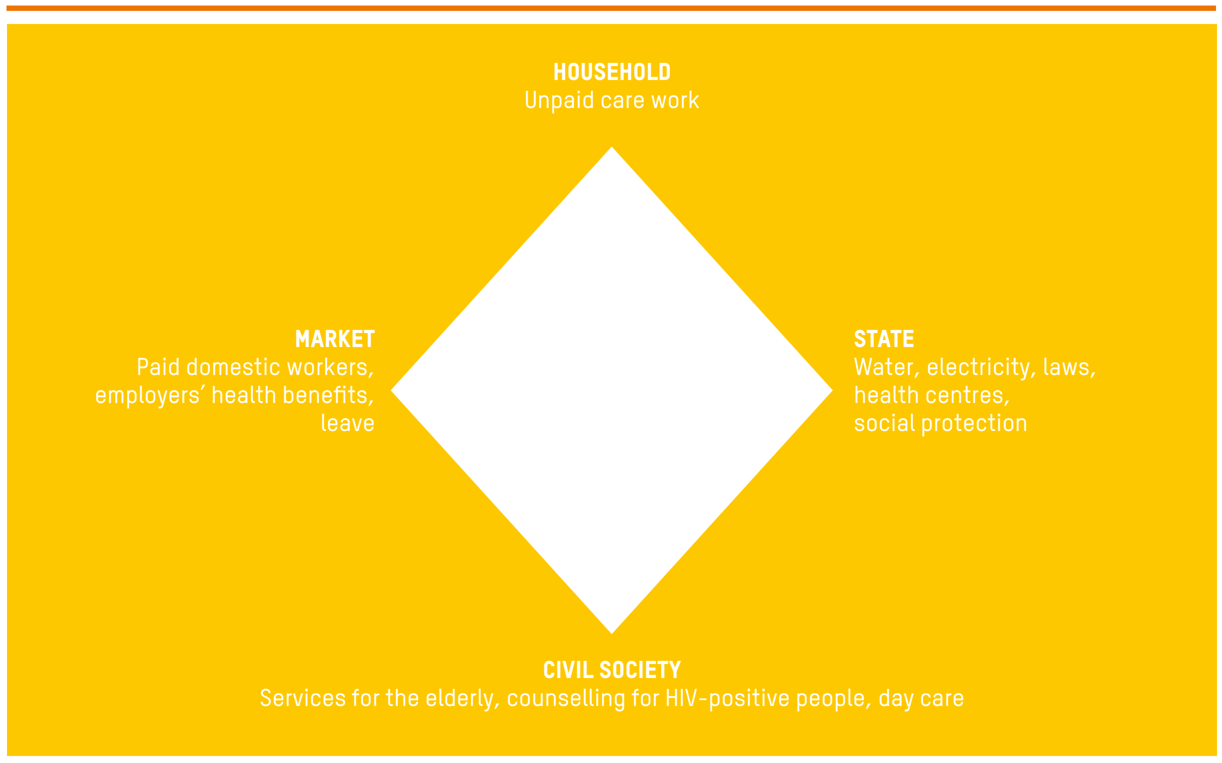
Table 2.7: Comparative analysis of the 'burden' of care on women

	Time Burden	Restriction on Mobility	Adverse Impact on Health of Carer	Risks
Fetching water	● ●	● ● ●	● ●	●
Cooking	● ● ●	●	● ● ●	
Going to the market to buy food and clothes	● ●	● ●	●	
Looking after the children	● ● ●	●	● ● ●	
Key: Three dots: most challenging; two dots: manageable; one dot: only slightly challenging				

2.9 Developing options and solutions

In order to come up with solutions for the most problematic care activities that could be feasible and impactful, the RCA facilitators reviewed with the participants the '4 Rs' and the 'care diamond' (Figure 2.2). The care diamond represents the four main categories of actor (household, market, civil society, state) that can play a role in rebalancing the distribution of unpaid care work in the society.

Figure 2.2 Care diamond



This was later followed by a brainstorming session with the participants on options for recognizing, reducing and redistributing care work in their communities. The groups agreed on four different strategies, each of them addressing a different problematic care activity.

Table 2.8: Potential solutions to the most problematic care activities

Care activity	Potential solutions
Fetching water	Drill boreholes and construct concrete wells in the communities
Cooking	Plant trees in the communities for firewood and get men to share tasks with women
Buying food from the market	Develop kitchen gardens
Child care	Establish a community-based child care centre

2.10 RCA conclusions

RCA sessions showed the unequal distribution of care work between men and women, with this being particularly acute among younger members of society. Participants explained that this was due to traditional norms and beliefs. They linked women's unpaid care work, such as washing clothes, cooking, fetching firewood and collecting water, with their traditional role as mothers, which involves caring for children and having responsibility for most of the caring tasks that ensure the welfare of the family.

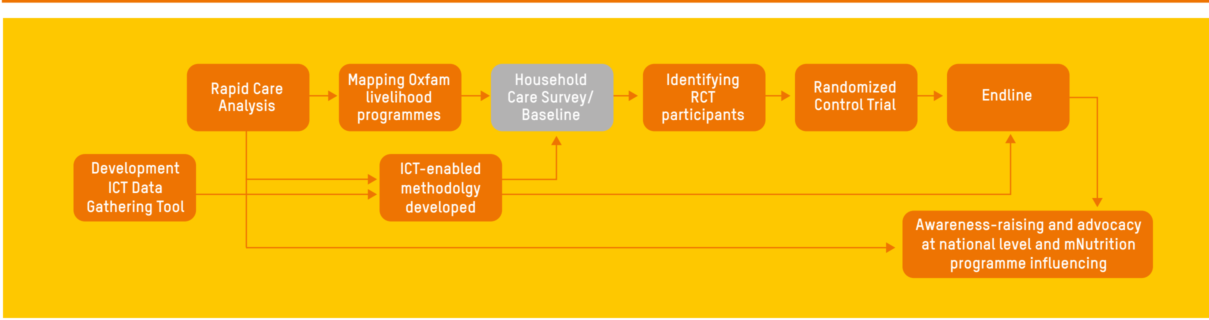
The RCA and group discussions helped men recognize the unequal distribution of care work between men and women, and the need to reduce and redistribute this work. Time poverty rooted in care work has prevented women from fully participating in decision-making and leadership processes and income-generating activities, and negatively affects the well-being of women in Lilongwe and Chitipa.

The RCA methodology proved to be successful in the Malawian context and has demonstrated that dialogues of this nature are possible and can be successful. It also served as a first step for the design and implementation of broader livelihoods and gender justice programmes.

3. HOUSEHOLD CARE SURVEY

3.1 HCS – RCT baseline

Figure 3.1: Mean hours spent on unpaid care work within households



When assessing unpaid care work, obtaining a precise estimation of the time devoted to particular care activities is extremely important; however, it can be difficult and time-consuming to do this. The selection of appropriate care assessment tools may vary depending on the relative weight given to unpaid care work in the project's theory of change. As shown in the previous section, RCAs can be useful and easy to use to get an initial idea of the distribution of unpaid care work at the household and community levels, as well as some indications of the most problematic care activities and potential solutions. Household Care Surveys (HCSs) build on the RCAs and consist of one- to two-hour-long questionnaires that offer a more thorough analysis of the current distribution of care work at the household level and between family members. An HCS also provides a more holistic understanding of the implications of the unequal distribution of care work on women's empowerment and gender justice.

One of the most critical sections of the HCS and the RCA is the individual 24-hour recall of time dedicated to different primary and secondary activities. In the case of the RCA, this recall is self-classified into six different work categories and is collated at the group level, while in the case of the HCS the enumerators code each of the activities into 25 different sub-categories. This provides better insights into the different types of unpaid care work activity and can then be correlated with a multitude of influencing and demographic factors.

In the case of Malawi, the WE-Care programme used mobile phones to interview a total of 594 households from Lilongwe and Mchinji; this helped to speed up the data collection process and reporting and analysis of findings. It also helped to minimize the number of errors and increase the outreach of the survey. The HCS also served as the baseline for the Randomized Control Trial. The research team used the standard HCS but also included additional questions to help identify potential participants in the RCT and to use as reference points for analysing the impact of the RCT intervention.

3.2 HCS findings

The main findings of the HCS are presented in Tables 3.1–3.5. Table 3.1 shows the mean values of primary care hours for women, as well as other members of the household. It is evident from this table that women in Lilongwe and Mchinji dedicate more time to unpaid care work than any other member of their households. It is also important to note that husbands do less care work than any other member of the household.

Table 3.1: Distribution of unpaid care work of household members in a 24-hour period of time

	Mean	Standard error	95% confidence interval (CI)
Primary care hours			
Respondent / woman	**5.3**	0.09	(5.13, 5.48)
Husband	**1.11**	0.05	(1.00, 1.22)
Daughter	**3.67**	0.13	(3.41, 3.93)
Son	**2.48**	0.11	(2.25, 2.71)
Primary/secondary care hours			
Respondent / woman	**6.04**	0.11	(5.83, 6.26)
Multi-tasking care hours			
Respondent / woman	**8.17**	0.10	(7.96, 8.38)

Table 3.2 shows a comparison of primary, primary/secondary and multi-tasking care hours calculated for the other five WE-Care countries. These results indicate that women in Lilongwe and Mchinji dedicate a similar amount of time to care work as a primary and primary/secondary activity as women in Zimbabwe and Uganda. However, women in Malawi seem to dedicate more time to multi-tasking care hours than their counterparts in any other country.

Table 3.2: Comparative distribution of unpaid care work hours based on care activities undertaken by respondents and other household members in a 24-hour period for other WE-Care countries

	Colombia	Ethiopia	Uganda	Zimbabwe	Philippines
Primary care hours					
Women	4.26	6.88	5.00	5.07	7.65
Men	1.19	4.16	3.12	2.69	
Primary/secondary					
Women	7.30	9.12	6.36	6.26	9.70
Men	2.17	2.27	1.39	0.34	
Multi-tasking care hours					
Women	4.8	6.66	3.32	3.94	5.30
Men	1.06	0.83	0.22	0.10	

This table also shows that men are doing fewer hours of care work than women in all countries. It is also worth noting that men in Malawi seem to be engaging in primary care work less than men in any of the other five countries. These findings call for concerted efforts geared towards reducing the unequal distribution of unpaid care work for women, using targeted interventions.

Table 3.3: Multivariate regression model for the analysis of factors associated with primary care activities by women in Lilongwe and Mchinji (n = 594)

Variable	Co-efficient	95% CI	P-value
Farmers group membership			
Not a member	1		
Member of group	-1.24	(-1.85, -0.63)	0.000
Access to public water			
Not accessible	1		
Accessible	-0.53	(-0.908, -0.159)	0.005
Age of respondent	-0.021	(-0.035, -0.0071)	0.003
Savings		(0.164, 0.910)	0.005
No savings	1		
Has savings	0.537		
Number of children under six years	0.046	(0.019, 0.074)	0.001
Education			
None	1		
Pre-primary	1.114	(0.149, 2.079)	0.024
Primary	0.263	(-0.192, 0.719)	0.256
Junior secondary	1.788	(0.758, 2.819)	0.001
Secondary	0.613	(0.401, 2.24)	0.202
Tertiary	0.245	(-0.329	0.873

Table 3.3 shows the relationship between selected variables and primary care work hours. The table was calculated using a linear regression model, as primary care hours is a continuous variable. The independent variables were put in the regression model one by one to examine their individual effects on primary care hours. The variables that remained significant in the univariate model were put in the multivariate model to investigate factors related to primary care hours. The multivariate model above reveals the following findings:

Education: Women with pre-primary education spend 1 hour 11 minutes more on primary care responsibilities each day compared with women who have no education. Women with junior secondary education spend 1 hour 47 minutes more each day on primary care responsibilities compared with women who have no education.

Group membership: Farmers group membership decreases the number of women's primary care hours by 1 hour 14 minutes a day compared with women who are not members of a group.

Accessibility of public water sources: Access to a public water source reduces women's primary care hours by 32 minutes a day compared with women who do not have access to a public water source.

Age of respondent: A one-year increase in a woman's age reduces primary care responsibility by about 1.5 minutes a day.

Savings: Women who have savings have 32 minutes more a day of primary care responsibilities than women who do not have savings.

Children under six years: For each child under six years old, the amount of time spent by women on primary care work increases by 2.76 minutes a day.

Relationship between primary care hours and violence against women: The HCS also aimed to gain a better understanding of the relationship between primary care work and violence against women. Respondents were asked if they thought there were circumstances where it was acceptable for a household member to beat a woman or a girl. Of the 594 women sampled, 76 responded affirmatively to the question. Those 76 respondents were asked about the acceptability of gender-based violence to punish the unsuccessful performance of particular care work activities. Table 3.4 shows that none of the answers linking GBV and particular care work activities were significant at 5 percent of significance level.

Table 3.4: Univariate linear regression model for the analysis of association between primary care hours and unsuccessful performance of particular care work activities

Variable	Co-efficient	95% CI	P-value
If she fails to care well for children No Yes	 1 0.21	 (-0.69, 1.11)	 0.642
If she leaves a dependant/ ill adult unattended No Yes	 1 -0.11	 (-1.01, 0.78)	 0.816
If she fails to prepare food for husband No Yes	 1 0.59	 (-0.35, 1.55)	 0.215
If she fails to fetch water/ firewood No Yes	 1 0.81	 (-0.084, 1.70)	 0.075
If she fails to clean clothes for husband No Yes	 1 0.85	 (-0.097, 1.80)	 0.078

Respondents were also asked about the acceptability of shaming or mocking men for doing housework. Of the 594 respondents, 87 responded positively. Table 3.5 shows activities that are statistically significant in the univariate model.

Table 3.5: Multivariate linear regression model for the analysis of association between primary care work and mockery of men

Variable	Co-efficient	95% CI	P-value
If he is taking care of dependant/ill adult No Yes	 1 -1.93	 (-3.36, -0.51)	 0.008
If he is bathing a dependant/ill adult No Yes	 1 0.56	 (-0.87, 1.98)	 0.437

These findings point to women's perception of gender roles being associated with particular unpaid care work activities as one of the root causes for the unequal distribution of care work at the household level.

3.3 Implications of the unequal distribution of care work between genders

Public engagement, including political participation

Care work, as can be observed across tasks such as accessing safe water, basic health and education and assuring food security for the household, is intense and demanding, yet someone has to perform these activities. The noticeable absence of women in public dialogues is to a large measure linked to their need to care for the household and at times communities, at the expense of their active participation in public forums.

Social empowerment (in addition to social norms)

The unfavourable conditions in which women find themselves are mainly perpetuated by cultural restrictions, marginalization in decision making and ignorance due to limited education. Women are at most times confined to the household due to the expectations of household members (including their own expectations) that they have to perform all manner of care work.

Personal empowerment and confidence

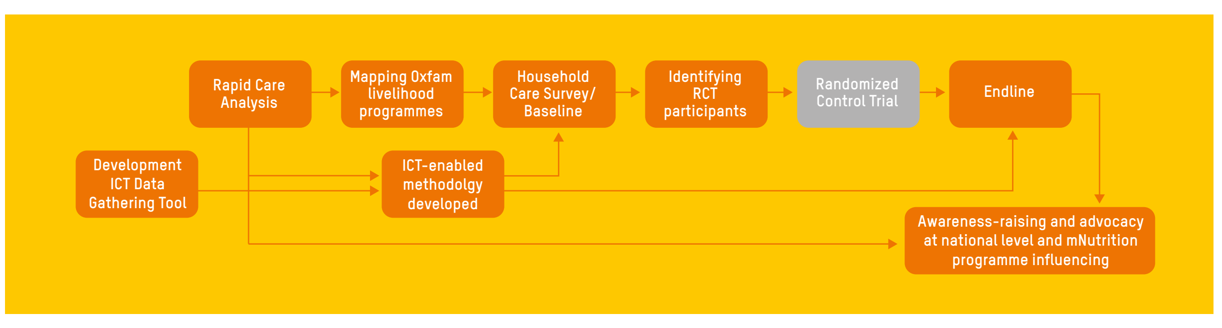
The origin of care work being regarded as 'petty' or not worthy of men's time derives from the division of labour in which women are traditionally charged more with non-monetized activities such as collecting firewood, child rearing, fetching water and tilling the land. With the responsibility of making food available in the home, women are left with almost no time to pursue anything that they may choose for their own personal development. Meanwhile men, who are regarded as heads of the household, own all the factors of production and therefore make nearly all the important decisions in the household. Men also have more leisure time to socialize and to pursue personal interests and development.

Women's participation in productive work

The majority of women work from dawn to dusk, but such work is not even recognized as work. They remain the primary care-givers in the household; often they are the major contributors to markets as well. Even when they may be working longer hours than men, their work is regarded as falling into the realm of caring, nurturing and household duties, not into the realm of 'economic' activity as such. This poor or negative attitude towards women engaging in income-generating activities and earning their own income appears to cement the view that non-income-generating work is the preserve of women, even if the work is technically productive (e.g. kitchen gardens). This attitude has come to be the norm over time. As a result, women do not control the proceeds from whatever goods are produced or what is sold in the market.

4. RANDOMIZED CONTROL TRIAL – DESIGN, IMPLEMENTATION AND RESULTS

Figure 4.1: The results chain of the WE-Care component of the mNutrition programme



The Randomized Control Trial (RCT) was the final research methodology used by the WE-Care programme in Malawi, and it built on the results that emerged from the RCAs and the HCS. The RCT was divided into three main phases: design, implementation and endline (follow-up) survey. This section is structured according to these three phases.

4.1 RCT design

Oxfam appointed a technical taskforce consisting of an impact evaluation adviser, a thematic programme adviser and two programme staff for the design of the RCT. The result of this collaboration was an RCT protocol that was shared with all members of the RCT steering committee and validated prior to the implementation of the study. This sub-section captures some of the key areas covered by the protocol and describes the main research questions and the methodology used for the implementation and monitoring of the study.

4.1.1 Research questions

Primary research question:
Is the daily allocation of time to non-paid care work different between women smallholder farmers who are members of farmers' clubs in Lilongwe and Mchinji and who access mNutrition mobile-enabled services (health and agriculture) through a mobile phone in their household and women smallholder farmers who are also members of farmers' clubs in the same regions but who do not access mNutrition mobile-enabled services?

Secondary research questions:
Is the daily allocation of time to non-paid care work (primary and secondary care hours) different between women smallholder farmers who are members of farmers' clubs in Lilongwe and Mchinji and who access mNutrition mobile-enabled services (health and agriculture) through a mobile phone in their household and women smallholder farmers who are also members of farmers' clubs in the same regions but who do not access mNutrition mobile-enabled services?

Is the daily allocation of time to non-paid care work (multi-tasking care hours) different between women smallholder farmers who are members of farmers' clubs in Lilongwe and Mchinji and who access mNutrition mobile-enabled services (health and agriculture) through a mobile phone in their household and women smallholder farmers who are also members of farmers' clubs in the same regions but who do not access mNutrition mobile-enabled services?

4.1.2 Hypotheses

This RCT is based on the hypothesis that access to mNutrition information services will have an effect (increased or decreased) on the allocation of time to non-paid care work; this is based on the assumption that recipients of such services will change their health or agricultural behaviour based on the information received.

Null hypothesis (H0): The daily allocation of time to non-paid care work is the same between women smallholder farmers who access mNutrition (mAgri and mHealth)-enabled services through their mobile phones and those who do not.

Alternative hypothesis (HA): The daily allocation of time to non-paid care work is different between women smallholder farmers who access mNutrition (mAgri and mHealth)-enabled services through their mobile phones and those who do not.

4.1.3 Objectives

Primary objective:

- To determine the impact of mNutrition services on women's time allocation, particularly for unpaid care work.

Secondary objectives:

- To build an evidence-based narrative around the importance of addressing women's heavy burden of unpaid care work and its implications for time allocation when designing mobile services and messages around health and agriculture that target women smallholder farmers.
- To build a business case for mobile network operators (MNOs) on the importance of addressing women's time constraints as a way to improve customer uptake of mobile-enabled information services.
- To use evidence gathered through the RCT to improve the design of the mNutrition programme in Malawi and other mNutrition countries to better address women's time poverty.
- To use evidence generated through the programme to raise awareness of key national stakeholders around the unequal distribution of care work at the household level in Malawi.

Other objective:

- By comparing the results obtained in the baseline and the endline, this study will also try to obtain a better understanding of the unequal distribution of unpaid care work at the household level.

4.1.4 Study site and populations

It was decided to concentrate the RCT on two regions (Lilongwe and Mchinji) where Oxfam had experience of implementing livelihoods programmes that targeted women smallholder farmers. The main reason for choosing these sites and populations was that the pilot phase of the mNutrition programme took place in the same two regions and also aimed to reach women smallholder farmers.

4.1.5 Study design

The study consisted of two groups: the intervention or treatment group and the control group. To achieve the objective of the study, Oxfam randomized 160 women from Mchinji and Lilongwe into intervention and control groups. The implementation period was originally intended to be between December 2015 and February 2016, but due to some unexpected delays in the delivery of the messages the implementation finally took place between January and March 2016. This limited time duration is critical for the analysis of the results, as the impact of the treatment on unpaid care work could have varied if it had been applied over a longer period of time.

4.1.6 Subject selection

All subjects needed to meet the following requirements to be eligible to become participants in the study:

- Be women;
- Live in Lilongwe or in Mchinji;
- Be involved in smallholder farming for home-consumption, income generation or both;
- Be members of a farmers' club, farmers' association or cooperative;
- Have participated in a current or previous Oxfam livelihoods programme;
- Have been surveyed during the HCS/baseline of the WE-Care programme in Malawi.

Based on the baseline results, the number of eligible participants was 213, from which Oxfam randomly selected 160 for the study.

4.1.7 Subject recruitment

Participants in the RCT did not receive monetary compensation for taking part in the study, but were given a mobile phone through which they received free access to information services. This served for one group as the treatment (access to mNutrition services) and for the other as control (access to other types of information services, such as entertainment).

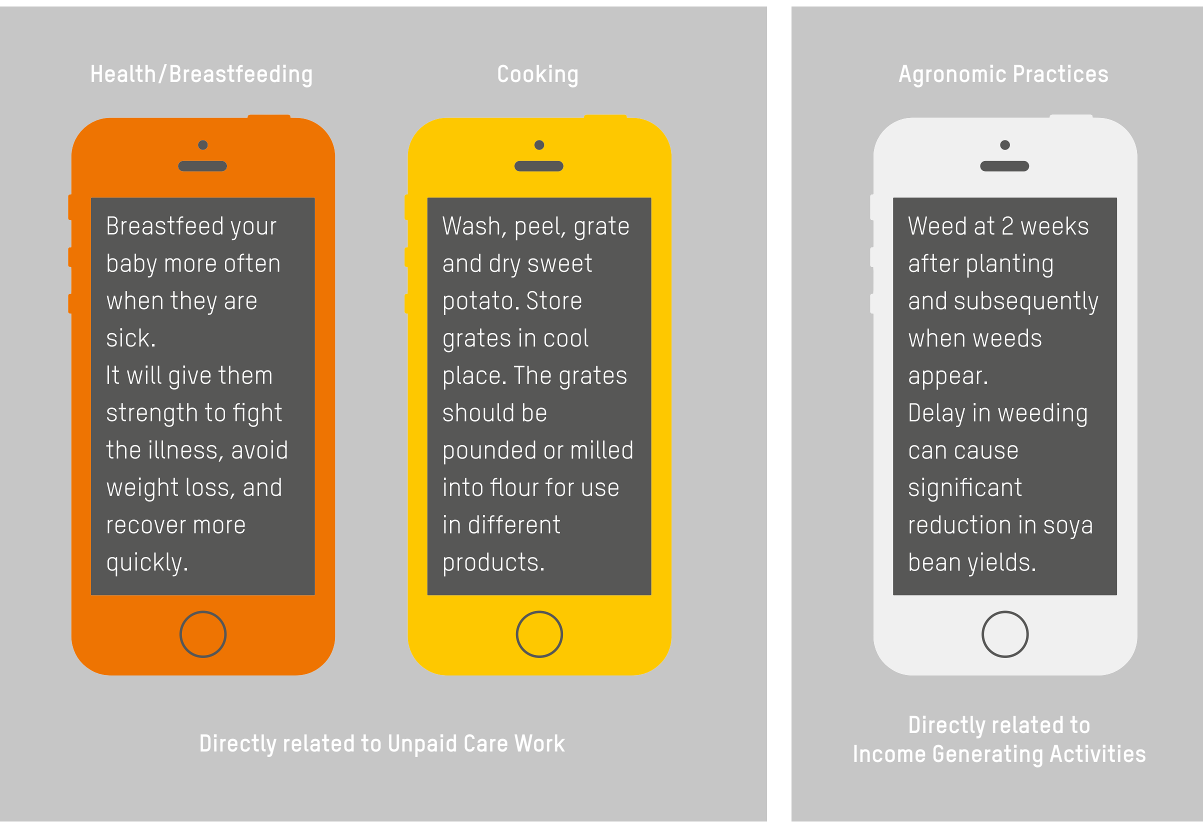
Once eligibility was confirmed, a field coordinator asked potential participants about their willingness to join the trial. If they were interested, participants received a consent form to formalize their participation in the study.

4.1.8 Trial interventions

Treatment group

Participants in the treatment group received a total of 24 SMS messages on their mobile phones. Twelve of these messages were developed as part of the mHealth services and 12 as part of the mAgri services. There were three main content categories in which the messages could be classified: health practices, cooking practices and agronomic practices. Both health and cooking practices offered directive advice to recipients on how to change their behaviours to improve the health and nutrition levels of their families. If adopted by the participants, the recommendations contained in these messages would have a direct impact on the allocation of time to unpaid care work (e.g. breastfeeding or cooking). However, the messages related to agronomic practices were directly related to income-generating activities and only indirectly to improved nutrition levels through greater income dedicated to buying and consuming more nutritious foods. If adopted, the recommendations in these mAgri messages would have a direct impact on the time allocated to income-generating activities and an indirect impact on the time dedicated to unpaid care work. Figure 4.2 shows three examples of messages used during the study and classified in each of the three content domains.

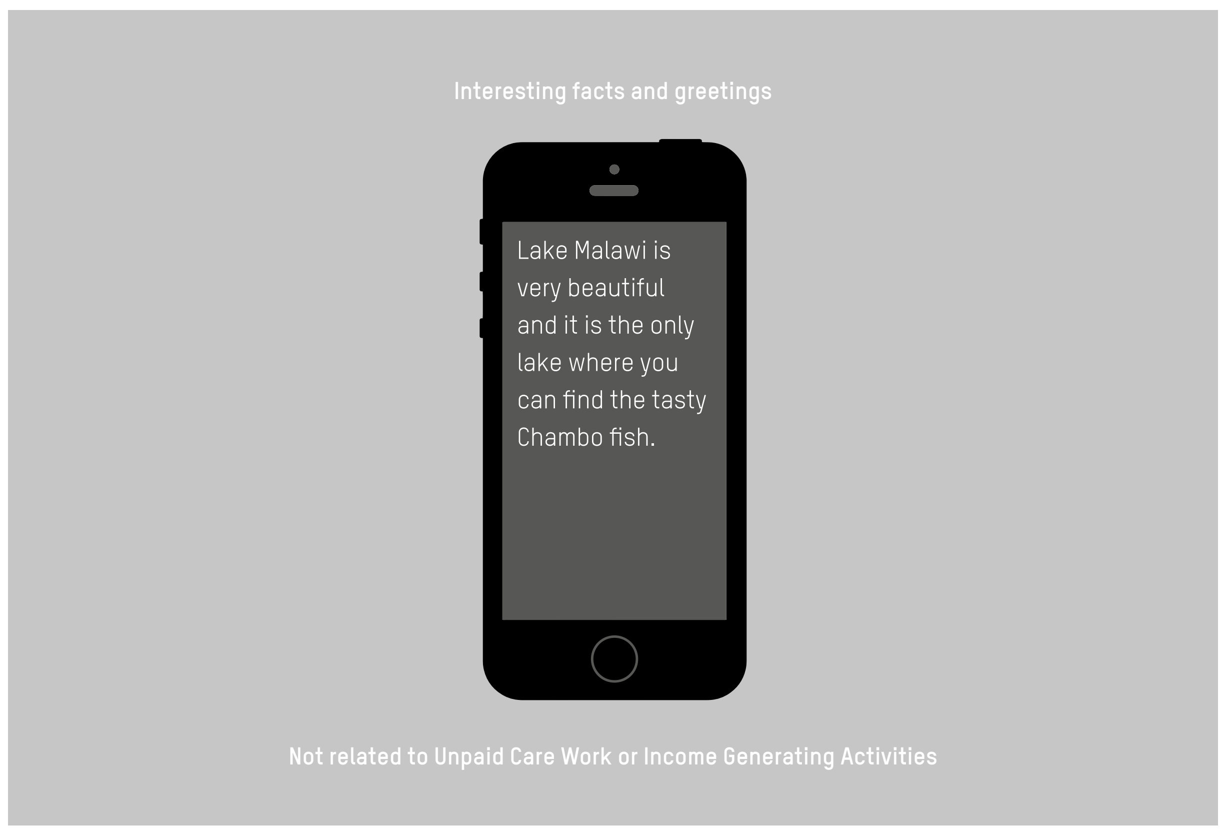
Figure 4.2: Examples of treatment group messages



Control group

The control group received a total of 12 messages, unrelated to agriculture, health or cooking. These messages were intended to have no effect on the distribution of time to any activities, particularly the distribution of time to unpaid care work. Some of these messages contained interesting facts or even seasonal greetings. Figure 4.3 shows an example of a message sent to the control group.

Figure 4.3: Example of control group messages



4.2 RCT implementation

4.2.1 RCT steering committee

Prior to the implementation of the RCT, a steering committee was created to ensure quality control and transparency of the study. The following organizations formed the RCT steering committee:

- Malawi Ministry of Gender, Children, Disability and Social Welfare
- Malawi Ministry of Agriculture and Food Security
- Malawi Ministry of Health
- Airtel Malawi
- Human Network International (HNI)
- Oxfam.

The steering committee met a total of three times: prior to the commencement of the study for design and inception purposes, halfway through the study for monitoring purposes and at the end of the study for the evaluation of results.

4.2.2 RCT monitoring, quality control and assurance

Three different monitoring tools were used during the implementation of the RCT to ensure quality control of the study:

- Monitoring calls from mobile operator Airtel were used in the initial implementation phase of the RCT to ensure that the participants were receiving messages on a regular basis and to gain a better understanding of the kinds of messages they were receiving.
- Face-to-face meetings were used to complement the monitoring calls and to get additional insights into the relevance of the messages and potential constraints to usage and to map potential risks to the implementation of the study.
- Message delivery reports were generated by HNI on a weekly basis to track delivery and receipt of messages by each participant in the study.

4.2.3 Issues encountered during implementation of the RCT

Frequency of messages

Initial monitoring calls and face-to-face meetings indicated a low frequency in the delivery of messages to both treatment and control groups. This issue was discussed by the steering committee and successfully addressed through collaboration between Oxfam, HNI and Airtel. All 24 treatment and 12 control messages were delivered to the participants. However, the initial delay had implications for the end date of the study: this was originally scheduled for February 2016, but the study was finally concluded in March 2016.

Information spill-over

Information spill-over is a common risk in RCTs that use information as treatment. This risk is usually avoided by increasing the sample size of the study and by randomizing at the village level instead of the household level. Due to the reduced sample size of this RCT, the steering committee acknowledged the difficulty involved in completely eliminating the risk of spill-overs and agreed to randomize at the household level to preserve the statistical power of the analysis. However, the committee also agreed to put in place contingency mechanisms in case of potential information spill-overs during the implementation.

Initial face-to-face monitoring meetings identified a potential spill-over effect in the study. Participants from the treatment group reported that they had shared some of the information received in the first three messages with other members of their communities, including participants in the control group.

This potential risk was identified and discussed by the steering committee, which put in place a set of measures to reduce the spill-over effect:

- Participants were explicitly requested not to share the messages they received on their phones for the duration of the study.
- Oxfam's partners were asked to ensure that no messages were shared between participants in the study during meetings of savings and loans groups.
- The frequency of messages was increased for both groups. This helped to reduce the likelihood of participants sharing and comparing all content received in their mobile phones with other community members.
- The endline survey included a set of questions and indicators to evaluate the levels of contamination between treatment and control groups.

Follow-up face-to-face monitoring meetings and data collected in the endline point to low levels of spill-over at the end of the study. As shown in Table 4.1, this is also corroborated by the individual recall of behaviours changed by the control group after the end of the study.

Table 4.1: Self-reported changes from the study – control group

I have Airtel mobile money banking.
I now know when the multi-party system started in Malawi.
I now know events that are taking place.
I now know some facts about the history of Malawi.
I know when Kamuzu Banda started ruling.
I now know some interesting facts about my country.
I now know some international football teams.
I'm able to make free calls at times.
Lake Malawi has beautiful species of fish.
I now know some historical events.

4.3 RCT findings

It is worth noting that behavioural change does not happen overnight, and that all these results might have varied if the study had been conducted over a longer period of time

4.3.1 Care work, income-generating activities and sleep hours

This section aimed to look at the overall daily allocation of women's time to different activities, focusing particularly on the allocation of time to unpaid care work. The results are shown in Table 4.2, which highlights the differences between the treatment and control groups and provides data from the baseline for comparison.

Figure 4.2: Activities undertaken by respondents and other household members in a 24-hour period with regard to care

	Baseline mean (n=594)	Treatment mean (n=80)	Control mean (n=78)	P-value 10% significance level
Number of hours spent by **women on care as a primary activity**	5.30	5.27	5.40	0.7437
Number of hours spent by **women on care as a primary and secondary activity**	6.04	6.06	6.23	0.6762
Number of hours spent by **women on income-generating activities**	1.7	2.6	1.5	0.094
Number of hours spent by **women sleeping**	10.8	8.67	9.26	0.097
Hours spent by **husbands on specific care activities each week**	1.11	1.78	1.60	0.5907

Preliminary findings point to a low uptake of the messages that were directly related to care work activities (e.g. cooking or breastfeeding), showing no significant difference in the total care hours (primary and secondary) between control and treatment groups and when compared with the baseline. However, households in the treatment group show some redistribution of total care work responsibilities from women towards their husbands when compared with the control group.

The analysis indicates an early uptake of those messages related to income-generating activities, resulting in an overall increase of over 70 percent in time dedicated to these activities in the treatment group compared with the control group. This points towards a prioritization of the messages received by the treatment group of messages related to income-generating activities over those related to health and cooking practices.

Overall there was a significant reduction in the sleep hours for women in the treatment group. This echoes research findings from other WE-Care countries, where Oxfam has observed that women engaged in in livelihoods programmes dedicate more time to productive work and less time to care work as a primary activity, have higher overall workloads and on average have less time for leisure and sleep.

An increment in the time dedicated to income-generating activities could potentially lead to improved nutrition levels through consumption of higher quantities of nutritious foods. However, deprivation of sleep can have negative effects on the health and nutrition levels of the recipients.

4.3.2 Time constraints, care work and personal care

This section aimed to identify the implications of the treatment for different care work activities at the household level and also for personal care. With that aim, participants were asked if over the previous week they had always had enough time to perform different activities.

Table 4.3: In the last seven days, did you always have enough time to cook food?

	Treatment (n=80)	Control (n=78)
Yes, always	75%	73.08%
No, I didn't have time **at least once last week**	23.75%	21.79%
No, I didn't have time **at least once a day**	0%	2.56%
No, I didn't have time **several times a day**	1.25%	2.56%
I do not cook	0%	0%
Pearson chi2 (3) = 2.4965 Pr = 0.476		

Table 4.3 shows that there was no significant difference between the two groups regarding time constraints for cooking. This implies that none of the messages sent to the treatment group had an effect on the time allocated to food preparation in the household.

This could point to a certain level of rigidity in specific care work activities and limited capacity for changing practices related to that activity.

Table 4.4: In the last seven days, did you always have enough time to wash, iron or mend family members' clothes when needed?

	Treatment (n=80)	Control (n=78)
Yes, always	67.5%	78.21%
No, I didn't have time **at least once last week**	25%	10.26%
No, I didn't have time **at least once a day**	1.25%	5.13%
No, I didn't have time **several times a day**	6.25%	6.41%
I do not wash, mend or iron clothes	0%	0%
Pearson chi2 (3) = 7.3448 Pr = 0.062		

Table 4.4 shows how the messages received by the treatment group had an effect on the time allocated by this group to other care work activities, like washing, ironing or mending family members' clothes. This means that even if the total amount of time dedicated to primary and secondary care work remained the same, specific care work activities were affected by the intervention. This points to a de-prioritization of activities like washing clothes in favour of others directly targeted by the intervention, such as breastfeeding.

Table 4.5: In the last seven days, did you always have enough time for personal care and hygiene?

	Treatment (n=80)	Control (n=78)
Yes, always	72.5%	85.9%
No, I didn't have time **at least once last week**	23.75%	14.1%
No, I didn't have time **at least once a day**	3.75%	0%
No, I didn't have time **several times a day**	0%	0%
Pearson chi2 (2) = 5.7569 Pr = 0.056		

Table 4.5 reflects the allocation of time for personal care and hygiene between the two groups. It is clear from the table that women in the treatment group had less time for personal care and hygiene than the women in the control group. These results build on the initial finding that women in the treatment group have less time for sleep than women in the control group, and it is supported by findings from other WE-Care countries. If time allocation to income-generating activities increases, it usually happens to the detriment of sleeping hours, leisure and time dedicated to personal care.

4.3.3 Relevance and uniqueness of the treatment messages

The endline survey also intended to gain a better understanding of the relevance and uniqueness of the messages sent to the treatment group. This would serve as feedback for the mNutrition programme and as a proxy to understand potential reasons for the prioritization and uptake of messages received.

Participants were asked if they had ever heard the actual content of the messages before or if the content was new to them. The majority reported that they had never heard the content before.

Table 4.6: Is this the first time that you heard the actual content, the information?

	Treatment (n=80)	Control (n=78)
Yes	63.75%	58.97%
No	36.25%	41.03%
Pearson chi2 (1) = 0.3800 Pr = 0.538		

4.3.4 Behavioural change

Behavioural change literature suggests that changes in attitudes and beliefs cannot be promoted by simply sending information to a target population. Before change happens, recipients of the messages need to share and compare this information with other members of their households and communities. It is in that open conversation where the new information is contrasted with previously acquired knowledge and the new practices are internalized or discarded.

With the aim of gaining a better understanding of how changes in behaviour occur, the endline attempted to check whether respondents sought clarification after receiving the messages. In this regard, participants in the treatment group were asked where/whom they sought clarification from after receiving the information through their mobile phones. Table 4.7 shows how the majority of participants asked a male family member, a friend or community member, or a member of their village savings group when they needed clarification on any message received.

Table 4.7: Once you have received the information through your mobile phone, who do you ask if you have any clarification questions?

	Treatment (n=80)		Control (n=78)		
	No	Yes	No	Yes	P-value
Male family member	42.5%	57.5%	42.31%	57.69%	0.980
Female family member	82.5%	17.5%	96.15%	3.85%	0.006
Friend or community member	50%	50%	62.82%	37.18%	0.104
Agricultural extension worker	85%	15%	92.31%	7.69%	0.148
Community health worker	81.25%	18.75%	89.74%	10.26%	0.130
Village savings and loan groups	43.75%	56.25%	57.69%	42.31%	0.080
NGOs working in the area	90	10	96.15	3.85	0.129

Table 4.7 also shows that more women in the treatment group sought clarifications from female family members regarding the messages received from their mobile phones than women in the control group. In addition, more women in the treatment group sought clarification from village savings and loan groups than women in the control group. These findings are statistically significant at 1 percent and 10 percent respectively.

The endline also tried to understand which practices had changed in the treatment group as a result of the messages received.

Table 4.8: From the messages you have received, which practices have you changed?

	Treatment (n=80)	
Topic	No	Yes
Agriculture	50%	50%
Health	62.5%	37.5%
Nutrition information	53.75%	46.25%
Other information	100%	0%

Fifty percent of the respondents said they had changed their agricultural practices after receiving the messages. Similar figures applied to the nutrition information, such as breastfeeding and cooking practices. However, a smaller percentage of respondents replied that they had changed their health practices. This self-reported behavioural change could have been affected by a social desirability bias of the respondents, who in reality had not already adopted all the practices and recommendations, as seen in the daily allocation of time to different activities, but believed that they should have.

Participants in the treatment group were also prompted to recall some of the messages they had received during the study. The intention of this exercise was to assess which messages had actually been internalized by the participants and to use this as a comparison with the self-assessment made by the participants on behaviours changed.

Table 4.9: Which kinds of messages do you recall that helped you change these practices? Please provide an example of a message you received

Agronomic practices/income-generating activities	Health	Food preparation
Agricultural practices – early weeding	Breastfeeding, washing hands	How to prepare soya flour
Boiling water before drinking	Breastfeeding a baby intensively	How to prepare soya porridge
Building fences around the fields	Breastfeeding a child up to six months	Providing children with a well-balanced diet
Cleaning the *kraal*	Hygiene and cleanliness	Caring for children through good diet
Fencing the field within the compound	Washing hands after using the toilet	Cooking potato flour for porridge
Fertilizer application		Eating a balanced-diet meal
How to protect chickens from disease		
How to control plant disease		

Table 4.9 shows a quite comprehensive recall of the messages received during the study and supports the findings from the self-assessment exercise.

4.3.5 Gender-based violence

The HCS indicated a high level of perception of the occurrence of GBV at the household level. The endline also included questions on domestic violence to assess the effect of the treatment on the perception of GBV at the community level.

Table 4.10: How often do you think instances of domestic violence happen in your community?

	Baseline mean (n=594)	Treatment mean (n=80)	Control mean (n=78)
Frequently	23.23%	36.25%	30.77%
Sometimes	36.20%	38.75%	28.21%
Rarely	28.62%	18.75%	32.05%
Never	11.95%	6.25%	8.97%
Pearson chi2 (4) = 5.4281 Pr = 0.246			

Table 4.10 shows that there is no significant difference between the two groups. However, initial findings point to a higher perception of the occurrence of domestic violence by participants in the treatment group compared with those in the control group.

Respondents were also asked whether they thought there were circumstances when it was acceptable to shame or mock men for doing housework. Table 4.11 shows that a greater percentage of women in the control group felt that it is acceptable to shame men for doing housework than women in the treatment group, although this finding was not statistically significant.

Table 4.11: Do you think there are circumstances when it is acceptable to shame/ mock men for doing housework?

	Treatment mean (n=80)	Control mean (n=78)
Yes	5%	10.26%
No	95%	89.74%
Pearson chi2 (4) =5.4281 Pr = 0.246		

4.3.6 Implications for mNutrition

The results that emerged from the RCT are highly informative for the mNutrition programme as a whole and for the development of mobile content and services in Malawi specifically. However, the short period of time in which the RCT took place must be taken into account when analysing the implications of the results for the mNutrition programme. These results might have varied if the study had been conducted over a longer period of time.

The overall goal of the mNutrition programme is to improve the nutrition levels of women and children. This is achieved in two different ways: the agricultural services aim to increase productivity and reduce post-harvest losses of nutritious crops, which leads to increases in household income and potentially higher consumption of nutritious foods by women and children; the health and food services aim to directly influence practices that affect the health and nutritional status of the recipients of the information.

The results of this RCT indicate that if all three types of message are delivered simultaneously to the programme's target population, recipients may tend to prioritize the application of those messages relating directly to income-generating activities during the first two months of receiving the information, to the detriment of those messages directly linked to health and food practices. A change in behaviour relative to agricultural practices would seem to represent a longer and more indirect way to increase the nutrition levels of the target population, compared with an early uptake of the health and food preparation information.

One of the main reasons explaining the participants' need to prioritize the uptake of certain messages is the lack of flexibility in time allocation to unpaid care work, which amounts to around a quarter of the total available time on a daily basis. The remaining time is dedicated to any other activities, ranging from farm work to sleep. A change in behaviour around productive work translates into an increased time allocation to these activities and a reduction in the time allocated to more 'time-flexible' activities, such as sleep and personal care.

An increase in the time spent on income-generating activities, like farm work, might increase calorie consumption. A reduction in sleep hours might also lead to an increase in calorie consumption. These two factors combined mean that participants in the treatment group need to consume more calories than those in the control group to maintain the same nutrition levels, meaning that in the short term an early uptake of mAgri messages to the detriment of health and food messages can lead to a reduction in the nutrition levels of the recipients and users of the information.

Three recommendations for the mNutrition programme can be drawn from the results of this RCT:

- Parallel messages and interventions that unlock part of the time dedicated to unpaid care work should be promoted. This would ease the pressing need for message prioritization and provide more flexibility for behavioural change, without resulting in a reduction of time dedicated to sleep and personal care. This would also help to ensure customer usage and retention over the mid- to long term, as users would have more time flexibility to change their behaviours according to the information received.
- mAgri advice should always be accompanied by other messages, like food preparation advice, that are more directly related in the short term to improved nutrition than those the current mAgri service is offering. This could be done by involving content specialists in designing the service. This would help balance the need for increased calorie consumption derived from the additional time dedicated to farm work.
- Alternative channels and interventions should promote spaces for knowledge sharing and information uptake, particularly with friends, community members and other members of savings or farmers' groups. This will increase the likelihood of promoting behavioural change.

5. CONCLUSIONS

The WE-Care programme in Malawi has successfully applied three different research methodologies to gather context-specific evidence about the existing distribution of unpaid care work at the household and community levels. It has also harnessed the use of new communications technologies for the implementation of the programme and has engaged with in-country stakeholders for the replication of care research methodologies and sharing of findings at the national level.

The following are some of the key findings generated by the WE-Care programme in Malawi.

Inequality of hours of care work

- **Unequal distribution of unpaid care work:** On average, women undertake considerably more unpaid care work than men. This is particularly acute among younger populations.

Factors influencing care hours

- **Age:** Women's unpaid care hours vary by age; younger adult women spend more hours than older women on unpaid care work.
- **Children:** Women's unpaid care hours increase with the number of children in the household aged under six.
- **Education:** Women with education spend more time on primary care work compared with women who have no education.
- **Group membership:** Farmer group membership decreases the number of women's primary care hours compared with women who are not members of a group.
- **Access to a public water source:** Access to a public water source reduces women's primary care hours compared with women who do not have access to a public water source.
- **Savings:** Women who have savings dedicate more time to unpaid care work than women who do not have savings.
- **Income-generating activities:** Women who take up income-generating advice (e.g. mAgri messages) dedicate more time to productive work and less time to care work as a primary activity, have higher overall workloads and on average have less leisure and less sleep time.
- **Time rigidity of certain activities:** The flexibility to reallocate time to certain types of work varies depending on the specific activity. Unpaid care work has less flexibility than other activities like sleeping. Within unpaid care work some activities, like cooking, are also more rigid than others, such as washing clothes.

Consequences of heavy and unequal care

- **Social harm:** Findings from the three research methodologies point to an association between inequality of unpaid care work and different social harms (violence against women, marital discord, adverse effects on health, limited mobility and even threat to life).
- **Women's empowerment:** The unequal distribution of care work between genders constrains women in Malawi from engaging in political participation and income-generating activities, limiting their decision-making power and control over assets at the household level. Moreover, it prevents women from fully enjoying basic needs/rights such as sleeping or personal care, and has a direct negative impact on their well-being.

Effectiveness of care research methodologies

- **Recognition of unpaid care work:** RCAs and group discussions proved to be an effective way to help men recognize the unequal distribution of care work between men and women, and the need to reduce and redistribute this work.
- **Factors influencing care hours:** The HCS proved to be a successful methodology to gather insights on the main factors influencing care work in Malawi.
- **Programme design:** RCAs proved to be a good methodology to gather insights on the unequal distribution of unpaid care work in a community prior to the design of a programme or an intervention.
- **Evidence for influencing:** The RCT proved to be a useful methodology to develop a strong evidence base linking access to mobile value added services and unpaid care work.

6. RECOMMENDATIONS

The WE-Care programme in Malawi has proved the importance of recognizing, reducing and redistributing the unequal burden of unpaid care work for women's enjoyment of their human rights and to move towards greater substantive equality between women and men. These findings highlight the need for government, the private sector and development practitioners to recognize and evaluate ways in which addressing unpaid care work can help them achieve their organizational and development goals. Understanding the distribution of unpaid care work is a necessary prerequisite for all programmes, products and services that have women as their primary target population.

Development projects can benefit from a greater integration of unpaid care work in their theories of change, leading to more comprehensive approaches to women's empowerment and an improved impact on gender equality. The Rapid Care Analysis has proved to be a useful and easy-to-use methodology to gather insights prior to the design of a development intervention. This methodology, developed by Oxfam, is publicly available at http://bit.ly/1UK2j8G. For those programmes where a deeper understanding of the factors affecting unpaid care work is needed, the Household Care Survey would be the most appropriate methodology. A generic questionnaire for both women and men is publicly available at http://bit.ly/1quWRtY. This generic questionnaire should be tailored to the specific needs of the programme and, where possible, should build on the findings from the RCA.

The findings from the WE-Care programme in Malawi highlight the importance of considering unpaid care work when designing and implementing nutrition- and market-based livelihoods programmes. Otherwise, interventions of this kind can lead to negative unintended outcomes that reinforce gender power imbalances and can even have a negative short-term impact on the nutrition levels of programme beneficiaries. CSOs also have a role to play in identifying the most problematic care work activities in the communities where they operate. They can help to increase recognition of the unequal distribution of unpaid care work at the community and household levels, promote stakeholder dialogues and even develop interventions that can help reduce problematic and inefficient activities.

Private companies have an important role to play in the promotion of products and services that help reduce the amount of time dedicated to inefficient care work activities (e.g. fuel-efficient cooking stoves). They can also promote new technologies that help reduce the intensity and lack of time flexibility of certain care activities (e.g. solar panels and light bulbs). Private sector actors should also consider unpaid care work as a core barrier to the uptake and retention of female customers, particularly in rural areas. Care assessment methodologies like the RCA can be easily integrated into product design processes, building on methodologies such as human-centred design, and play a central role in the development and support of sustainable business models.

Government bodies also have an important role to play in moving towards greater substantive equality between women and men. A range of measures can be implemented to achieve this, including the enforcement of international labour standards so that employers provide employees with enough time to care (e.g. parental leave or sick leave) and a minimum living wage to help them finance care-giving. It would also require the Government of Malawi to provide quality accessible public services and comprehensive social protection systems to help reduce the amount of time dedicated to unpaid care work at the household level (e.g. child-care facilities or accessibility to public water sources). All these measures require sustainable public financing that is gender- and care-responsive. Additionally, particular government-provided services (e.g. agricultural extension or healthcare) should take into account the impact of the unequal distribution of unpaid care work in the discouragement of behavioural change by women. A deeper understanding of the implications of unpaid care work on the adoption of health and agricultural practices would help increase the effectiveness of these government-provided services.

Finally, national stakeholder dialogues between government, the private sector, academia and CSOs are critical to maximize the transformational impact and sustainability of these interventions. These conversations will play a crucial role in raising awareness on the importance of addressing unpaid care work for the development agenda of Malawi, and the alignment of individual organizational priorities and approaches.

Women's Economic Empowerment and Care (WE-Care) initiative is a multi-country Oxfam programme running in over 6 countries including Uganda. In Uganda, the project runs in 3 sub counties in Lamwo district since August 2014.

We work with local partners such as the Women and Rural Development Network (WORUDET) which is a local NGO implementing WE-Care activities (like training and community meetings) in Lamwo district and works in collaboration with Uganda Women's Network , another local partner, to profile unpaid care work at national level.

Front cover: Women farmers participated in the WE-Care programme and Randomised Control Trial research in Malawi. Photo: Alvaro Valverde.

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WE-CARE
WOMEN'S
ECONOMIC
EMPOWERMENT
AND CARE