FACTORS AND NORMS INFLUENCING UNPAID CARE WORK

Household survey evidence from five rural communities in Colombia, Ethiopia, the Philippines, Uganda and Zimbabwe

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WE-CARE
WOMEN'S ECONOMIC EMPOWERMENT AND CARE

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1. INTRODUCTION

Care work is essential for personal well-being and for maintaining societies. But across the world, it is overwhelmingly the preserve of women, and it often restricts their opportunities for education, employment, politics and leisure. While interest in assessing care work in development policy has increased, there remains a lack of understanding of the full spectrum of women's work, paid and unpaid. Development practitioners are increasingly seeking ways to measure care and women's empowerment, and for evidence to advocate for government investment in care services. Oxfam has long worked on recognizing and addressing care work in programmes promoting gender justice, livelihoods and waged workers' rights. For several years, Oxfam GB has made increased efforts to address 'heavy' and 'unequal' care work and to raise the profile of care as a cross-cutting development issue. This involves supporting local organizations and women's groups to raise public recognition of care work, advocating for investments to reduce the unnecessary drudgery of care, and redistributing care responsibilities more equitably.

Building on these past efforts, the Women's Economic Empowerment and Care (WE-Care) initiative started in 2013. The WE-Care project, *Evidence for Influencing Change* was launched in 2014. Funded by the William and Flora Hewlett Foundation, this project aims to produce new methodologies and context-specific evidence about care work in order to influence existing development initiatives and policy. This research fills an important gap. While the many national time-use surveys highlight the contribution of women and girls to care work, they are less useful in designing context-specific interventions.

The project involves research and interventions in selected communities in districts of six countries: Colombia, Ethiopia, the Philippines, Malawi, Uganda and Zimbabwe.[1] In each context, WE-Care project activities take place within an existing 'host programme' with broader development objectives, such as women's leadership, agricultural enterprises and markets, or the rights of people living with HIV/AIDS. The project's aim is to generate evidence that helps local organizations to address problematic aspects of care work, with the intention of contributing to women's ability to participate, lead and benefit from development initiatives. The evidence is then used to develop project interventions that recognize, reduce and redistribute existing unpaid care work within the household, the immediate community (civil society), the market (private sector) and the state authority (central and local governments). More specifically, project activities have included baseline research, interventions to address care work – here called care 'strategies' – and follow-up research to monitor and evaluate change.

In the initial research phase (2014), qualitative focus group exercises called Rapid Care Analysis (RCA) and a quantitative Household Care Survey (HCS) were implemented in five of the project countries – all but Malawi, where a different programme was followed.[2] The RCA enables a rapid assessment of household and care workloads in local communities. It provides women, men and practitioners with a space to identify and prioritize practical solutions to address care work collaboratively. The RCA was implemented before the survey and it informed adjustments to the questionnaire.

As a baseline, the HCS helped to document the existing conditions, which in turn influenced the design of care interventions. It also helped to develop questions to measure more accurately the extent and division of care-work hours in households, and perceptions about care and care roles. The HCS data were collected between June and December 2014 by local research consultants and in collaboration with partner organizations.[3]

The baseline research helped to develop strategies to address care work in the communities. For about one year (2015), local organizations supported by Oxfam have implemented different interventions in the project areas in the five countries: (1) to reduce the difficulty of unpaid care tasks – such as fuel and water collection, cooking, washing and dependant care; (2) to promote positive social norms about care and care roles; and (3) to advocate for the redistribution of unequal care responsibilities from women to men, and from poor families to state-provided and employer-provided services, equipment and infrastructure.

In November/December 2015, a revised version of the HCS was implemented in the communities. As a follow-up survey, the HCS monitored change and impact, and gathered evidence on 'what works' to address care work in specific contexts. Learning from the first round of data collection led to improvements in the survey instruments; for example, in changes to the questions on social norms and children's time use.

This report summarizes the findings of the follow-up round of the HCS data collection in the districts in Colombia, Ethiopia, the Philippines, Uganda and Zimbabwe. The report proceeds as follows. Section 2 outlines the motivation for this work and the issues that the WE-Care surveys focus on. Section 3 outlines the approach and propositions that guide the research design and analysis. The fourth section describes the findings of the 2015 HCS in three areas: (1)

time use of adult women and men; (2) time use of girls and boys aged 0–17; and (3) factors conditioning time use, including household composition, access to equipment, public services and infrastructure, social norms and participation in programme activity. Section 5 analyses changes that occurred between the baseline and 2015 surveys in Ethiopia and Zimbabwe, the two countries in which panel analysis was possible. Finally, the conclusion discusses methodological challenges and implications for further research.

Vidalina Muñoz is 49 years old and manages a nursery of ornamental and fruit plants which she sells locally and in Bogotá every fortnight in the Farmers Markets. She has two daughters and a son. She also cares for her new-born grandson three times a week. Sometimes she has workers who help with the crops and she provides food for them too. She cooks for twelve adults and four children on a daily basis. Photo: Cineskrúpulos/Oxfam

2. CONTEXT AND BASELINE[4]

Unpaid care work and its importance in policy

The term 'unpaid care work' describes direct care of persons and domestic work for family members and other households (Budlender 2007). It includes activities such as caring for children and the elderly, as well as cooking, cleaning, washing and fetching water or firewood (Figure 1). Domestic work is included in the definition because it serves the well-being of people; indeed, it is often argued that the distinction between direct and 'indirect' care work is problematic, both because direct care requires the 'indirect' care activities needed to run a household, and because direct care is often a secondary activity – e.g. when women watch their children while working in fields or selling in a market (Samman *et al.* 2016:16). In contrast to 'housework' or 'domestic labour', the term 'unpaid care work' emphasizes that the work is unpaid and does not take place exclusively within households (Esquivel 2014), i.e. it may also take place within the wider community.

Figure 1 Defining unpaid care work

UNPAID CARE WORK	
Direct care of persons	Domestic work
Childcare Elder care Care of ill or disabled people Care of community members	Cooking Cleaning Washing, mending, ironing clothes Fetching water Collecting firewood

Care is essential for human survival and personal well-being. It can build the intellectual, physical and emotional capabilities of care recipients, to the benefit of themselves and others, and also confers benefits on carers (Folbre 1995, England 2005). However, the benefits of care to society are often not recognized and the provision of care – mostly by women – may be taken for granted.

Excessive caring duties have been identified as a barrier to various human rights of girls and women, including the rights to freedom of speech, association and leisure, and the rights to work and social security (Sepulveda Carmona 2014). Heavy care workloads can decrease health and well-being, while certain activities – for example, fetching fuel or water – can expose girls and women to the risk of assault. By reducing the time available for study or training, care work can constrain education and professional development. A heavy workload of caring duties can also limit women's paid work opportunities, resulting in long total work hours. Furthermore, 'heavy' and 'unequal' care work can negatively affect women's participation in politics, local leadership and development programmes (Woodroffe and Donald 2014).

Care work is often not considered in development policy, with potentially severe consequences for outcomes (Chopra 2013, Bibler and Zuckerman 2013). The 1995 Beijing Platform for Action appealed for making women's contribution in the domestic sectors more visible through time-use studies (UN Women 1995), and in recent years, care work has increasingly attracted attention in national and international policy agendas. In 2013, the 19th International Conference on Labour Statisticians adopted a resolution recognizing unpaid care work as one of five types of work (ILO 2013, cited in Samman et al. 2016: 46). Moreover, the 2030 Sustainable Development Agenda includes a target on care work under Goal 5, 'Achieve gender equality and empower all women and girls':

> *'5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.'*

In September 2015, the UK Department for International Development (DFID) launched a Call to Action, 'Transforming Economies: Empower Women and Girls'. One of three pillars of action for empowerment, based on Goal 5.4, calls on states, employers and donors to recognize and invest in care, and increase the evidence base on care work, including time-use studies.[5]

The renewed focus on care increases the need for evidence on the factors associated with changes in women's hours of care work, in order to design more effective strategies to transform care.

Addressing unpaid care work

The aim of Oxfam interventions focused on care is to reduce 'heavy' and redistribute 'unequal' care work (Sepulveda Carmona 2013).

Oxfam builds on Dianne Elson's (2008) 'three Rs' framework that seeks to define specific objectives of care interventions. These objectives are:

1. Recognize care at policy, community and household level.

2. Reduce difficult care work, for example through time- and labour-saving technology and services.

3. Redistribute the responsibility, costs and work of care provision from women to men, employers, the state and civil society.

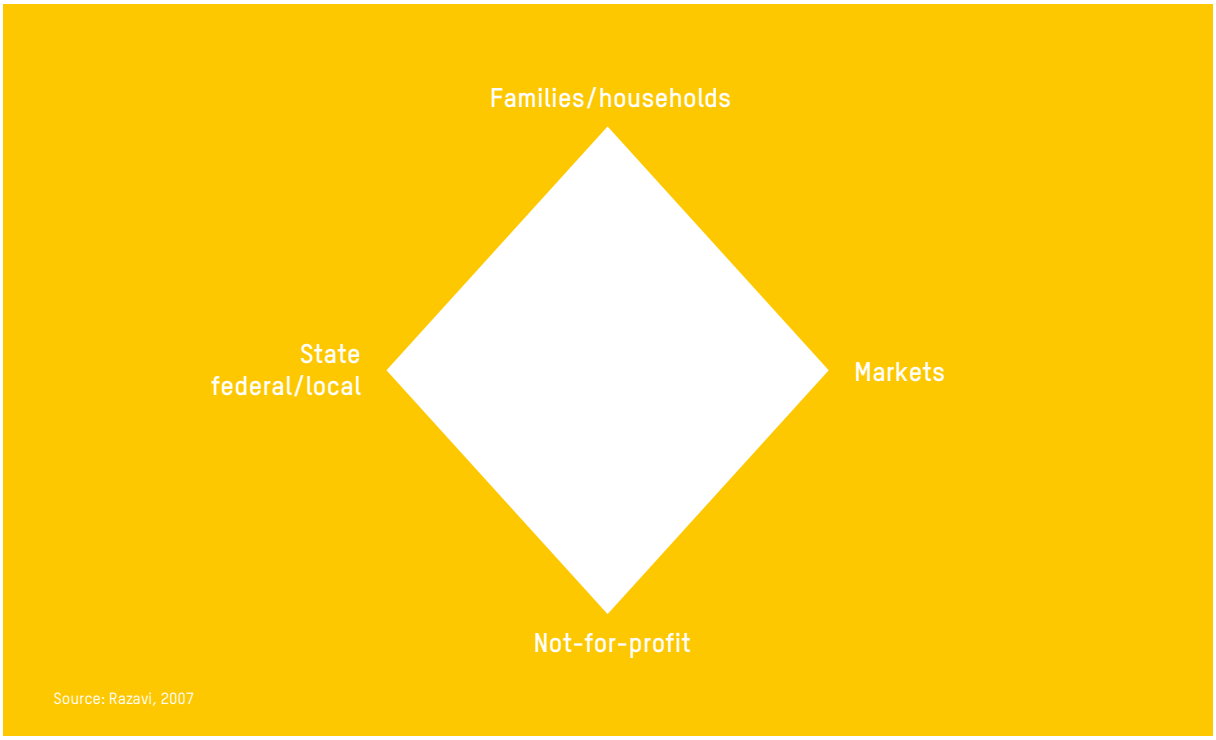
Oxfam together with ActionAid and the Institute for Development Studies have added a fourth 'R' (IDS 2015):

4. Improve **Representation** of carers in decision making, so they can be involved in policies that shape their lives, and policies reflect the needs and interests of carers.

The 'four Rs' approach aims to promote recognition of the importance of care work while reducing the drudgery that is often associated with it.

Heavy and unequal care work should be reduced, redistributed and recognized at multiple levels. Razavi's (2007) 'care diamond' (Figure 2) is useful to highlight that unpaid care work is provided, paid for and/or facilitated by four groups of actors: families and households, the state, the market and employers, and civil society groups. It follows that the redistribution can take place either within the household and/or between households and outside actors.

Figure 2 The care diamond that identifies the key actors involved in unpaid care



Source: Razavi, 2007

Factors shaping the amount and intensity of unpaid care

Despite the increased attention that has recently been given to unpaid care work, the evidence base on factors that influence levels and changes in household care responsibilities remains limited. Family size and structure clearly matter – for example, research from six developing countries showed that care workloads decreased as the age of the youngest child increased (Budlender 2008). Other direct influences are access to equipment and services, while indirect influences include women's bargaining power and gendered social norms.

Having the use of time- and labour-saving equipment can reduce care workloads. For example, grinding a basin of cassava with a machine takes one minute, compared to two hours by hand (Barwell 1996). Fuel-efficient stoves, rainwater-harvesting systems, washing facilities and cleaning equipment all save time and effort. Access to public infrastructure and services, including childcare facilities, can also be important – as in Eastern Uganda, where having a water source within 400m of the home saved women and girls more than 900 hours a year (Ibid. 1996).

Two key indirect determinants of unpaid care loads are women's bargaining power and gendered social norms. Cooperative collective bargaining models hold that household members reach decisions based on their relative bargaining power (Doss 2011). The models suggest that household members with more bargaining power are more likely to spend their time on activities that benefit them. Bargaining power is determined by the strength of individuals' 'fall-back position' or 'threat point', or the outside options that determine how well off they would be if household cooperation were to fail. It can be influenced by economic factors such as employment, income or access to the labour market. It is also associated with non-economic factors such as education, laws and policies, age, and participation in development programmes or support networks (Quisumbing and Maluccio 2000, Doss 2011, Lundberg and Pollak 1996).

Gendered social norms also influence care responsibilities, typically prescribing that women and girls spend relatively more time on care work. Women and girls are often perceived as being 'naturally' more suited to care work and more 'altruistic' and 'loving' than men and boys (Chopra and Sweetman 2014). Social norms and bargaining processes are closely related (Agarwal 1997), in that social norms might make people accept a status quo that is not necessarily beneficial to them (Nussbaum 2000). For example, women or girls might undervalue their own well-being or their contribution to the household, which can negatively affect their negotiating power (Sen 1987). Research demonstrates that some women consider the division of labour 'fair' even if they work more than men (Demo and Acock 1993). Furthermore, social norms can affect women's and girls' bargaining power by weakening their 'outside options' (Gupta and Stratton 2008, Agarwal 1997) or prescribing more 'quiet' and 'covert' behaviour to females (Agarwal 1997). Certain normative roles might be so strongly embedded in people's lives that they become 'normal' and no longer subject to bargaining (Kabeer 2002). It follows that women's bargaining power in household decisions is also shaped by what subjects are considered suitable for bargaining. For example, in some contexts women may not consider it possible to bargain about whether or not to marry or to plan and space children, however much agency they have in their livelihoods and in public participation.

In quantitative assessments, care is often underreported as an activity partly because participants may not perceive it as work – as this research on social norms would suggest – and partly because people often undertake care alongside other activities. To elicit a more granular picture of time spent caring, the HCS sought to distinguish care as:

1) a primary activity – i.e. the only activity in which a person was engaged during an hour;
2) a secondary activity – i.e. undertaken alongside another activity;
3) the supervision of, or responsibility to 'look after', a child and/or a dependent adult.

It also aimed to elicit the extent of multitasking – i.e. carrying out two or more care activities at the same time.

The 2014 baseline Household Care Survey

The 2014 HCS surveyed between 80 and 500 households in selected communities in each of the countries – Colombia, Ethiopia, the Philippines, Uganda and Zimbabwe. These added up to 1,139 households, with one adult male and one adult female respondent in each household.[6] In each country, the research sought to establish the amount of care work that women and men undertook, and what factors shaped the amount and intensity of their respective care loads.[7]

In the project areas of all five countries, the data showed that women and girls spent significantly more time on care work than men and boys. However, the measurement of children's time use was rather limited, as the survey only asked parents to estimate the frequency with which their children were involved in care activities. Women who also undertook paid work spent somewhat less time on care as a primary activity but spent an equal amount of time on secondary care, resulting in longer total work time than women who had less paid or productive work. In most countries, women with children under six years old spent more time on secondary care work and on supervision, but not on primary care work. Older women tended to have fewer care responsibilities.

The analysis did not find a consistent association between several factors and the amount of care work that women undertook. The factors that were analysed included education, relative household wealth, income and savings, and whether or not the women had access to time-saving equipment such as water taps and fuel-efficient stoves. Having access to a government-provided/public water source decreased care work in three countries, but access to electricity, healthcare and childcare only mattered in some contexts. Moreover, social norms relating to care work did not appear to have any effect on hours spent caring. Researchers questioned whether this might have been the result of how the questions were sequenced in the survey and the way norms were measured, as findings from qualitative research undertaken at the same time strongly emphasized the importance of social norms in shaping care responsibilities.

The baseline findings influenced the design of the follow-up HCS research in terms of focus and questions asked. The next section outlines the main research questions and adjustments that were made to the survey tools.

Betty Angeyo, 42, is married to Alex Otemo, 44, and they joined a training run by WORUDET about the benefits of sharing responsibilities in unpaid care work and productive work. Shared responsibilities and their new fuel-efficient Lorena stove has contributed to Betty now having time to play a key role as a partner in their business, including running and managing the grinding mill which serves the community in which they live. Photo: Julius Ceaser Kasujja/Oxfam

3. CONCEPTUAL FRAMEWORK

This report focuses on analysis of the 2015 HCS, and on identifying any changes that took place between the baseline and follow-up survey, particularly those that might be linked to Oxfam interventions. For the purposes of this study, we sought to translate the '4 Rs' outlined above – the framework shaping potential interventions directed at reducing care workloads– to the household level. This had two aims. First, it sought to determine what factors are likely to be associated with levels of care work, and the reduction and redistribution of problematic care work within households. Second, it sought to explore social norms related to care and care roles, the recognition of care by household members, and the representation of women in household decision making. These latter two factors are important outcomes in themselves, but are also potential means to the ends of reducing and redistributing care work.

Propositions

Building on the previous HCS and associated research, this analysis examines six propositions or hypotheses about possible levers for change. These propositions are based on common 'strategies for change' employed by various development actors seeking to transform how care is provided, and the conceptual frameworks discussed above. If these propositions are supported by the data, then they could inform programme activity seeking to diminish the problematic aspects of unpaid care work in women's lives. A reduction in unpaid care work could be in terms of time (e.g. hours worked) and/or the physical intensity or 'difficulty' of care work; indeed, it is likely that these two aspects are connected. However, owing to difficulties in measuring the intensity of care work, our analysis is confined mostly to the amount of time spent on care. A redistribution of care work refers to the division of labour between family members; in this case, our focus is on the relative amount of time spent on care by women and men in the same household.

PROPOSITION 1: Recognition of the need for and importance of unpaid care tasks, and their potentially problematic nature, is necessary for steps to be taken to redistribute and reduce it.

If men and women are aware of how much time that they and others in their household spend on care-related activities, and if they perceive some care tasks as problematic, then they are more likely to take steps to redistribute or reduce care work. Moreover, if men and women perceive this work as valuable (both in absolute terms and relative to activities usually undertaken by men), they will be more likely to take steps to reduce what is problematic about it (e.g. by investing in labour-saving activity) or to redistribute it. Therefore, we would anticipate that in households where unpaid care work is perceived as relatively valuable and skilled compared to other paid and unpaid activities, women will undertake (relatively) less care work.

PROPOSITION 2: A reduction in and redistribution of problematic care work has positive impacts on the well-being of women and their families.

Undertaking excessive and/or problematic care work is likely to have negative outcomes on well-being through various channels – for example, a higher likelihood of accidents, of leaving dependants unsupervised, reduced time for sleep, and an increased incidence of stress and illness. Women undertaking excessive and/or problematic care work may also be more susceptible to abuse, conflict or physical violence. A reduction and/or redistribution of such work, in turn, is likely to have positive impacts on the well-being of women and their families. Therefore, we posit that in households where care activities occupy relatively more time and are relatively more onerous, women will experience lower levels of well-being.

PROPOSITION 3: The representation of women in taking decisions within their households is associated with greater redistribution of their caring activities.

Higher levels of bargaining power within households, as reflected in influence over a range of household decisions (or ability to have an influence) may render women better able to redistribute and/or reduce care work such that the workload of care is less problematic. Consequently, we expect that in households where women undertake – or can influence – more decisions, they would undertake relatively less care work.

PROPOSITION 4: Changes in social norms are essential in redefining care responsibilities, thereby enabling a redistribution of care activity.

Norms can dictate that women and girls spend more time on care (relative to men and boys) and can affect the bargaining power of girls and women, preventing them from bargaining to redistribute care work responsibilities. It follows that a change in norms could provide an opportunity for redistributing care work. Norms may include perceptions and expectations of women and girls (e.g. their suitability for care work), as well as perceptions of the visibility, value of and burden posed by unpaid care. Here, our expectation is that when respondents adhere more strongly to social norms, and such norms prescribe an unequal distribution of caring activity (or make punishment acceptable for a perceived failure to carry out such activity well), women will undertake relatively more care.

PROPOSITION 5: Publically available and government-provided infrastructure and services can directly reduce problematic unpaid care workloads.

Where governments and/or other actors (e.g. civil society, the private sector) provide services, this can free up time that women spend on difficult, inefficient or excessive unpaid care tasks – such as gathering water or firewood. Therefore, in households with greater access to services, women may have a lower care workload.

PROPOSITION 6: Ownership of time- and labour-saving equipment, products and services, and/or the ability to draw on the support of others, can directly reduce women's unpaid care work hours.

Household ownership of assets and their adoption of equipment, products or services that save time and/or labour (e.g. a mill instead of a hand grinder) may directly result in a relatively lower care workload, in terms of time and/or physical effort – or in women spending more time on care activities that they value more.

New questions and rationale

Although for the sake of continuity efforts were taken where feasible to keep questions consistent from the 2014 to the 2015 survey, new questions were added for two reasons. First, given that some questions asked in the first round were not collecting valid information, efforts were made to improve them. For example, new questions were used to collect information about household assets, the value of unpaid care work, and children's time use.[8] Second, an effort was made to understand better social norms, household decision making and gender-based violence – factors which other evidence suggests may be associated with problematic levels of unpaid care.

(i) Social norms

In line with work by Mackie and colleagues (Mackie et al. 2015), the survey sought to measure the strength of existing norms via: (1) *behaviour* – what women and men do (i.e. the amount and intensity of their care work); (2) *attitudes* – what women and men believe they should do; (3) *empirical expectations* – what women and men believe others do; and (4) *normative expectations* – what women and men believe others think they should do. In the subsequent analysis, we sought to probe the extent to which behaviours, attitudes, and empirical and normative expectations were aligned. Where strongly correlated, this would suggest that social norms are stronger; where they are more weakly correlated, this could hint at lower adherence to norms (or a process of norm change). We included in the survey two new types of questions.

The first new questions involved the use of vignettes in which three situations are described, each involving a different distribution of paid and unpaid care work between a woman and her spouse. These range from a relatively equal distribution to a very unequal distribution. The respondent is asked their opinion of each vignette, how they think other members of their community would respond to each one, and how they would compare the situation within their own household (Box 1).

Box 1 Example of a vignette included in the 2015 Household Care Survey[9]

Susan			
My husband Brian works as a carpenter, he leaves the house early and comes back in the evening. After preparing breakfast for my family, I work in the field in the mornings. I prepare lunch for my children. I fetch water and firewood, make sure the house and compound are clean. When my husband comes back from work he is very tired. I bring him water to wash his hands and serve him food. I do the dishes and prepare the beds for all of us.			
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A	What do you think about the way Susan and Brian divide tasks?	0=Strongly approve 1=Approve 2=Disapprove 3=Strongly disapprove	
B	What do you think most other members in your community would think about the way Susan and Brian divide tasks?	0=Strongly approve 1=Approve 2=Disapprove 3=Strongly disapprove	
C	How do you and your partner compare to Susan and Brian?	0=Very diffferent 1=Different 2=Similar 3=Very Similar	

The second new questions are modelled loosely upon those used to construct the relative autonomy index (RAI), a measure of women's agency recently used in the Women's Empowerment in Agriculture Index (see Alkire et al. 2013, Vaz et al. 2013). In the HCS, the questions seek to assess the extent to which women's motivation for undertaking the care of people and domestic work is autonomous and self-determined versus circumscribed by their perceptions of what others do, or by what the respondent perceives as the expectation of others.

(ii) Household decision making

The 2015 survey included a new set of questions for women which asked them who takes various decisions, or has the ability to influence these decisions, within their household. The aim was to capture both actual decision-making ability and so-called delegated decision making, in cases where respondents *could* take a decision if they wanted to but chose not to. For example, a woman might choose to let someone else in the household take decisions over minor purchases – this does not necessarily indicate an inability to choose herself. The list of potential decisions included activities relating to domestic work and children as well as the woman's own healthcare, how to spend her time, large and small purchases, visits to friends and whether to take out a loan. Where questions referred to a woman's own activity (e.g. healthcare, time use, visits), we were only interested in whether or not she took decisions. In other areas related to family life, we valued direct and delegated decision making equally. These questions are adapted from Demographic and Health Survey (DHS) questions on household decision making (see Kishor and Subaiya 2008), with the addition of a question on the potential to influence decision making (see Ibrahim and Alkire 2007, Oxford Poverty and Human Development Initiative 2007).

(iii) Attitudes to domestic violence

A series of new questions aimed to measure attitudes toward gender-based violence and whether the respondent thinks others in the community might have experienced beating or criticism for actions relating to domestic tasks and/or caring for others.

The focus is on attitudes and on the likelihood of violence in the community rather than on the respondents' actual experience of violence, because eliciting valid responses to the latter requires specialized enumerator training and conduct of the survey. However, attitudes are indicative of norms around violence, and have been shown to predict acts of domestic violence (Kishor and Johnson 2004, Uthman *et al.* 2010). To probe whether problematic unpaid care was associated with violence or the threat thereof, we included questions on the extent to which respondents – female and male alike – felt wife beating and/or emotional abuse to be an acceptable response to a failure to undertake various domestic and/or care activities adequately. These questions are modelled upon those asked in the

DHS (see Kishor and Johnson 2004). Respondents were also asked about the perceived acceptability of mocking a man for participating in various forms of domestic work and/or caring, and whether they thought violent acts against women (beating or shaming) and men (shaming) had taken place in their community within the previous month.

As noted, the survey was designed as a panel, with efforts taken to ensure that a set of identical (or, in some cases, comparable) questions were asked in both the 2014 and 2015 rounds. This enabled, in Ethiopia and Zimbabwe, further joint analysis of data sets from the two rounds, with the aim of documenting any changes in the amount and share of unpaid care work being undertaken by women and men, and the extent to which such shifts represented a reduction or redistribution of care work; and to identify factors that related to any shifts. Catalysts could include explicit interventions conducted in the field sites that aimed to reduce and redistribute care loads; and/or triggers that were outside the realm of the study. Our analysis focused specifically on WE-Care programme activity around providing equipment, access to services and training relating to various care activities and gendered norms around care. Annex 1 provides the 2015 HCS and Annex 2 provides details of how the survey was conducted in each country.[10]

Florence, 31, is carrying a jerry can full of water. She is married to Zakayo David Opwonya who is two years older than her.For the most of their marriage, Florence was the typical Acholi wife, waking up earlier than the rest each morning to fetch water and firewood, bathe the children, prepare and serve them and the husband breakfast, before heading to the field to dig.
Photo: Julius Ceaser Kasujja/Oxfam

4. FINDINGS FROM THE 2015 HOUSEHOLD CARE SURVEY

This section discusses the results of our analysis of the 2015 HCS. Following a profile of survey respondents, we describe the time use of adult women and men, and of their children. We review the findings on social norms related to care work and gendered care roles. We then consider the extent to which the survey findings align with the propositions outlined in Section 3 above, concerning factors which could potentially trigger a reduction and redistribution of care loads at the household level. In particular, we examine to what extent six factors are associated with levels of care and its gendered distribution: recognition of care work; women's decision making and autonomy; access to public services; the use of labour-saving equipment; social norms; and participation in Oxfam We-Care programme activities.

In terms of time use, key findings that we highlight are as follows:

- the large and disproportionate amount of time that women spend on care – as a primary and secondary activity, and in supervising children and dependent adults;
- the disproportionate amount of time that girls spend on care relative to boys;
- the (limited) changes found between the 2014 and 2015 surveys.

We then provide a detailed assessment of potential factors that may be linked with a lower care load for women. Key factors that the quantitative analysis supports are access to electricity, more progressive social norms and, in some contexts, participation in the WE-Care programme activities, particularly those relating to norms. For example, in households where at least one member participated in a norms-related project, respondents were more likely to disapprove of a gendered description of labour, and men expressed greater autonomy in carrying out care work; the strength of the relationship was even greater in households in which both the man and woman participated. In addition, in households in which adults valued care work relative to paid work, boys carried out less care work, and their care responsibilities were equal to or higher than those of girls. The results also suggest that labour-saving equipment has some potential to alleviate youth care workloads and to redistribute care work between boys and girls.

Our analysis relies heavily on the assessment of whether differences between men and women (and boys and girls) are significant statistically, and on regression analysis in which we analyse the likelihood that various factors, such as woman's decision making or more progressive norms, affect women's care hours or the distribution of care hours between women and men, compared to the counterfactual that they do not. The use of regression analysis allows us to look at the relationship between two variables while controlling for other factors that are likely to affect that relationship – for example, household size and wealth, and the presence of young children and/or dependent adults. We describe the results of the bivariate and multivariate analysis in the text in a non-technical manner, but additional technical details are provided in the footnotes, and the tables that are referenced contain complete results. Annex 3 contains details of the indicators used in the analysis and their construction, and additional technical details on the methodology.

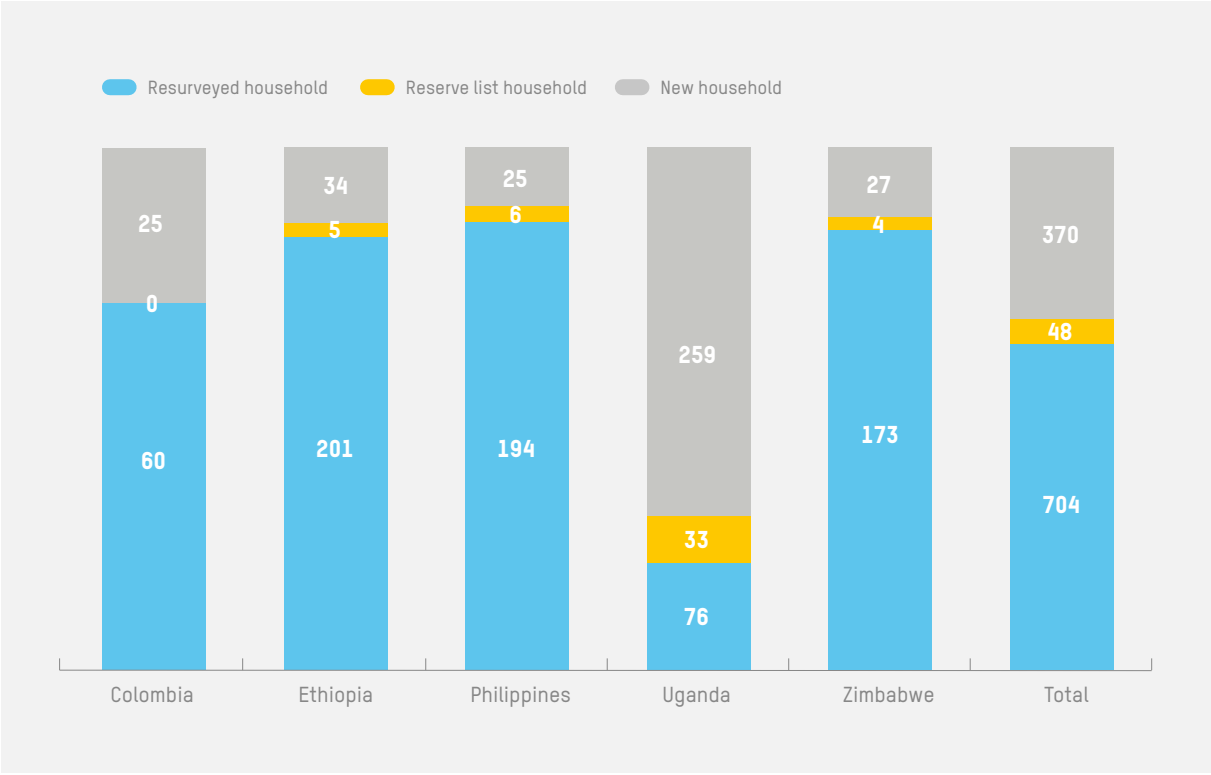
PROFILE OF SURVEYED HOUSEHOLDS

The 2015 HCS has multiple aims. First, it seeks to provide a baseline on new areas that were not included in the 2014 survey, namely the time use of children, attitudes and norms, and access to equipment and services. All of these are important to inform future policy design. Second, it sought to explore the relationships between hours of care work and factors presumed to influence the amount and distribution of these hours, including participating in WE-Care programme activities. The HCS was designed as panel survey in an effort to understand better whether and to what extent WE-Care programme activities were associated with changes in care responsibilities, and what underpinned them. For this reason, the teams which conducted the 2015 round of surveys in each country made efforts to locate the same households and to interview the same individuals as they had done in 2014 – with varying degrees of success. In the end, the panel analysis was conducted only for the samples from Ethiopia and Zimbabwe.

Overall, of the 1,123 households that were interviewed for the baseline HCS in 2014, 63% were resurveyed in 2015, and the range varied from 21% in the Uganda sample to 86% in the Philippines sample (Figure 3). Migration (including seasonal migration)[11] posed the biggest challenge to tracking baseline households, notably in the Uganda context. As noted above (and described more fully in Annex 2), the surveys were conducted in selected communities within each country and are not nationally representative. For the sake of convenience, we refer to findings between countries, but this important distinction should be borne in mind.

Almost equal numbers of women and men were surveyed: 1,123 women (52%) and 1,036 men (48%). Women and men were present in the majority of households (92%, on average) – including all households surveyed in Ethiopia, Uganda and Zimbabwe. The share was lower in Colombia (64%), given an explicit decision to include female-headed households, and in the Philippines (75%), where many men were absent primarily owing to migration or illness. Across the five countries, the average household consisted of six people (Table 1).[12] Nearly three-quarters of households (72%) had at least one child under the age of six, and the average was closer to two children under six. The profile was somewhat distinct in Colombia, where a minority of households – just 21% – reported having a child under the age of six, and the average household consisted of just under four members.

Figure 3 Number of households in the 2015 Household Care Survey and their relationship to the 2014 survey



Note: Resurveyed households were included in both the 2014 and 2015 HCS. Reserve-list households were sampled in 2014 but only surveyed in 2015. New households were added to the 2015 HCS owing to attrition.

TIME USE OF ADULT WOMEN AND MEN

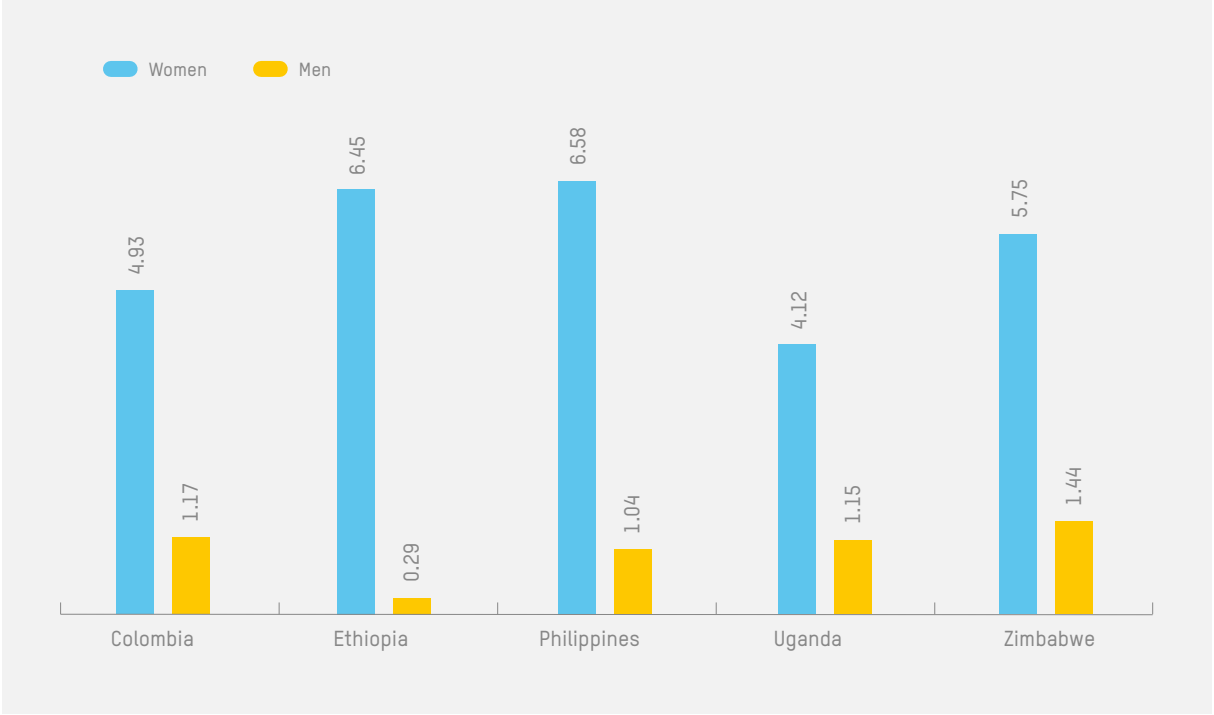
As noted above, this survey took an innovative approach to capturing time use, in seeking to measure care as a primary and secondary activity, time spent supervising children and/or dependent adults, and multitasking. Following standard methods, respondents were asked to recall how they spent the day prior to the survey, specifying what activity or activities they had carried out in each hour of the day. Enumerators specifically inquired whether each hour was spent in primary care, secondary care, supervision of a dependent, and/or in conducting more than one task.

Consistent with baseline findings, our results show that across the five countries, women are spending considerable amounts of time on care work. Moreover, they spend more hours on care as a primary activity, care as a primary or secondary activity, and any care responsibility, compared to men (Table 2). Results also show that women spend relatively more time than men on total work, while spending less time on leisure and personal care. We assess each type of work in turn, then consider the implications for overall time use.

Care work

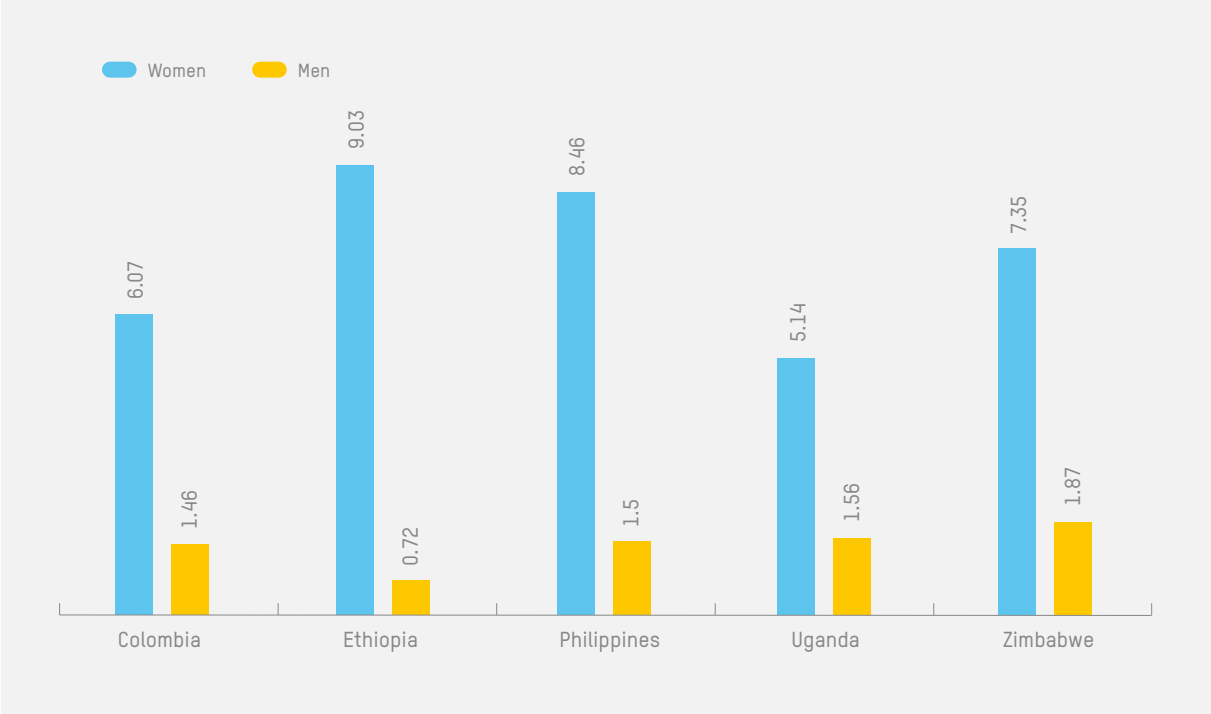
Across the five countries, women spent significantly more time than men on care as a primary activity. On average, women had spent 5.4 hours primarily on care in the day before the survey, compared to just under one hour (0.99 hours) for men.[13] For women, the range was between 4.1 hours in Uganda and 6.6 hours in the Philippines, while for men, it was between 1.4 hours in Zimbabwe and 0.3 hours (20 minutes) in Ethiopia (Figure 4). Male-female differences were acute in all countries, but they were highest in Ethiopia and lowest in Uganda.[14] These data capture the average amount of time spent per person on care work, without screening for whether or not each person participates in care work. In fact, more than half (59.6%) of all men in our sample reported spending zero hours on care as a primary activity. This proportion ranged from 52% in Zimbabwe to 88% in Ethiopia.

Figure 4 Number of hours spent on care as a primary activity by women and men in the samples from the five countries, 2015



Women also spent more time than men on care as a secondary activity. Indeed, the number of hours that women spent on care as a primary or secondary activity was significantly higher than for men across all countries. Overall, women spent an average of 7.0 hours on care as a primary or secondary activity, while the average for men was 1.4 hours.[15] The range for women was from 5.1 hours in Uganda to 9.0 hours in Ethiopia, while for men it was between 0.7 hours in Ethiopia and 1.9 hours in Zimbabwe (Figure 5).

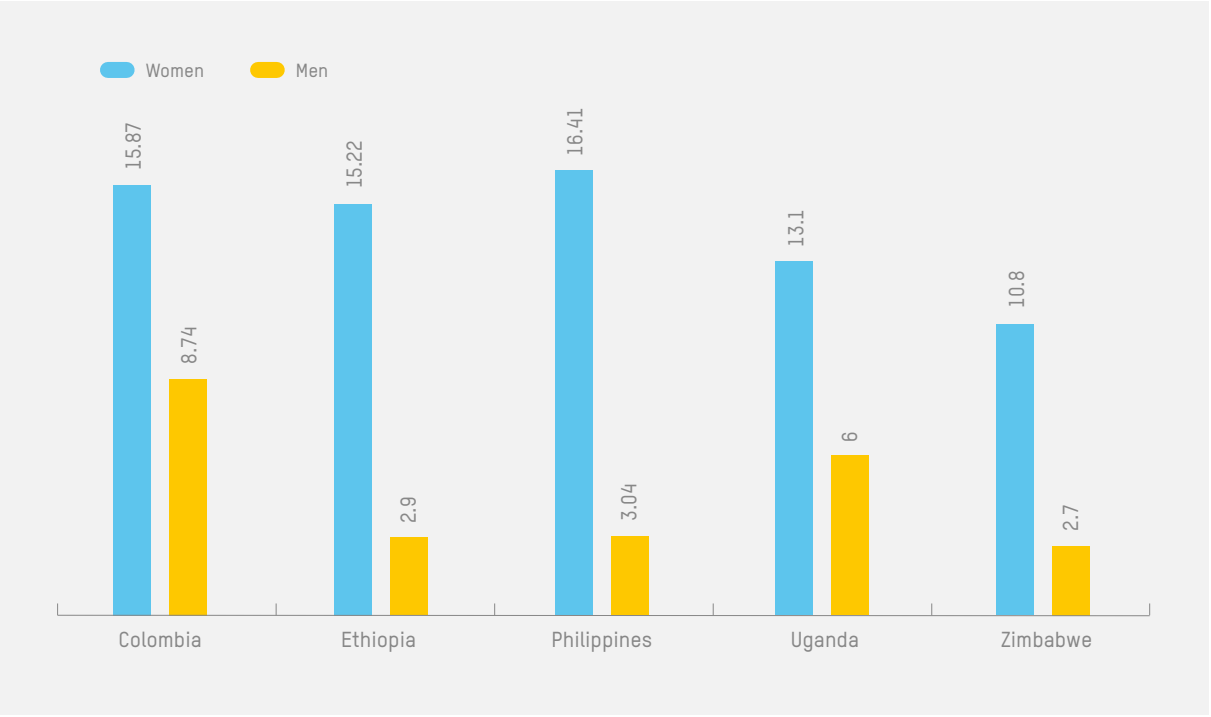
Figure 5 Amount of time spent on care as a primary and a secondary activity by women and men in the samples from the five countries, 2015



A significantly higher number of women spent time supervising a child or a dependent adult, relative to men. An average of 78.5% of women had been responsible for looking after a child in the previous 24 hours, compared to 48.1% of men;[16] while about 11.4% of women had been responsible for looking after a dependent adult, compared to 8.6% of men.[17]

We include time spent supervising children or a dependent adult to arrive at the total number of hours in which respondents had any care responsibility in the previous day. This total was much higher for women than for men. Across the five countries, women had spent an average of 13.8 hours in the previous day on at least one care responsibility, compared to 4.3 hours for men (Figure 6).[18] The range for women was from 10.8 hours in Zimbabwe to 16.4 hours in the Philippines. For men, in contrast, the range was between 2.7 hours (Zimbabwe) and 8.7 hours (Colombia). The highest male-female difference in total care hours was in the Philippines, while the lowest was in Uganda.[19] Moreover, over one-third (34.5%) of surveyed men reported spending zero hours on any care responsibility; this proportion ranged from 18.5% in Colombia to 41.4% in the Philippines.

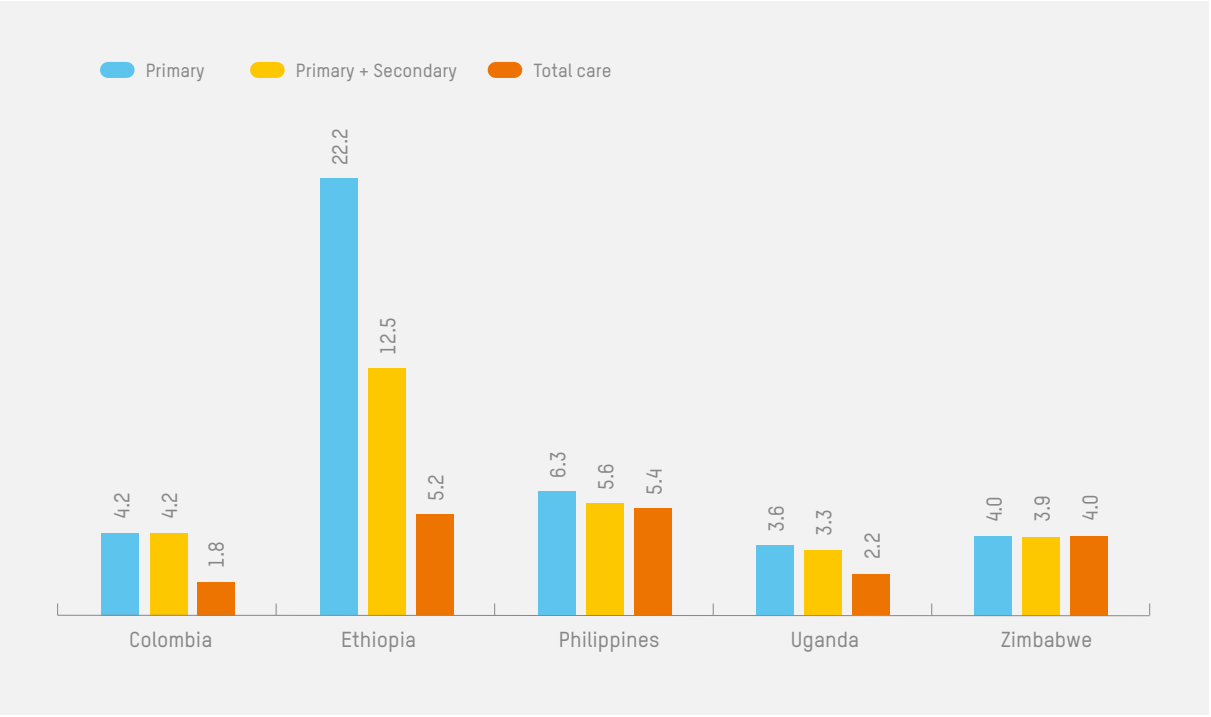
Figure 6 Total hours of care responsibility by women and men in samples from the five countries, 2015



Finally, the number of hours spent on multitasking (i.e. undertaking at least two care activities at the same time) was also higher for women than for men across all countries. On average, women had spent 6.1 hours on at least two care activities, compared to 1.2 hours for men.[20] For women, the range was between 4.5 hours in Uganda and 8.9 hours in the Philippines, while for men it was between 0.7 hours (Ethiopia) and 1.9 hours (Colombia). The overall male-female difference was lowest in Uganda and highest in Ethiopia, but gaps were marked in all countries.[21]

It is clear that women are undertaking far more unpaid care work than men. At least three additional facts stand out from these data. First, from a measurement perspective, our approach of carefully probing different types of care responsibilities – including the supervision of dependants, even if it does not require active work – significantly expands our understanding of the reality of 'care' in women's lives. When 'supervision' is taken into account, the average number of hours that women reported having *some* care responsibility rises by 250%, from an average of 5.4 hours a day of care work as a primary activity to 13.8 hours per day that women have any care responsibility. Second, the amount of time that women are spending relative to men in these predominantly rural, developing country contexts is much greater than the global figures suggest. A recent analysis by Samman et al. (2016) drawing on up-to-date analysis of time-use surveys from 67 countries found that, on average, women undertook 3.3 times as much care work as men did. In our analysis, in contrast, the ratios for the amount of time women spent on primary care relative to time spent by men ranged from 3.6 to 22.2 (Figure 7). Third, when we add the amount of time spent on secondary care and supervision of dependants, not only does the number of hours spent on care by women and men increase markedly, but the ratio between them decreases somewhat. In other words, inequality in time spent on care is slightly less acute when taking into account all care activities.

Figure 7 Ratio of time spent by women on care activities relative to time spent by men



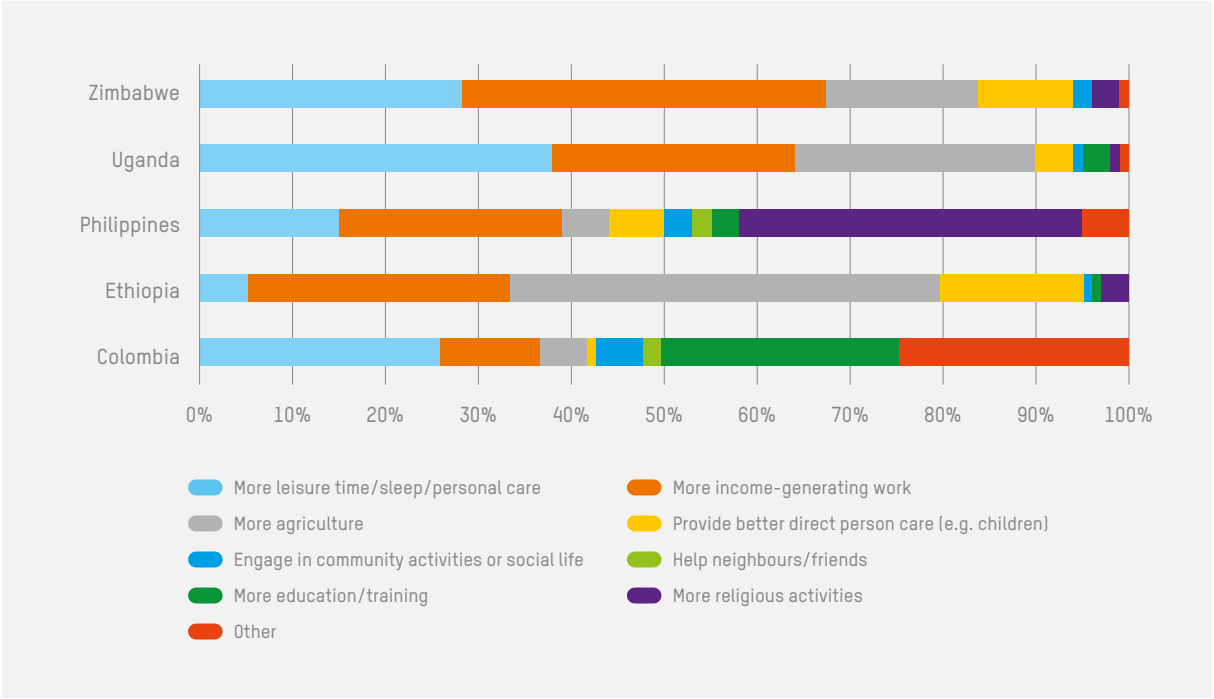
The analysis did not point to any consistent association between various socio-economic factors and the amount of care work that women undertook. Factors that were analysed included education, relative household assets, income and savings, and whether or not the household had access to time-saving equipment such as water taps and fuel-efficient stoves. As discussed in Rost et al. (2015), these findings are not consistent with commonly held perceptions by development actors that income, education or household wealth will lead to reductions in the time that women spend on care work.

Furthermore, our results suggest that younger women spend more hours on care as a primary activity and on any care responsibility, compared to their older counterparts.[22] As might be expected, women in households with children below age six and/or a dependent adult spent more hours in any care responsibility.[23] Larger households had a less gender-equal distribution of primary care work, all else equal; and the gender distribution was more equal in households with younger women and with children below age six.

Although a significant minority of women report negative consequences related to unpaid care work, such as exhaustion, headaches or not having enough time for personal care and rest, there were no consistent patterns in the relationship between the number of hours of care work and women's reported well-being. This points to a need for further exploration of how they interact.

The results do point to time scarcity as a problem. For example, when asked if during the previous week they had been supposed to cook but had not had the time, the share of women reporting that this had happened at least once ranged from 11% (Zimbabwe) to 38% (Colombia). And 16% of women in Colombia and 19% in the Philippines reported that this situation had occurred 'several times a day'. When asked if they were to spend less time on care what they would do with the extra time, most women would take on more income-generating activity/agriculture, followed by additional leisure, sleep and personal care (Figure 8).

Figure 8 What women in the samples would do if they spent less time on care work (%)



Paid work and leisure

Men spent more hours on paid and productive work[24] as a primary activity than women did – on average 6.4 hours daily, compared with 3.7 hours for women.[25] The range, for men, was from an average of 5.9 hours in the Philippines to 7.9 hours in Colombia, while for women it was from 1.6 hours in the Philippines to 5.7 hours in Colombia. The biggest difference between women's and men's paid work hours was in the Philippines, while the lowest was in Uganda.[26]

However, when factoring in paid, unpaid and care work, women spent nearly 2 hours more working each day than men did (Table 2). Across all countries, women spent an average of 9.1 hours working, compared to 7.3 hours for men.[27] The total number of work hours for both women and men was highest in Colombia – at 10.7 hours and 9.0 hours, respectively – and lowest in the Philippines (8.2 hours for women and 7.0 hours for men). Across all countries, women spent less time on leisure and personal care[28] compared to men (see Table 2). Women had spent an average of 4.6 hours on leisure and non-work activities as a primary activity in the previous day, compared to 6.0 hours for men.[29]

Time use of boys and girls

Patterns of time use among women and men were echoed in the analysis of the data on youth, and reflect what is known about the time use of boys and girls.[30] Across the samples from the five countries, mothers reported 48% of all boys (n=423) and 30% of all girls (n=255) spending zero hours on care work. In 58% of households with both boys and girls, girls spent more time on care work than boys did, with a range of between 47% of households in Uganda and 77% in Ethiopia.

Among children aged 0–17, mothers reported that the average girl spent more hours on care activities, more hours on education, fewer hours on paid work and fewer hours on leisure than the average boy in the same household, across all countries (Table 8). On average, girls had spent 0.44 hours on care work in the previous day, compared to 0.25 hours for boys.[31] Also, mothers reported girls had spent an average of 3.37 hours on education in the last 24 hours, compared to an average of 2.96 hours spent by boys.[32] Boys, in turn, spent on average 6.26 hours on leisure, 0.46 hours more than girls.[33] Boys also spent relatively more time on paid work – an average of 0.46 hours, 0.18 hours more than girls.[34] Similar differences emerged when focusing solely on youth aged 13–17.

In larger households and in wealthier households, boys were likely to spend fewer hours than girls on care work, while youth care work[35] tended to be more equally distributed in households with children below age six than in households without young children.

FACTORS INFLUENCING THE LEVEL AND DISTRIBUTION OF CARE WORK

Having documented levels of care work and its distribution, analysis then sought to determine which factors, at the household level, were more likely to be aligned with a lower care workload for women and a more equal distribution of care within households. The six factors focused upon are recognition of care, women's decision making, use of labour-saving equipment, access to public services, social norms, and participation in Oxfam-supported WE-Care programme activities.

Recognition of care

The HCS included several questions that were intended to capture the extent to which men and women recognized the importance and potentially problematic nature of care. We then sought to measure whether such recognition was associated with fewer care hours for women and/or a redistribution of care within households.

Value and skill embedded in care

On average, across the five countries, women respondents valued care tasks more highly than men, except caring for the elderly, ill and/or disabled, where the value assigned was more equal (Table 3a). Men valued paid tasks relatively more than women did. Women valued most (in rank order) meal preparation; washing, ironing and mending clothes; and cleaning the house or compound. Men, in turn, stressed the care of farm animals, and house construction and repair.[36] When asked about the skills required for a range of tasks, across all countries both women and men ranked planting/harvesting crops, house construction/repair, and the care of farm animals as the tasks requiring the most skill. Notably, respondents considered these tasks as requiring more skills than caring for the elderly, disabled and children. Women ranked house construction and repair highly (though less so than men did), and meal preparation. In addition to house construction and repair, men identified carpentry and furniture making as requiring skill.[37] If we combine the measures of the value and the skill that women and men attribute to diverse activities, women's recognition of care was higher than that of men, both in absolute terms and relative to paid work.[38]

Women's contribution to household well-being

The HCS asked men and women who they felt made the most significant contribution to their household's well-being (Table 3b). In 41% of all households, at least one adult recognized a woman as making the most significant contribution – this proportion was lowest in Zimbabwe (33%) and highest in Ethiopia (54%). About 40% of women across the five countries named themselves or another woman in their household (from 13% in Ethiopia to 83% in the Philippines), while close to half (48%) of men did so (ranging from 26% in Colombia to 85% in the Philippines). However, the man and woman within the same household recognized a woman as the most important contributor in fewer than one-quarter (22%) of households, with a range of between 5% (Ethiopia) and 55% (the Philippines).

Identifying domestic or care work as problematic

On average, in 83% of households both the woman and man named at least one care task as potentially problematic for the household. The most common tasks identified were fuel collection (23% of women, 21% of men), caring for children (22% of women, 23% of men) and meal preparation (17% of women, 13% of men).

Regression analysis probed whether the recognition of unpaid care tasks was associated with fewer care hours and/or their more even distribution, accounting for other relevant factors such as the age of the respondent, household size and assets, household savings, women's decision making, and responsibility for the care of children and adults within the last 24 hours.[39] In other words, in households where there was greater recognition of care (by the woman, man or both), all else equal, did women work fewer hours and/or share care responsibilities more with men?

Perhaps counterintuitively, in households with greater recognition of the woman's contribution, women reported spending more hours on care as a primary activity.[40] This finding is consistent across all models (Tables 8a and 8b). We did not find any other measure of recognition to be significantly associated with women's unpaid care hours. Our results show a difference between the ranking of the 'value' of care and of 'skills required' for care tasks, in terms of the equality of care hours (Table 5a and 5b in the online annex). On the one hand, in households in which men and those in which women valued care work more – both in absolute terms and relative to paid work – the gender distribution of care work was more equal.[41] On the other hand, in households in which men believe care work required greater skill, primary care hours were less equally distributed.[42] The interpretation is not very straightforward. It could be that men justify a lack of participation in care work on the basis of the special skills it requires, and that accordingly, they report that women are better equipped to carry it out. But it may be that men genuinely believe that care tasks require particular skills, and thus shy away from them. Furthermore, in households that identified a woman

as the most significant contributor, the distribution of care was less gender equal. This experimental measure of recognition may in fact be capturing acknowledgement of the status quo, i.e. that women do indeed spend more hours on care.

Our regression analyses also sought to test the association between adult recognition of unpaid care and the amount and equality of youth care hours, controlling for household characteristics (Table 18 in the online annex).[43] In households where care work is valued more than paid work, boys spent fewer hours on care tasks – compared to boys in households where care work is valued less than paid work.[44] The association between household-level recognition of care work and youth care hours was not found to be significant for girls.

Our results for equality of care work are less consistent. A first model showed no association between adult recognition of care work and youth care hours, but this model had limited explanatory power, explaining less than 7% of variation in youth care hours (Table 18, Model 1 in the online annex). But when we analysed inequality as a binary variable, the results suggest that in households where both adults value care work more than paid work, boys carry out equal or more care work than girls.[45]

Woman's decision-making ability and autonomy

Two factors that give insights into women's motivations for carrying out household care tasks are the extent to which they can take decisions, and the extent to which their care activity is autonomously determined.

Women's decision making

Our measures of decision making probed a woman's ability to take decisions regarding herself, her children and family affairs. Across the five countries, on average, women were involved in eight out of the 10 decisions that the survey probed. In the Philippines, Uganda and Zimbabwe, some women had a score of 0 – i.e. they did not take decisions about any of the 10 items, while in Colombia and Ethiopia, all women took decisions on at least one item. When incorporating 'influence' into the decision-making measure (to give weight to women who choose to delegate decision making to others), the average score for these women was 1.8 (on a scale of 0 to 3). On this indicator, the mean score ranged from 1.2 in Colombia to 2.1 in Ethiopia.[46] Uganda was the only country in which some women scored 0 on this measure, meaning that they were neither involved in nor able to influence decision making over any of the 10 items.

Relative autonomy in carrying out care

A series of questions sought to probe the motivations informing care work – whether people perceived this to be an autonomous decision or whether it was conditioned by their perceptions of what others do, or by what others think they should do. Across the five countries, the data suggest that women's motivation for their behaviour tends to be relatively autonomous (Table 4).

Our hypothesis was that women who are involved in decision making and are more autonomous will be able to bargain for a redistribution of care responsibility. In fact, our findings on decision-making ability are inconsistent. Some of our regression models show that women who took more decisions (and who had greater decision-making and influencing ability) spent more hours on care.[47] Other results suggest that where women had more decision-making ability, the distribution of hours spent on care as a primary activity was less equal (Model 2 in Table 7a in the online annex).[48] Importantly, results show that women with greater decision-making and influencing power reported spending fewer hours collecting water compared to women with less decision-making power (Table 15 in the online annex).[49] However, other than for water collection, there was no clear association between women's decision-making ability and equality of care hours in any of the other models that we tested (Tables 7a and 7b in the online annex).[50] We did not find any association between women's decision-making ability and the distribution of care hours between boys and girls, controlling for household characteristics (Table 19 in the online annex).

Further research is needed to understand why women who are abler to take decisions at the household level appear to be carrying out more care work and doing a higher share of that work themselves. One interpretation is contained within the proposition on social norms: that norms are sufficiently strong that (even) women with greater decision-making ability do not consider negotiating about gendered care roles. In contrast, our results suggest that women with greater relative autonomy experience more equal primary care hours.[51] It could be that more autonomous women select into more gender-equal households.

Access to public services

The HCS inquired about access to distinct types of public infrastructure and services, namely water, electricity, health facilities and childcare (Table 5). We then sought to ascertain whether household access to these services was associated with fewer care hours and/or their more equal distribution (within households and/or between households and the state). The logic was that provision of these services could reduce care demands at the household level – e.g. where electricity is provided, households may rely less on the collection of fuel – and/or provoke a redistribution of household labour. Our focus was on the state provision of services, because rarely do employers or NGOs provide care services in the study areas.

Water

Across the five countries, 77% of households reported using an improved water source, of which 68% reported that it was government-provided. The share of households with access to an improved water source ranged from 52% in Ethiopia to 94% in Zimbabwe.

Electricity

On average, one-third of households (32%) reported having electricity in their homes – but with a range from 0% in Uganda and Zimbabwe to 98% in Colombia, where the programme operated in a peri-urban area. Among those households with electricity, the majority in the Philippines (65%) and Colombia (83%) reported that it was government-provided. However, this was the case for only 20% of households in Ethiopia, due to the higher level of NGO activities in the communities studied.

Healthcare

Nearly all respondents (96%) reported using health facilities when household members were ill, and this share was consistently high across all the countries. Among these respondents, 77% reported that their health facility was government-provided – however, this was only the case for 6% of households using health facilities in Ethiopia.

Childcare

On average, 17% of households in our sample reported using childcare facilities, two-thirds of which reported that these facilities were government-provided.

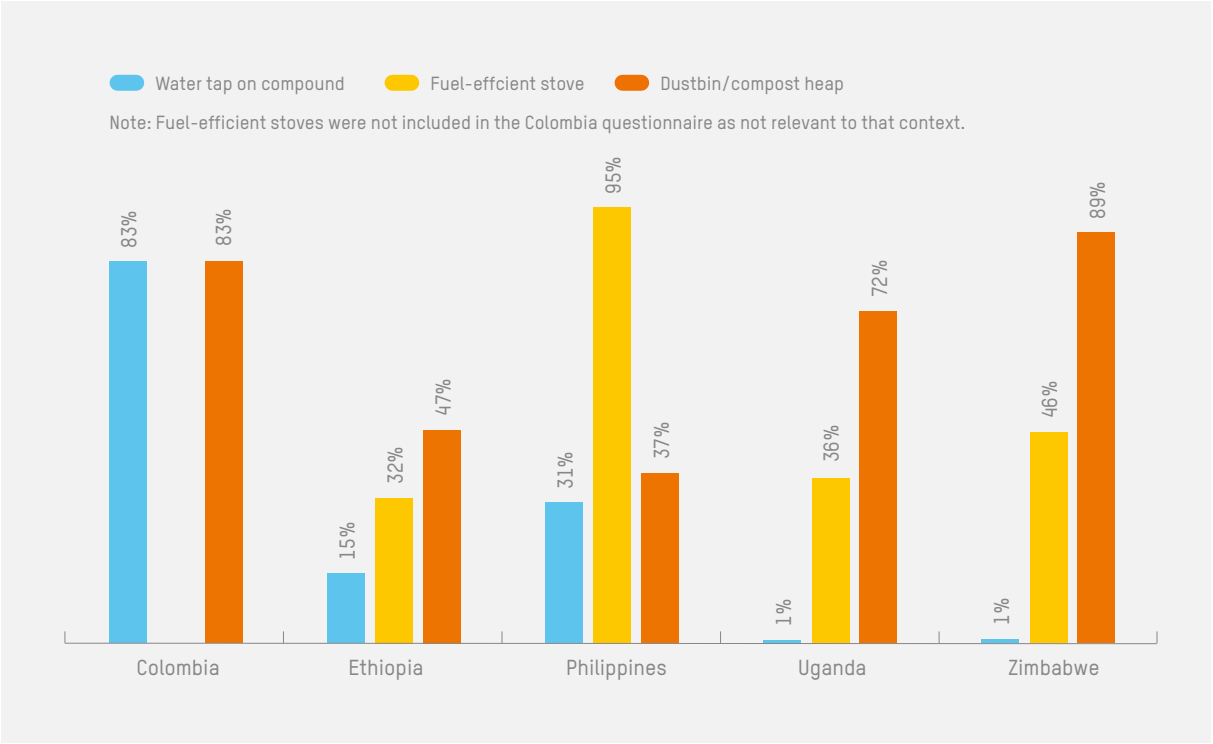
Our regression models tested the associations between access to these publically available services and women's care hours, controlling for a range of relevant characteristics.[52] Compared to households with no electricity, in households with electricity women spent fewer hours on care as a primary activity; they also spent fewer hours on any care responsibility.[53] We found no association between any other services and women's care hours.

Additional regressions tested the association between household access to services and hours spent on care work by girls and boys (with the appropriate controls). In households with government-provided electricity compared to those with no electricity, boys spent more hours on care work in general and on water and fuel collection in particular.[54] Moreover, boys in households using government-provided childcare facilities spent more hours on care work than boys in households without access to these facilities.[55] In households with access to a public water source, girls spent more hours on water and fuel collection.[56] Potentially, where water is provided, households opt to collect more water, and water collection is safer for girls to do.

Access to time-saving and labour-saving equipment

The HCS collected information on a wide range of time- and labour-saving equipment available to surveyed households. In all countries, the survey asked about common types of equipment – e.g. a water reservoir/storage tank, water tap on the compound, flask for liquids/food, dustbin. Other equipment types were specific to particular contexts – e.g. fuel-efficient stoves, transport for fetching water. Table 6 contains detailed descriptions of each type of equipment available to households in our sample. Our focus here is on the three types of equipment that our analysis suggested were most related to care loads: having a water tap on the compound, fuel-efficient stove, and dustbin/compost pit (Figure 9). Ownership of these items varied widely between the communities – while just one-third of households owned a fuel-efficient stove in Ethiopia and 36% in Uganda, the share was 95% in the Philippines. The share of households with a water tap on their compound varied from 1% in Uganda and Zimbabwe to 83% in Colombia, while the share of households with a dustbin/compost pit ranged from 37% in the Philippines to 89% in Zimbabwe.

Figure 9 Share of households in the samples owning equipment that was most linked with care workloads



Note: Fuel-efficient stoves were not included in the Colombia questionnaire as not relevant to that context.

We conducted regression analysis to test the association between access to time- and labour-saving equipment and women's unpaid care hours, including a range of relevant controls.[57] The first set of regressions included the types of equipment that were available in all five countries (Table 12a in the online annex). The results suggested that women in households with a dustbin or compost pit spent fewer hours on care compared with women in households with no dustbin/compost pit.[58] No other equipment type was found to be significantly associated with women's care hours.

Second, we added two more important items to our model – i.e. transport for fetching water, and fuel-efficient stoves. Since these items were not part of the Colombia survey, we computed this model for only four countries (Table 12b in the online annex). The results showed that women in households with fuel-efficient stoves spent more time on care as a primary activity compared to women in households that did not have those stoves.[59] That said, however, there was no significant association between having a stove and women's food preparation hours.

To examine household-level care hours more fully, we conducted additional regressions seeking to explain men's care hours (Table 13b in the online annex). Our results suggest that men in households with a water tap on their compound spent more hours on any care responsibility than men in households without a water tap on their compound, but the explanatory power of the model is limited (Table 13a in the online annex).[60] We were unable to conduct any additional analysis on men's water collection and food preparation hours, because 90.2% of all men in our sample reported spending zero time on water collection, and 92.0% of all men reported spending zero hours on food preparation.

Taken together, these findings suggest a negative association between households' access to some equipment (e.g. a stove, a water tap on the compound) and reduced care hours. This result may be due to the tendency of households with heavy care workloads to self-select to participate in the improved stoves and/or water projects. It is also possible that men undertake some care tasks only when certain equipment is available – as in Ethiopia, for example, where Oxfam partners suggested that men were more likely to engage in water collection when a water tap was available on the compound.

We also tested the association between the availability of time- and labour-saving equipment and youth unpaid care work, with the appropriate controls.[61] The results suggest that this equipment had some potential to alleviate care workloads and to redistribute care work between boys and girls. In households with a water tap on the compound,

girls spent fewer hours on care work in general and water collection in particular, compared to households with no water tap in their compound.[62] In households with a fuel-efficient stove, boys spent more hours collecting water and fuel.[63] Finally, in households with a dustbin/compost pit, boys spent less time on care work[64] and both boys and girls spent less time on water and fuel collection, compared to households that did not have a dustbin/compost pit.[65]

Social norms

As described above, an abundance of previous research highlights the influence of social norms in establishing and maintaining the gendered division of care. One aim – and innovative aspect – of the survey was to develop robust quantitative measures of norms. We included several experimental measures to capture the distinct facets elaborated in Section 3 – what people do, people's attitudes toward what they do, what they believe others do, and what they believe others think they should do. As Mackie and colleagues have elaborated, a lack of alignment between these factors may signify unstable or shifting norms.

The eight measures that shed some light on social norms investigate respondents':

1) recognition of a woman's contribution to household well-being;
2) perceptions of value of and skill involved in care work relative to paid work;
3) relative autonomy with respect to the amount of care work performed;
4) satisfaction with household division of labour;
5) perceptions of the acceptability of mocking men for involvement in care;
6) perceptions of acceptability of wife beating or criticism in cases of perceived 'failure' to carry out care work;
7) reactions to vignettes that describe household situations in which a man is engaged in paid work while a woman does all the care work, and in which couples share paid and care work, respectively;
8) whether a woman would like, asks for and receives help with care work from male household members.

We have examined the first three indicators already – the first two enabled an assessment of the extent to which respondents recognized household care, and the third gave insights into motivations for carrying out care work. We now describe responses to the other measures, and then assess how all these measures relate to the care loads of the survey respondents.

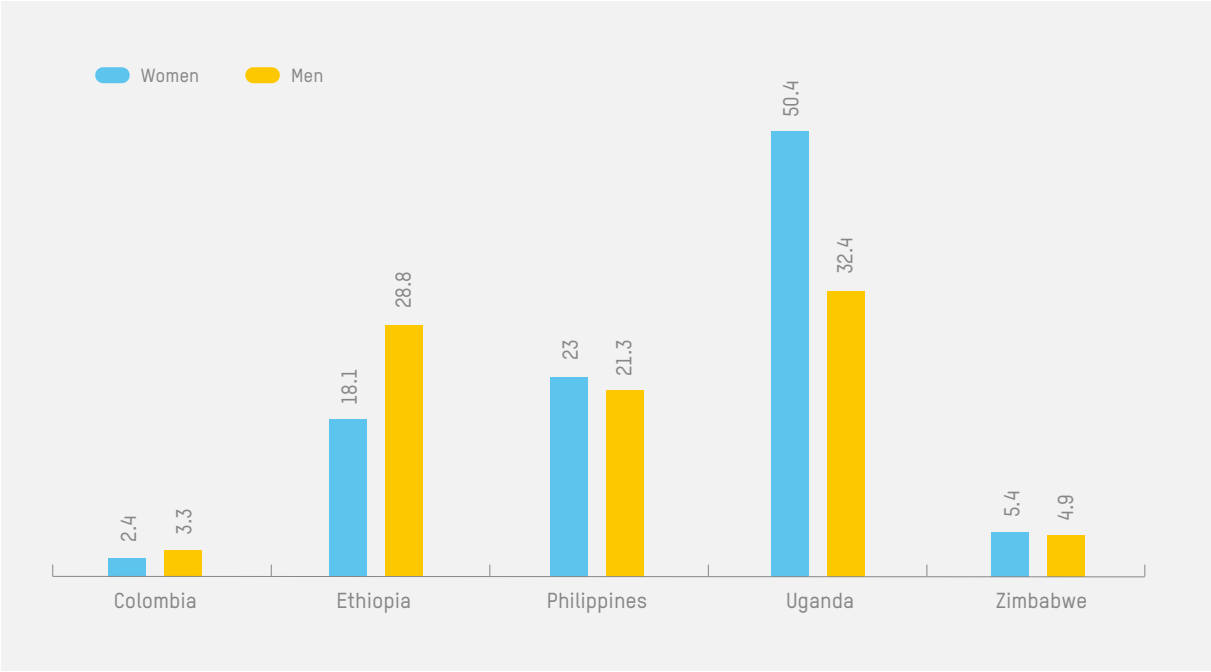
Woman's satisfaction with division of labour

Satisfaction is one measure of people's attitudes towards care work. Our data suggested that most women were satisfied with the division of labour in their households – some 87% overall, and as high a share as 94% of women in Zimbabwe and 96% in the Philippines. The lowest satisfaction levels were in Uganda, but there too, nearly three-quarters (72%) of women were satisfied.

Acceptance of beating, criticism and shaming

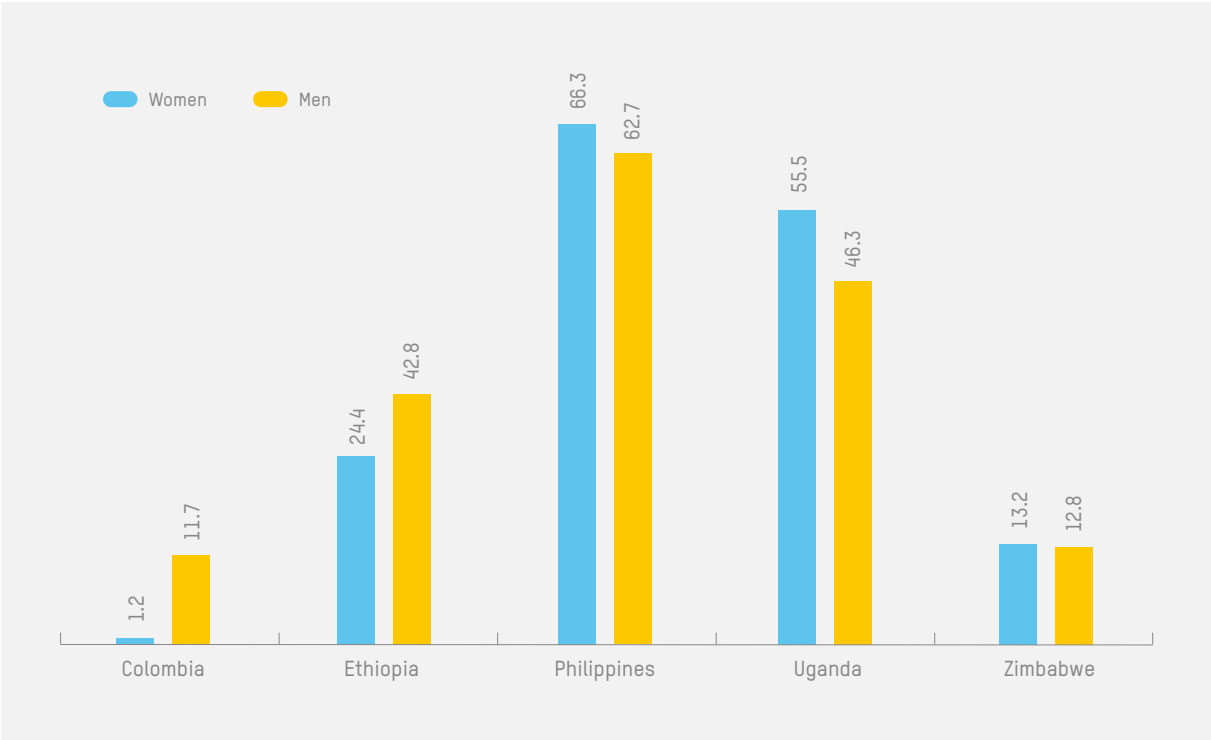
One way to gauge why people display certain behaviours, and their view of societal expectations of their actions, is by asking about the acceptability of physical violence or criticism/shaming in response to a perceived transgression of gender roles. The survey asked women and men under what circumstances it was acceptable to beat or criticize a woman for a perceived failure to carry out care-related activities, as well as when it would be acceptable to mock men for carrying out care work. Respondents were asked about a range of different tasks or failures (e.g. burning the food, bath not prepared on time, not taking care of children). Across the five countries, 26% of women responded that beating was an acceptable response to at least one perceived failure to carry out a specific care task; the proportions ranged from 50% in Uganda to 2% in Colombia (Figure 10). Notably, in Uganda a much higher share of women than men reported the acceptability of beating (the difference was about 18 percentage points).

Figure 10 Share of respondents in the samples who felt beating was an acceptable response to a perceived failure to carry out at least one care-related task



More respondents found criticism of women to be acceptable for at least one perceived failure – 38% of respondents supported this view, with a range of between 1% in Colombia and 65% in the Philippines (Figure 11).

Figure 11 Share of respondents in the samples who felt harsh criticism was an acceptable response to a perceived failure to carry out at least one care-related task



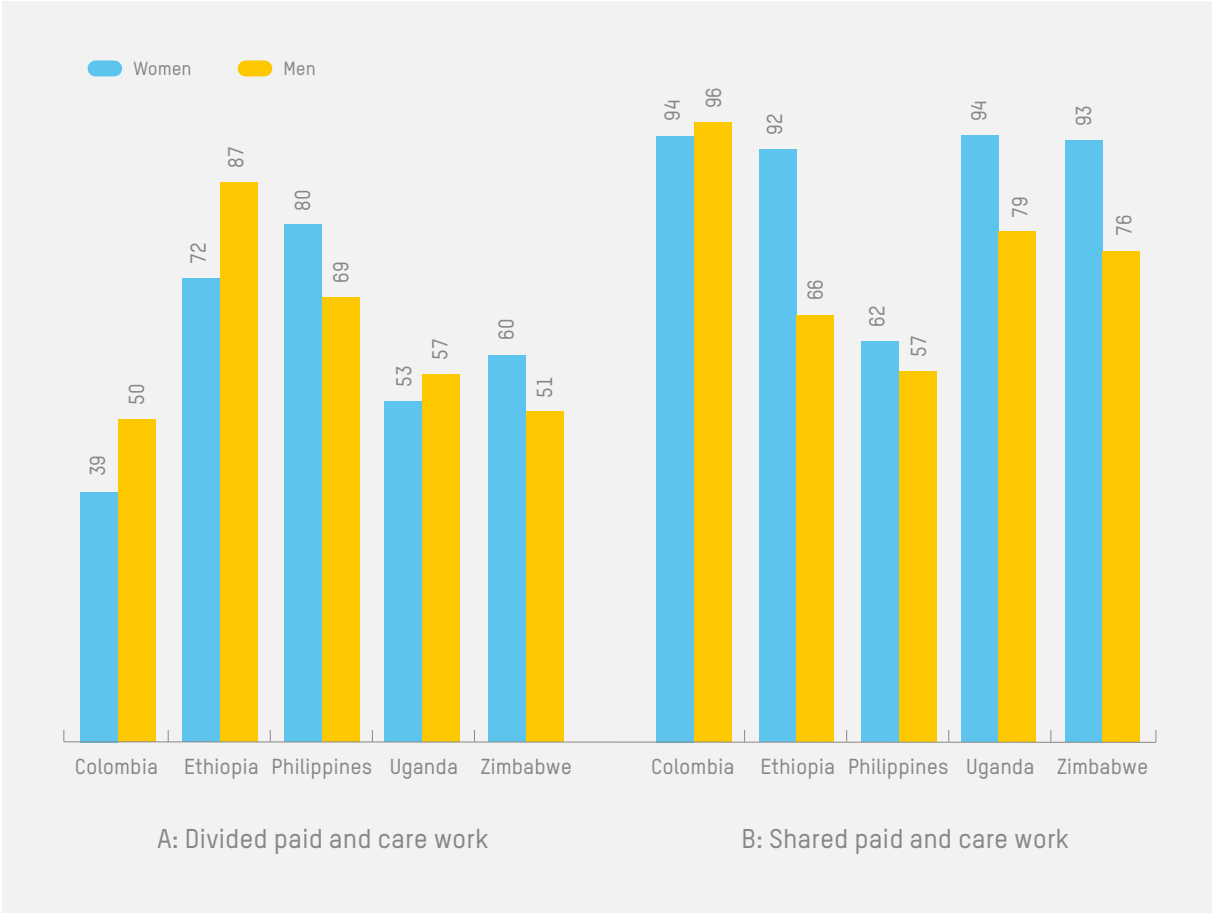
Similarly, in project communities across the five countries, 20% of women and 22% of men felt it was acceptable in at least one instance to mock or shame a man for participating in unpaid care tasks.

Reaction to vignettes

Most respondents – 63% of women and 64% of men – approved of a vignette describing a couple exhibiting a gendered division of labour, in which the man engaged in paid work while the woman carried out all the care work (Table 9). For women, the highest percentage was in the Philippines (80%) and the lowest was in Colombia (40%) (Figure 12a). For men, the highest percentage was in Ethiopia (87%) and the lowest was in Colombia (50%).

At the same time, most respondents (66% of women and 76% of men) also approved of a vignette that describes couples sharing care and paid work. For women, the highest percentage was again in the Philippines (74%) and the lowest was in Zimbabwe (60%) (Figure 12b). For men, the highest percentage was in Colombia (96%) and the lowest was in the Philippines (57%). Notably, in every country except for the Philippines, a higher share of women and men approved of the vignette describing a routine in which paid and care work were shared.

Figure 12 Share of women and men in the samples who approved of vignette describing (a) a gendered division of care work and (b) shared responsibilities



Women's desire for and receipt of help from male household members

Across the five countries, 80% of women expressed the desire that their husbands would help with one or more care activities – with a range from 71% (Colombia) to 85% (Zimbabwe). Women would have liked husbands to help mostly with water collection (69%) followed by childcare (66%), fuel collection, elder care and community care (59%), clothes preparation (56%), meal preparation (54%) and cleaning (50%). Furthermore, the data showed that about 50% of women who wanted their husbands to help them with care work had never asked for such assistance in the month before the interview. Those who did ask for help received it, at least sometimes, in 90% of cases. Some 80% of women felt it was appropriate that they receive help from their husbands – the share ranged from 64% in Ethiopia to 94% in Zimbabwe.

We conducted multiple regression analyses to test the associations between our measures of social norms and the redistribution of care activities between women and men, with the appropriate controls.[66] For each outcome variable – levels and distribution of care hours – we computed two different models. The first looks at the influence of individual-level norms (Table 23a in the online annex), and the other, at household-level norms (Table 23b in the online annex).

Individual-level social norms

Echoing the results above, in households with greater recognition of a woman's contribution the distribution of any care hours between women and men was less equal (Table 23a in the online annex).[67] Similarly, in households where men report that care work requires relatively more skill than paid work, primary care hours are less equally distributed between women and men.[68] Also consistent with earlier regression models, in households in which women attribute greater value and more skill to care work relative to paid work, primary care hours are more equally distributed.[69] Additionally, we found that women's reported autonomy in relation to care was associated with more equal gender distribution of primary care hours,[70] as was their satisfaction with the household division of labour.[71] Finally, we found that where men expressed stronger disapproval of an unequal gendered division of tasks, primary care hours were more equally distributed.

Household-level social norms

Analyses of household-level social norms (Table 23b in the online annex) show that in households in which both the woman and man recognize the woman's contribution to household well-being, the distribution of care is less equal.[72] As suggested earlier, this measure may be capturing the existing state of affairs – i.e. that women are carrying out more care work – rather than attributing value to the woman's role. Our results also show that in households in which both the woman and man consider care work to require more skills than paid work, the distribution of care hours is more equal.[73] Also, in households where both the woman and man disapprove of an unequal division of tasks (as described in the vignette), the distribution of care was more equal.

Multiple regression analyses sought to test the association between household-level social norms and the redistribution of care hours between boys and girls – controlling for household characteristics. The results showed that in households where care work is valued more than paid work, boys spent more hours doing care work than girls,[74] and that in households where respondents did not approve of criticism of women for perceived failures in care work, boys did equal or more care work than girls.[75]

PARTICIPATION IN OXFAM-SUPPORTED WE-CARE ACTIVITIES

The HCS contained a series of questions on respondent participation in WE-Care projects, which related to water, energy and gendered norms around care work (Box 2). Owing to an error in data collection, information on respondents' participation in WE-Care projects is not available for Uganda, so the analysis that follows focuses on the other four countries. We describe levels of participation in the three types of projects across countries, and then the extent to which respondent participation is associated with patterns of time use and with measures of social norms.

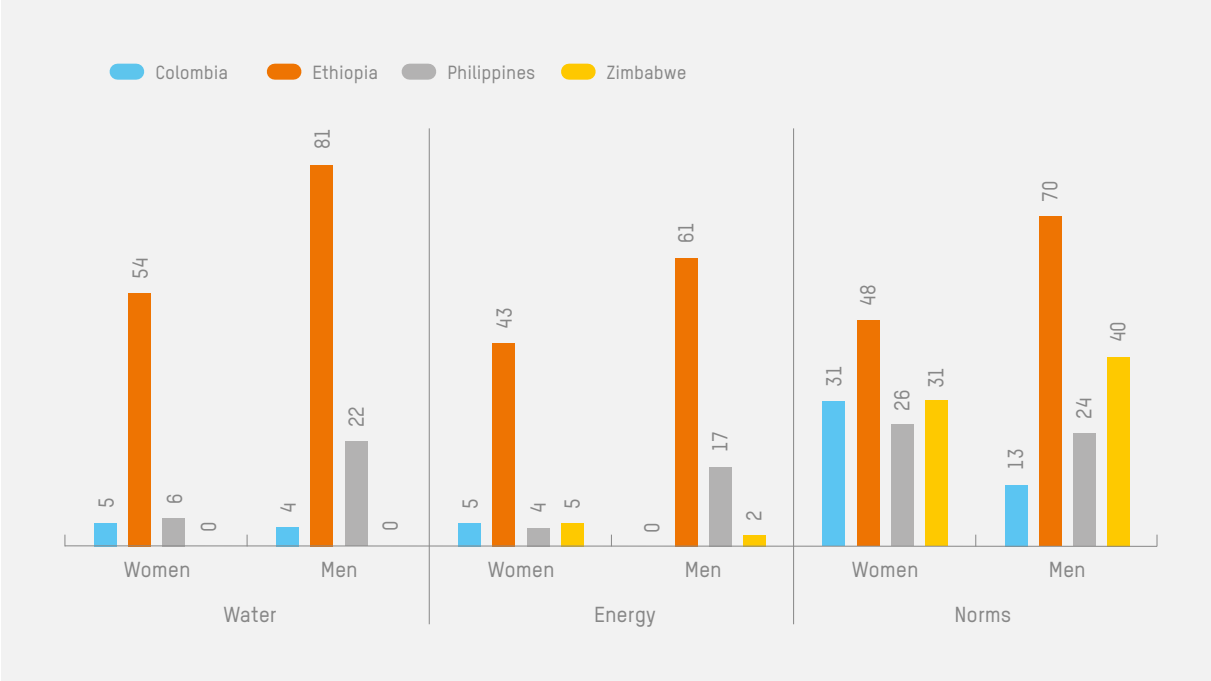
Box 2 Information on WE-Care programme activities: Zimbabwe

WE-Care programme activity centred on projects related to water, energy and social norms around care. Water-related projects included activities such as the distribution of water containers and wheelbarrows, and training on water storage and management. Energy-related projects included the design, manufacture and distribution of fuel-efficient stoves, the distribution of solar panels and training on energy-saving techniques. Projects that focused on social norms included activities such as workshops around the recognition and redistribution of care work, radio shows and events about care work, the training of WE-Care 'champions' to shift gendered care roles in families, and community dialogues around care-related topics.

Project participation

On average, across the four countries 20% of women and 35% of men reported participating in WE-Care water-related projects (Table 7). For energy-related projects, the figures were 17% and 27% respectively, and for norms-related projects, 35% of women and 44% of men were involved. These proportions, however, varied substantially across countries (Figure 13).

Figure 13 Proportion of women and men surveyed participating in WE-Care projects on water, energy and social norms (%)



Through regression analyses, we tested the association between women's participation in WE-Care water-related projects (Table 15 in the online annex) and energy-related projects (Table 16 in the online annex) and women's care hours, controlling for other relevant variables.[76] The regressions for water-related projects exclude Zimbabwe, because none of the respondents in the country reported participating in these projects. Our analysis suggests that women who participated in WE-Care water-related projects spent less time on care as a primary activity than women who did not participate.[77] However, we did not find a significant association between participation in WE-Care water-related projects and women's water collection hours, so this association is somewhat difficult to explain. On the other hand, women who participated in WE-Care water-related projects reported spending more hours on any care responsibility than non-participants, and the same was true of female participants in WE-Care energy-related projects.[78] Moreover, women in households in which a man participated in WE-Care energy-related projects spent more hours on any care responsibility than women in households in which men did not participate.[79] A selection bias might explain these findings, to the extent that women who spent more hours on care responsibilities may have chosen or have been selected to participate in Oxfam projects.

Encouragingly, our results point to a significant positive relationship between participation in WE-Care norms-related projects and two measures of social norms: (1) disapproval of the vignette that describes an extremely gendered division of labour; and (2) the relative autonomy index for men (Table 25a in the online annex). We first assess the strength of this relationship without any additional controls. Our results show that, compared to households in which at least one member participated in a norms-related project, respondents are more likely to disapprove of the vignette of the gendered description of labour;[80] and the strength of this effect is greater in households in which both the woman and man participated in these projects.[81] Moreover, in households in which at least one household member participated in these projects, men expressed greater autonomy in carrying out care work compared to households where neither the man nor the woman participated.[82] Again, the strength of the effect was greater in households where both the woman and the man were participating.[83] To obtain more robust results, we then computed regression models, introducing a range of relevant controls (Table 25b in the online annex).[84] These models explained the data very well and affirmed that, all else equal, participation in WE-Care norms-related projects was associated with a higher likelihood of expressing positive norms around care.

5. COMPARING CHANGE OVER TIME IN ETHIOPIA AND ZIMBABWE

As noted, the HCS was designed as a panel to enable more robust investigation of any changes between 2014 and 2015, and their causes. Longitudinal analysis was possible for the Ethiopia and Zimbabwe samples, as research teams were able to re-interview most (some 85%) of the households surveyed in 2014 in communities where programme activities had been carried out. In the other countries, the limited number of participating households who were surveyed twice restricted comparisons.

Having a panel rather than two cross-sectional surveys is useful to trace fluctuations within populations that a focus on averages may obscure. In this section, we analyse the differences in time use and in three of the underlying factors explored above that are liable to change in a relatively short time – namely access to household equipment and public services, and participation in WE-Care trainings (which, as noted above, included the provision of time- and labour-saving equipment, and awareness raising around gendered norms relating to care). We then investigate the extent to which new equipment and training may be related to changes in time use – recognizing that programme activities have been operating in these communities for less than a year. The analysis is focused on changes evident in 2015 relative to the 2014 survey, even if not explicitly stated.

Three key findings emerge from this analysis. First, women reported spending fewer hours on care in Ethiopia in 2015 than in 2014, but inequality in time use increased because men reported spending less time still. In Zimbabwe, in contrast, men reported conducting more care work in absolute and relative terms, so inequality fell. Accordingly, the change in hours allocated to care work over the year was as intended by the programme strategy and propositions, but only for women in Ethiopia, and for men in Zimbabwe. Second, sizeable shares of respondents in the survey reported acquiring and losing equipment and access to public services in the course of the year, and (relatedly) participating in trainings of the WE-Care project and/or of the wider development programme in which WE-Care activities were embedded. The gains relate to the WE-Care programme activity; the reported losses will require follow-up study. In a majority of households in Ethiopia and Zimbabwe, at least one person participated in at least one training in 2014, and in all five types of training in 2015.[85]

Finally, our results suggest that introducing infrastructure and time- and labour-saving equipment does not show a straightforward link with reduced hours or inequality, but participation in the trainings appears to be linked to the intended outcomes of reducing and redistributing care. Efforts to change gendered roles in project areas in Zimbabwe were more successful than those in the Ethiopian communities at increasing men's participation in care work. Follow-up qualitative research will be important to interpret further the results.

Time use of women and men

The time allocated to care from 2014 to 2015 changed in the direction hypothesized by Oxfam programmes, but only for women in Ethiopia and men in Zimbabwe (Table 10). In 2015 in Ethiopia, women reported spending fewer hours on care as a primary activity, and more time on personal care, sleep and paid work than in 2014 (Table 10). On the contrary, women in Zimbabwe reported spending fewer hours on personal care and paid work. Similarly, in 2015, men in Ethiopia reported spending more hours on personal care and fewer hours on care as a primary activity, on care as a primary or secondary activity, and on any care responsibility. In contrast, men in Zimbabwe in 2015 reported spending fewer hours on personal care and more hours on care as a primary activity and care as a primary or secondary activity. In Zimbabwe, women spent more hours on water collection and food preparation but fewer hours on fuel collection, and men spent more time on all three tasks in 2015, compared with 2014 (Table 10). Men in Ethiopia, however, spent zero hours on fuel collection and food preparation in 2015, and there are no pronounced differences in time spent on these tasks in 2014 and 2015 among women surveyed in Ethiopia. Finally, women and men in both countries spent fewer hours multitasking (performing two or more care activities simultaneously) in 2015 compared to 2014 (Table 26a in the online annex).[86] In both countries, 78% of women and 65% of men experienced reductions in multitasking (Table 27a in the online annex).

Figure 14 Significant changes in time use in the samples in Ethiopia and Zimbabwe between 2014 and 2015

Activity type	Ethiopia		Zimbabwe	
	M	F	M	F
Primary care	-	-	+	
Secondary care	-		+	
Any care	-			
Multitasking	-	-	-	-
Water			+	+
Food			+	+
Fuel			+	-
Personal care	+	+	-	-
Sleep		+		
Paid work		+		-

Inequality in time use

Men in Ethiopia spent fewer hours carrying out care work in 2015 (relative to women) when compared with 2014. In Zimbabwe, in contrast, men spent more time on care work in 2015 (relative to women) than in 2014, and more hours on any care responsibility. It follows that inequality in the distribution of care work – here, the ratio of male to female hours – increased in Ethiopia and decreased in Zimbabwe in 2015.[87]

In Ethiopia, 62% of households had a more unequal distribution of primary care work and 66% experienced more unequally distributed care as either a primary or secondary activity in 2015 (see Table 30 in the online annex). In Zimbabwe, however, in 2015 the majority (53%) of households in our sample enjoyed greater equality in the distribution of primary care work, of primary or secondary care (57%), or of any care responsibility (60%) (Table 30 in the online annex).

On average, men carried out less multitasking (relative to women) in 2015 than in 2014 (Table 6).[88] In other words, the intensity of care work was more unequally distributed in 2015 than in 2014. The percentage change was larger in Ethiopia than in Zimbabwe. On average, the ratio of male to female hours spent on multitasking went down in 59% of households in Zimbabwe, and 63% of those in Ethiopia (Table 30 in the online annex).

The data also enabled us to look at what factors were associated with changes over time. These appear to suggest a possible reinforcement of earlier inequalities. In particular, we look at whether the changes over the year related to the age of the women, the number of children or the 'starting point' of care hours (women who spent relatively more time on care than other women in 2014).

- In households in which women worked more primary care hours in 2014, inequality in primary care hours was likely to stay the same or decrease.[89] In other words, in these households, men are likely to spend more hours on care as a primary activity, or the same amount of hours (relative to women) as they did in 2014. This same pattern held for women's hours in each activity category.
- In households with older women, inequality in care increased. In other words, men in these households are likely to spend fewer hours or the same amount of hours on care work and total work (relative to women) in 2015 than they did in 2014.
- In households with a greater number of children below age six, inequality in care time was more likely to increase; men were likely to spend fewer hours or the same amount of hours on paid work (relative to women) as in 2014.

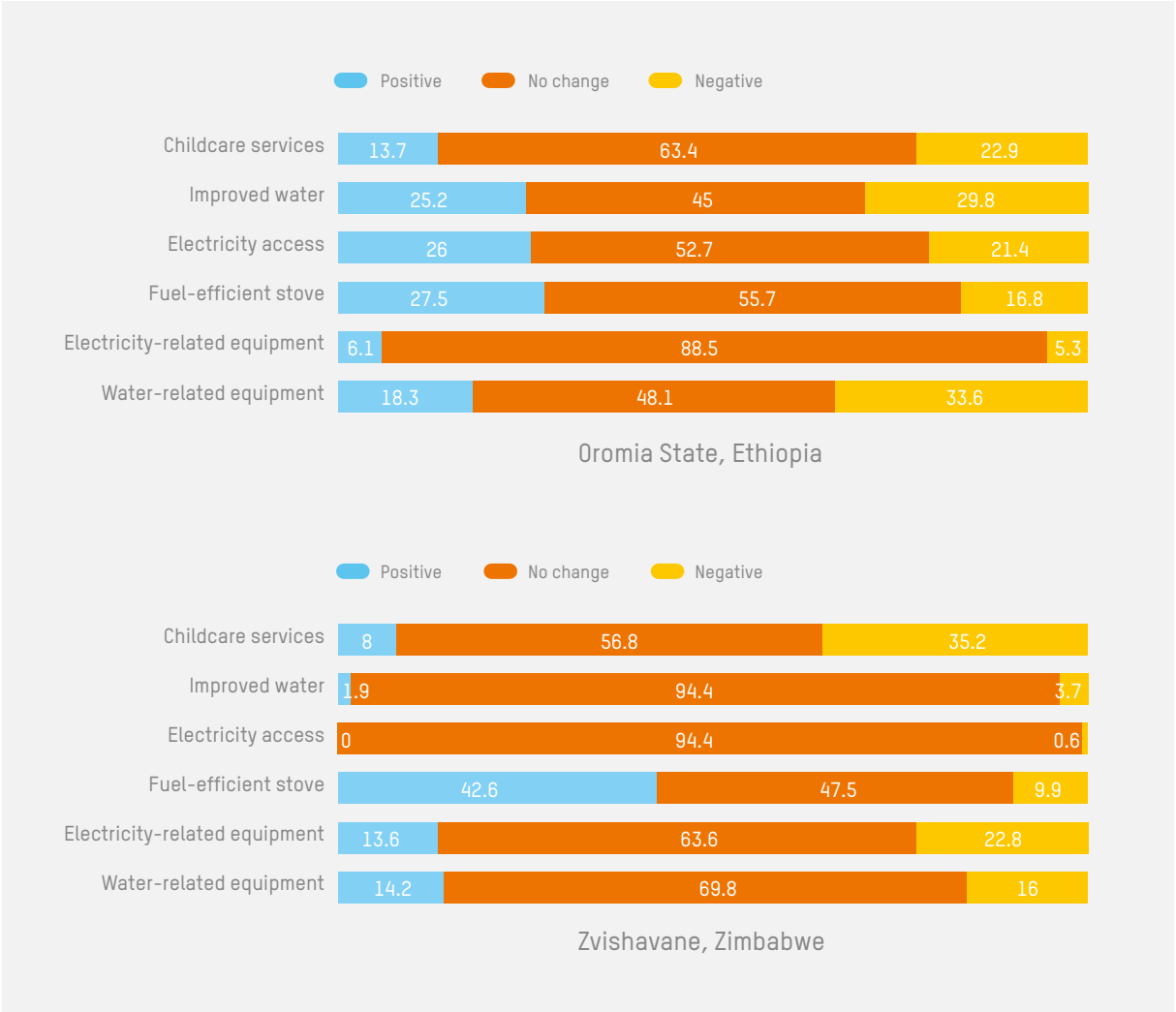
Changes in factors believed to influence care

So far the analysis points to fewer care hours for women in Ethiopia, but an increase in inequality owing to lower male involvement; and the opposite tendency in Zimbabwe, where male participation increased and total inequality fell. We now probe the changes that might underlie these shifts, as these could have implications for further programme activity. In particular, we focus on changes in equipment, in access to public services and in participation in training that occurred between the 2014 and 2015 surveys, and then analyse whether this is likely to have affected time use.

Change in access to equipment

Overall the data suggest some fairly sizeable changes in access to equipment (Figure 15). Notably, nearly one-third of households in Ethiopia and 43% in Zimbabwe reported having acquired a fuel-efficient stove, while 20% and 14% respectively acquired water-related equipment. However, perhaps surprisingly, some one-third of households in Ethiopia and 16% of households in Zimbabwe reported the loss of access to water-related equipment, while 5% and 23% respectively reported losing access to electricity-related equipment. Further qualitative work is needed to understand better the underlying dynamics of these shifts.

Figure 15 Share of households reporting positive, negative and no change in access to equipment and services in the samples from Oromia regional state, Ethiopia and Zvishavane district, Zimbabwe, 2014 and 2015



Changes in access to services

In Zimbabwe, 99.4% of households in our sample reported no change in access to electricity, 94.4% reported no change in access to improved water, and 57% no change in access to childcare services (see Table 32 in the online annex). Less than 2% of households reported a positive change in access to improved water and 8% of households reported a positive change in access to childcare services. The situation differs in Ethiopia: 26% of households reported a positive change in access to electricity, 25% in access to improved water, and almost 14% in access to childcare services. A similar share of households reported negative change: 21% (access to electricity), 30% (access to improved water), and 23% (access to childcare services). This will also require follow-up research.

Participation in training

In a majority of households in Ethiopia, at least one person participated in training on water, income, health or gender in 2014, and in all five types of training in 2015 (Table 12). Contrastingly, in a majority of households in Zimbabwe, at least one person participated in health-related training in 2014 and in all five categories of training in 2015.

Having separately examined changes in time use and in the factors that might explain such changes, we now seek to bring them together – in other words, to look at the extent to which demographic factors and changes in equipment, service access and training affected the levels and distribution of care work that women and men undertook.

Access to equipment and services

In households with access to certain equipment in 2014, women spent fewer hours on care-related tasks in 2015 (Table 36a in the online annex). In households that had a water tap on the compound, women spent fewer hours on water collection and fuel collection as a primary activity; in households with a solar energy system, women spent fewer hours collecting fuel; and in households with a generator, women spent fewer hours on water collection, fuel collection and food preparation, as well as on care as a primary or secondary activity, and any care responsibility. Finally, in households with electricity, women spent fewer hours on fuel collection. Along similar lines, in households with a rainwater-harvesting system, men spent fewer hours on water collection, while in households with a solar energy system they spent fewer hours on fuel collection and care as a primary activity.

In contrast, in households with fuel-efficient stoves in 2014, women spent more hours on food preparation, primary care and any care responsibility. Similarly, in households with access to childcare services, women spent more hours on fuel collection, multitasking, care as a primary or secondary activity and any care responsibility. It could be that the acquisition of a stove or help with childcare enabled women with heavy care loads to reallocate their time toward other pressing activities. Finally, in households with a water tap on the compound and a kerosene lamp, men spent more time multitasking.

Access to equipment and services

Finally, we test the association between changes in access to equipment and services in 2014 and change in time use in 2015 (Table 36b in the online annex). We divide the results into two categories: equipment that appears to be linked to reductions in inequality in time use within households, and that which does not. Further investigation will be needed to understand better why this is the case.

Changes associated with reduced inequality

The acquisition of certain types of equipment – a wheelbarrow or other transport for fetching water, and a fuel-efficient stove – was associated with reduced inequality in time use. In households with transport for fetching water in 2014, men were likely to spend more hours or the same amount of hours on any care responsibility and multitasking (relative to women) in 2015 as they did in 2014. In households with a fuel-efficient stove in 2014, men were more likely to spend more (or the same) hours on any care work (relative to women) in 2015 than they did in 2014.

Paradoxically, the loss of certain types of equipment – namely electricity-related equipment and fuel-efficient stoves – is also related to a likely decrease in inequality in time use. In households reporting a negative change in access to electricity-related equipment, men were also more likely to spend fewer (or the same number of) hours on primary care and any care responsibility (relative to women) in 2015. And in households reporting a negative change in access to fuel-efficient stoves, men were more likely to spend fewer (or the same) hours on primary care, any care responsibility and total work (relative to women) in 2015 than they did in 2014.

The acquisition of certain types of equipment appears to be associated with an increase in inequality in time spent on care – a relationship that requires further investigation. In particular, households with a flask for fluids/food in 2014 had a higher likelihood of increased inequality in hours spent on multitasking and sleep (Table 36a in the online annex). In households with a solar energy system in 2014, men were more likely to spend fewer (or the same) hours multitasking, on paid work or on total work (relative to women) in 2015 than they did in 2014 (Table 36a in the online annex).

Finally, the effect of access to services also appears to be mixed. Access to childcare is associated with reductions in inequality. In households with access to childcare services in 2014, men were more likely to spend more (or the same) hours on care work (relative to women) in 2015 than they did in 2014. However, in households with access to improved water in 2014, inequality in time spent on any care responsibility and on personal care was likely to increase (Table 36a in the online annex).

Participation in training

Women in households in which at least one adult participated in project activities on water equipment or storage spent fewer hours on care as a primary or secondary activity, and fewer hours on multitasking.[90] Additionally, in these households men spent fewer hours on any care responsibility.[91] In households in which at least one adult participated in training on health, women spent fewer hours on any care responsibility.[92] Finally, compared to households where no one participated in training, women in households where at least one adult participated in training on gender spent more hours preparing food while men spent more hours on fuel collection. In these households, both women and men spent fewer hours on multitasking.[93]

Discussion

The evidence from our analysis of the panel element of the 2014 and 2015 HCS for communities in Ethiopia and Zimbabwe raises some suggestive findings, but also numerous questions that warrant further study.

A key finding is that women in Ethiopia reported spending less time on care (although male-female inequalities in time use increased) while the converse occurred in Zimbabwe (men reported spending more time on care, and inequalities decreased). These different dynamics (and the absence of significant change among men in Ethiopia and women in Zimbabwe) require further qualitative study. The lack of reduction in women's care hours in the communities in Zimbabwe could be a function of increased expectations in the light of the provision of equipment such as a fuel-efficient stove or water storage container, particularly in a stagnant economic context. Alternatively, as further discussed below, women in 2015 may have been more aware of their own care work, which influenced their reporting – though it is not apparent why the Zimbabwean men in the sample took on more care while the men in the Ethiopian sample did not, as 'social norms trainings' were carried out in both contexts.

A second finding is the frequency of reported changes in the acquisition of equipment and infrastructure, and often its loss as well. The acquisition of equipment is straightforward to understand, as it was an explicit objective of WE-Care water- and energy-related programmes. For example, our data suggested that about one-third of households in Ethiopia and 43% of those in Zimbabwe in our selected areas acquired a fuel-efficient stove.

The reported losses (e.g. particularly in water-related equipment in Ethiopia and in electricity-related equipment in Zimbabwe) are more difficult to understand. It would be advisable to investigate further what occurred in these cases – e.g. if equipment fell into disrepair, was sold or given away, etc. With infrastructure too, some puzzling patterns also emerge – e.g. in Ethiopia, around one-quarter of households reported acquiring access to electricity and improved water, but around 20% reported losing access to electricity, and 30% to improved water. Along similar lines, about 14% of households in Ethiopia reported accessing childcare services, as did 8% of households in Zimbabwe. Yet in both countries, a higher share of households (23% and 35% respectively) reported the loss of childcare services. This also requires follow-up research.

Third, we found some expected connections between training, access to infrastructure and equipment, and time use, but also other results that showed the opposite relationship. The association with reduced hours or reduced inequality is not straightforward. In households which acquired water-transport equipment (e.g. wheelbarrows), fuel-efficient stoves, access to childcare and/or electricity, men did either the same amount or more care in 2015 than they had done in 2014. In other words, inequality in care hours was likely to decline. But in households that acquired a solar energy system, flask for fluid/food and access to an improved water source, men were likely to spend the same amount or less time on care in 2015 than they had in 2014. It will be important to understand better these seemingly paradoxical effects. Training was widespread and appears to have had several positive results – in terms of a reduction of care hours for women and for men.

Comparing change in time also raises an important methodological consideration. Respondents may have reported time spent on care more accurately in 2015 than in 2014, as they became more aware of time spent on care as work following the baseline survey and subsequent programme activity focused on gendered norms around care. Again, further work will be needed to understand better how time-use reporting fluctuates over time, and how awareness of care as work may influence how people spend (and report spending) their time.

In short, project outcomes relating to shifting norms around care appear to have been partially achieved. Efforts to change gendered roles in the project areas in Zimbabwe were more successful at increasing men's participation in care work than were the activities in the Ethiopian communities. We have suggested various reasons why this might have been the case, but also that follow-up qualitative research will be important to interpret the results.

Kitabe Terfe, 25,Oromia region, Ethiopia. Kitabe's has four children and her second harvest of onion seed will be ready to harvest in three months. She says: "I did realise the difference between the hours men worked and the hours women worked. We thought this was natural – we thought it was what everyone was doing. Now with training and conversations we know we can change. I never considered that holding a baby was a job". Photo: Abbie Trayler-Smith/Oxfam

6. CONCLUSIONS

Summing up both the 2015 HCS and the panel analysis for Ethiopia and for Zimbabwe, our results show – consistent with baseline findings – that across the five countries, women spent

more time than men on care as a primary activity, as a primary or secondary activity, and on any care responsibility. Women also spent more hours than men on total work, while spending less time on leisure and personal care.

Our findings on the association between recognition of care work and inequality in time spent on care are not conclusive. On one hand, in households in which care was more valued, the distribution of care hours between women and men was more equal. But in households where men perceived care as requiring greater skill, the distribution was less equal. More work is needed on what constitutes the most appropriate measure of 'recognition', and on why men believe care work to require specific skills.

Similarly, findings on women's decision-making power are not consistent – and counterintuitively, some models suggested that in households in which women took more decisions, care work may be more unequally distributed and women may be spending more time on care. Also, there was no association between any of the women's decision-making ability and the distribution of care hours between boys and girls. Again, follow-up research is needed to understand better these relationships, particularly given that half of the women who reported that they would like men to do more care work had not asked them to do so.

Access to electricity was associated with a reduction in women's care hours. However, no association was found between any other services (e.g. improved water, healthcare and childcare facilities) and reductions in women's care hours. Our findings indicate a negative association between households' access to some equipment (e.g. stove, water tap on the compound) and reduced care hours for women. This may be because households with heavier care workloads sought to obtain more equipment and to redistribute their care energies elsewhere. On the other hand, it is also possible that men undertake some care tasks only when certain equipment is available, as in Ethiopia, where men engaged in water collection once a tap was available on their compound.

We found significant association between participation in Oxfam's norms-related projects and two outcomes: men's relative autonomy in carrying out care, and household-level disapproval of a vignette that describes a couple where the man is engaged in paid work while the woman does all the care work. Both factors, in turn, were associated with a more equal distribution of care work.

The panel analysis contributed additional richness to this study in revealing contrasting situations in Ethiopia and Zimbabwe one year after the introduction of programme activities. In Ethiopia, women were carrying out less care work (but inequality in time spent on care had increased), while in Zimbabwe, men were carrying out more care and inequality was lower. Moreover, having had access to certain types of equipment or services in 2014 – or having acquired equipment or service provision in the course of the year – had some positive and some negative effects on time use. However, participation in training, independent of equipment access, appeared to have positive effects in terms of a reduction of care hours for women and for men. Here too, more research will be needed to understand why time-use patterns followed different trajectories in the two countries, and why access to different types of equipment and services had such mixed effects.

In short, the project objectives were partially achieved within a one-year period. In some contexts, there is evidence connecting WE-Care programme activity to reductions in women's care loads and a redistribution of time spent on care. But this project has also served to outline numerous areas in which more research is required to understand the diverse patterns of care work and the division of care responsibility between men and women, and girls and boys. Understanding the dynamics between perceptions of care, norms about gender roles, access to services, and time- and labour-saving equipment is critical to make future programme work even more effective. More work could be done to probe the effects of high levels of migrations on the time use of 'left-behind' households and on any trade-offs between paid and unpaid work and equipment acquisition, and for children, between work and schooling. Similarly, the significant differences in these patterns across the samples from the five countries demonstrate the importance of context-specific evidence in order for strategies and interventions to address the factors most critical to reduce care workloads, and to achieve quality and equitable care provision in each community.

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ANNEX 1: THE 2015 HOUSEHOLD CARE SURVEY

http://oxf.am/ZuWs

ANNEX 2: THE DATA COLLECTION PROCESS AND SURVEY DETAILS

This Annex gives an overview of the data collection process for the 2015 Household Care Survey (HCS) system and details of how the survey was carried out in each of the five countries.

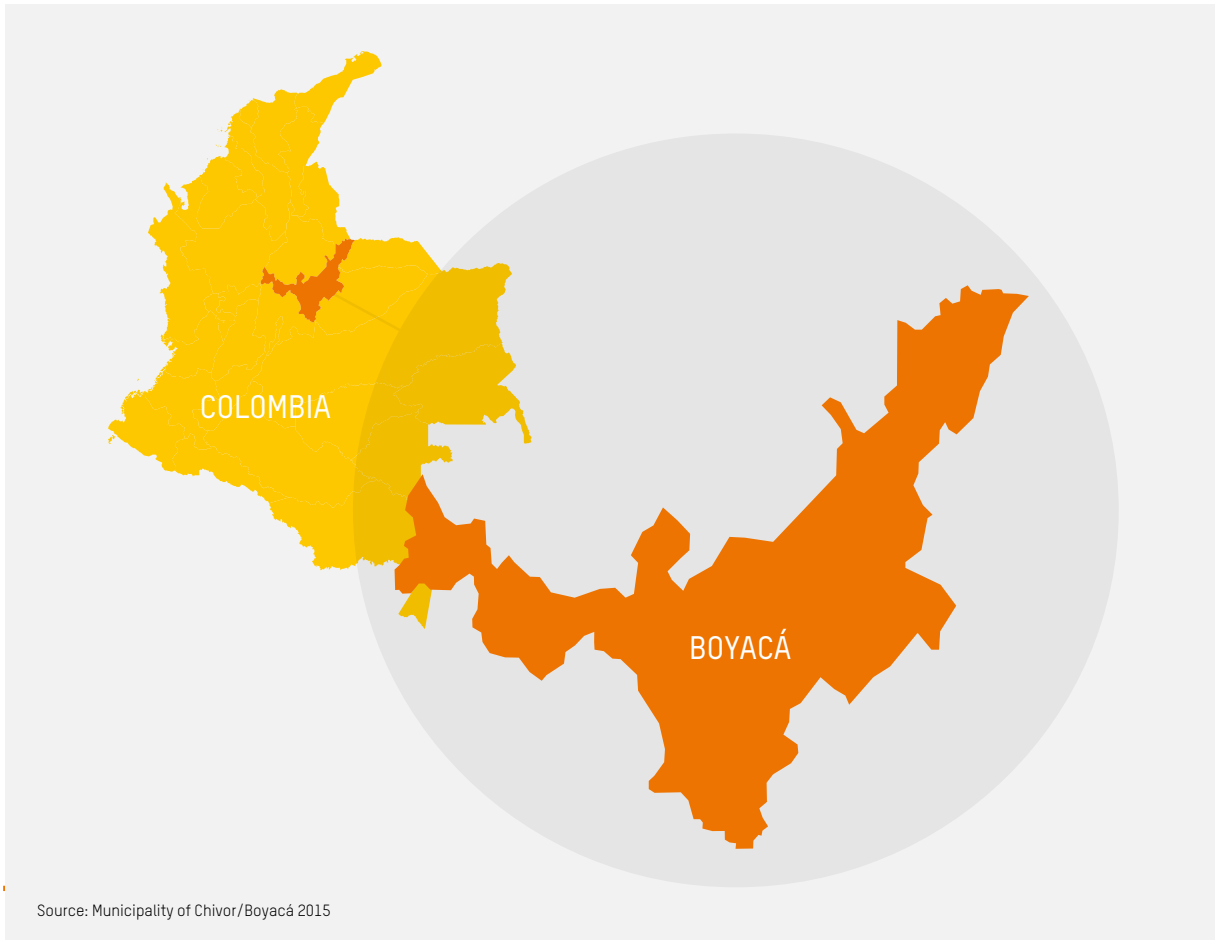
The 2015 HCS was administered using a digital data collection system, namely software called Survey CTO, which was installed on Android phones and tablets and allowed the daily uploading of collected data onto a server. Country teams reported that using the digital data collection system reduced the average data collection time per survey and reduced data entry errors. That said, the learning curve on using the digital data collection system was steeper in some countries than in others.

Each country team had two guidance documents developed by Oxfam to support the implementation of the HCS survey: General Guidance and Guidance for Training of Enumerators. The General Guidance contained information about the framework and rationale for the survey, as well as advice regarding sampling and piloting. The Guidance for Training Enumerators explained how and why to ask each question in the questionnaire – including ethical considerations. Other guidance documents addressed how to deal with sensitive questions, such as those relating to gender-based violence.

Colombia

The Colombia survey was conducted by Oxfam's contractor Isegoría in 14 municipalities in Boyacá community. Oxfam's partner organizations involved in project activities include ANMUCIC (Asociación Nacional de Mujeres Campesinas e Indígenas de Colombia) and FSI (Fundación San Isidro).

Figure 16 Boyacá department, Colombia



Source: Municipality of Chivor/Boyacá 2015

The survey was tested in a pilot survey conducted in the municipalities of Tuta and Sotaquirá, specifically in the settlements of El Hato and Cortadera Chiquita in Boyacá. The sampling frame for the full survey, provided by Oxfam, consisted of female participants and non-participants in Oxfam's WE-Care programme, across 14 municipalities in Boyacá. A total of 145 respondents (85 women and 60 men) were surveyed in 85 households. The main survey took place between 18 November and 18 December 2015.

Because the 2014 HCS identified a high percentage of female household heads who were actively participating in programme activities, it was decided to include these women in the 2015 sample. As a result, the sample of 85 women included 25 single women.

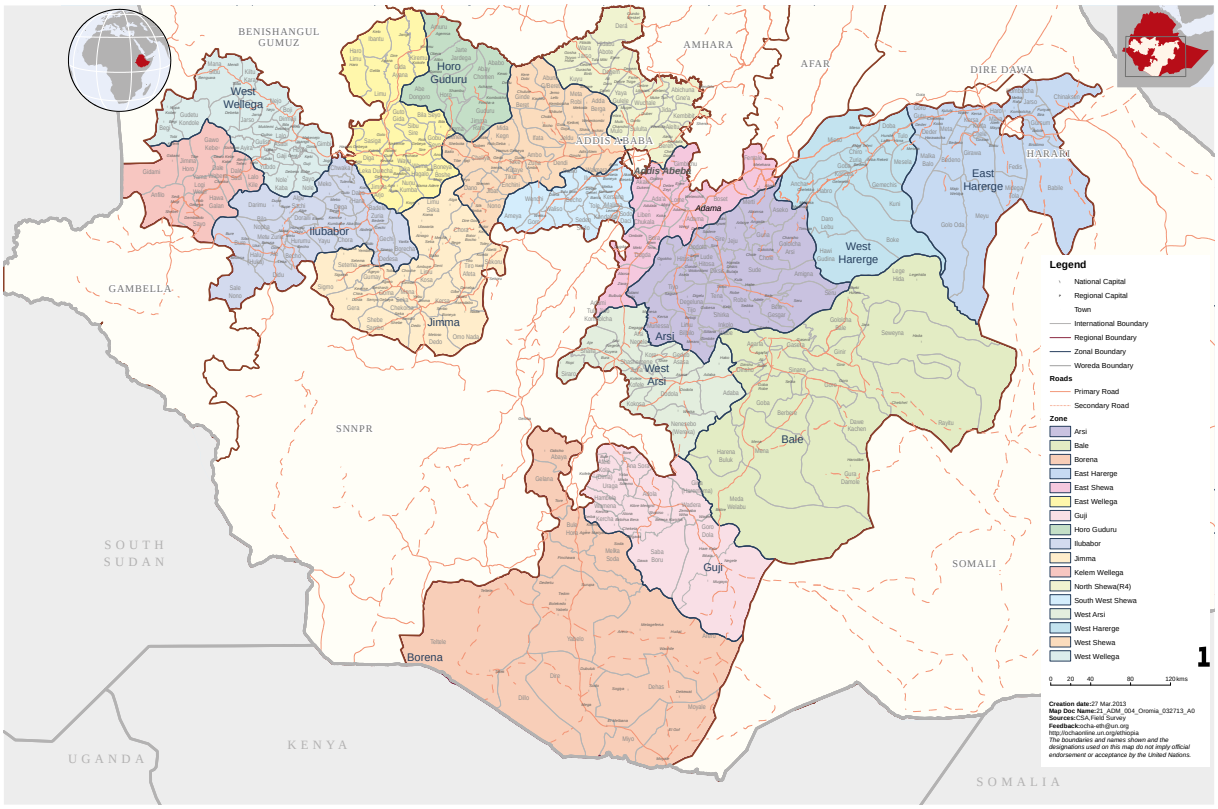
While it was not possible to track down every single household from 2014, 60 of the households surveyed in 2015 (71%) were the same as in 2014.

The use of digital data collection reduced data collection time by 20 minutes per survey. Moreover, enumerators were comfortable with the technology and reported more efficient data collection, given the ability it afforded them to manage the survey.

Ethiopia

The Ethiopia survey was conducted by Oxfam's contractor Praxis Consulting PLC in three districts of Adami-Tulu: (1) Judo-Kombolcha, (2) Arsi Negele and (3) Kofele. In Judo-Kombolcha district, three project intervention kebelles (neighbourhood associations) and one control group kebelle were surveyed. In the second district, Arsi Negele, three intervention kebelles were surveyed, while in the third district, Kofele, two project intervention kebelles were surveyed. The baseline HCS employed a proportional sample allocation.

Figure 17 Map of Oromia region, Ethiopia



The second round of the survey was administered between 8–16 December 2015, with efforts made to survey the same individuals as in the 2014 HCS. Of the 240 households interviewed in 2015, 84% (n=201 households) were the same as in 2014. The migration of households, particularly owing to El Niño-induced drought, created challenges in tracking baseline households.

The Philippines

In the Philippines, Oxfam's local partner, Al Mujadilah Development Foundation (AMDF), administered the survey. The data were collected within three municipalities in the Lanao del Sur province, Island of Mindanao, which is more than 1,200km from the capital, Manila. According to the national statistics authority, the province has one of the highest poverty rates (68.9%) in the country (PSA 2012).

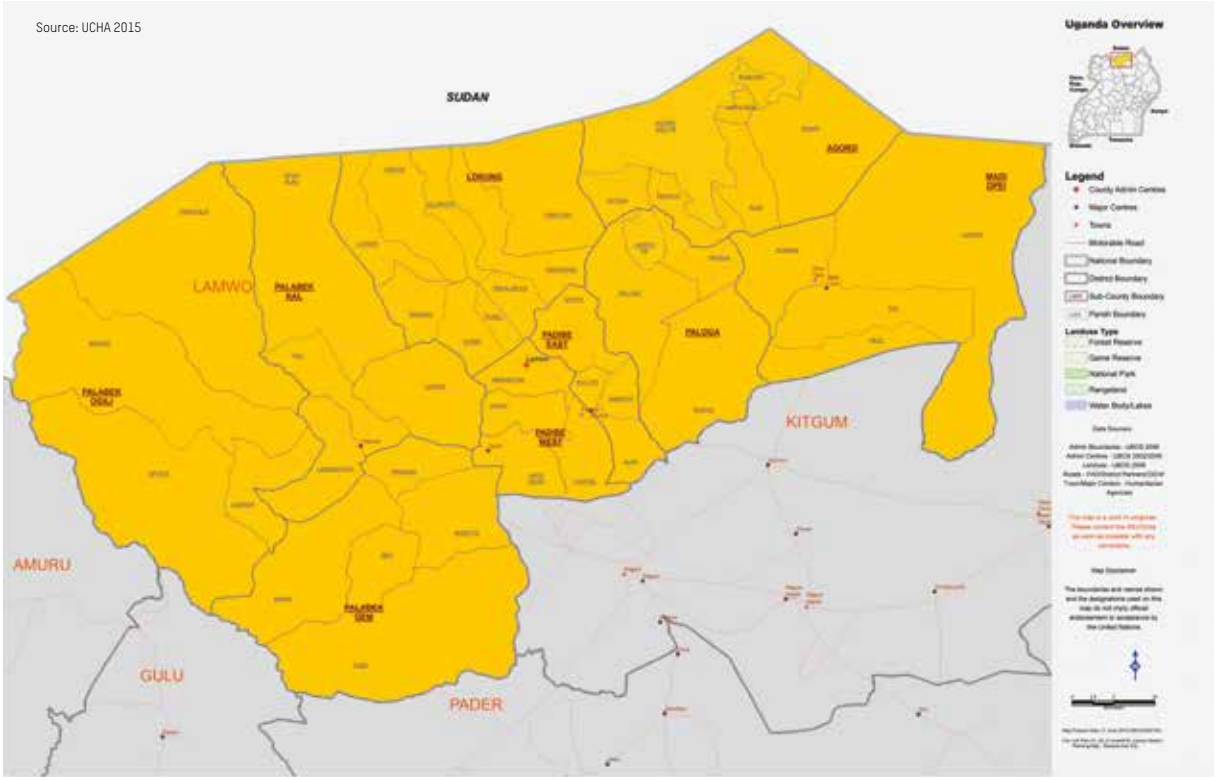
Figure 18 Map of Lanao del Sur, the Philippines

Of the 225 households interviewed in 2015, 86% (n=194) were the same as in 2014. Unlike Colombia, where surveying single-women households was part of the research design, in the Philippines the sizeable share of female-headed households (25% of the sample) resulted from the absence of men owing to illness or migration.

Uganda

In Uganda, WE-Care activities are integrated into a women's leadership 'host programme' in Lamwo district in the Acholi sub-region in Northern Uganda. The survey was carried out in three sub-counties where the programme has been active (Padibe East, Palabek Ogili, Lokung) and in three control sub-counties (Padibe West, Palabek Kal, Palabek Gem).

Figure 19 Map of Lamwo district, Uganda

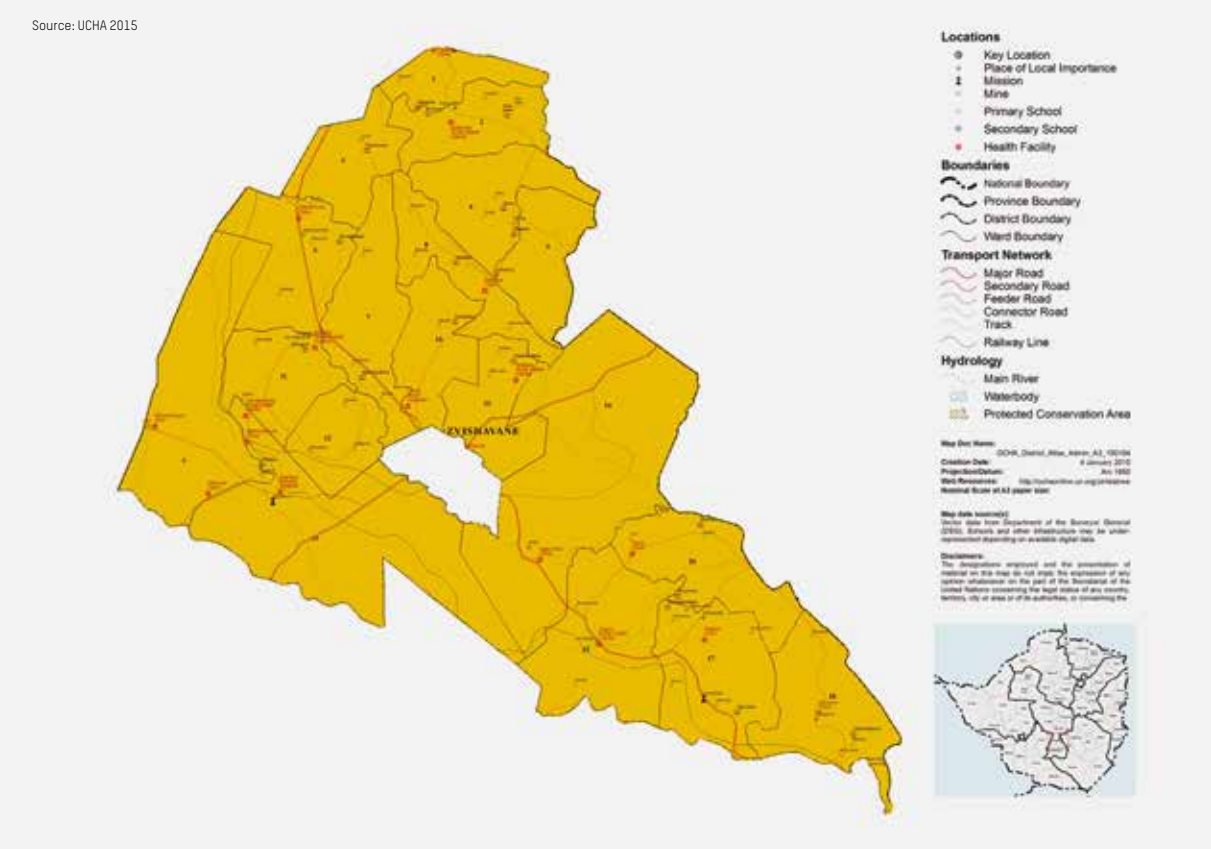


Out of 369 households surveyed in 2015, only 76 (21%) were the same as in 2014. The seasonal migration of families was a significant challenge to tracking the baseline households in Uganda.

Zimbabwe

Oxfam contractor Innovative Minds consultants carried out the survey in Ward 11 (also known as Ture) in the Zvishavane district of Zimbabwe. In implementing its projects, Oxfam partnered with three local CSOs: Umzingwane AIDS Network (UAN), targeting Umzingwane district in Matabeleland South, Bekezela Home Based Care in Bubi district in Matabeleland North, and Bethany Trust in Zvishavane district in the Midlands province.

Figure 20 Map of Zvishavane district, Zimbabwe



The survey was conducted between October and November 2015, with actual data collection taking place between 9–23 November. It aimed to reach a total of 400 respondents from 200 households who had participated in the 2014 HCS. To compensate for migration or other possible causes of attrition, enumerators conducted additional surveys in each village. As a result, the eventual 2015 sample consisted of 408 respondents from 204 households. Of these, 173 (85%) were resurveyed households and 31 (15%) were new households.

Enumerators did not identify any specific challenges in the data collection process and reported that most respondents were enthusiastic about participating in the survey. This level of enthusiasm had not been apparent at the baseline, and the difference was attributed to the interest generated by the project, namely through the distribution of wheelbarrows, solar energy systems and fuel-efficient stoves.

ANNEX 3: VARIABLES USED IN THE ANALYSIS AND DETAILS ON METHODOLOGY

This annex describes the variables that we constructed to analyse the data from the 2015 Household Care Survey (HCS) (Annex 1).

(i) Amount of care: adults and youth

The survey asked women and men in each household to report their main activity during each hour of the previous day. Respondents were asked about primary and secondary activities, and any responsibility for supervising children or dependent adults. On the basis of this information, we constructed the following variables:

Number of hours spent on care as a primary and secondary activity by adults (calculated separately for women and men): The number of hours that women and men reported being engaged in care as either a primary or a secondary activity. To avoid duplication, in cases where respondents indicated having conducted the same primary and secondary activity within an hour, that activity was counted as one hour.

Number of hours spent on care work by children (calculated separately for girls and boys): In each household, women were asked to report how many hours each additional household member had spent on certain activities in the past 24 hours – a tested methodology for collecting information on children's time use. These variables – averaged across all girls and separately across all boys within a household – indicated the number of hours spent by girls and by boys in the household, respectively.

(ii) Redistribution of care hours

Equality of hours spent on care between males and females (calculated separately for adults and children at household level).
The ratio of care hours spent by men (and boys) to those spent by women (and girls). A ratio below 1 indicates that men spent fewer hours than women did, and vice versa. Because the resulting variable exhibited a very skewed distribution, we used a log transformation (though this did not eliminate the problem).

(iii) Recognition of care work

Perceptions of value of care work, perceptions of skill involved in care work (calculated separately for women and men).
The survey asked women and men to rank 12 activities from most to least valuable, and those same activities from most to least skilled. We calculated the sum of the respective rankings of the value and of the significance of six care-related activities: meal preparation; cleaning the house or compound; caring for children; caring for the elderly, ill or disabled; fuel or water collection; and washing, ironing, mending clothes. Each measure took a value from 21 to 57, with **lower** scores indicating greater recognition of care work by the respondent.

Perceptions of relative value of care work, perceptions of relative skill involved in care work (calculated separately for women and men).
Additionally, we constructed measures of the relative value and the relative skill of care work by calculating the ratio of the value/(skill) of care work to the value/(skill) of the six 'productive'[94] activities that were listed. Again, lower scores indicated relatively greater recognition of care work by the respondent.

Perceptions of most significant contributor to household well-being (calculated at the household level).
The survey asked both women and men in our sample, *'Who in your household do you think generally makes the most significant contribution to the well-being of the household?'*. We interpreted responses of 'wife' or 'another woman in the household' as suggestive of greater recognition of care work. To construct this variable, we created a score combining the responses of the man and the woman in each household in the following way: 1=neither man nor woman recognizes woman's contribution; 2=either man or woman recognizes woman's contribution; 3=both man and woman recognize woman's contribution. In other words, household-level recognition of woman's contribution ranges from 1 (the lowest level of recognition) to 3 (the highest level of recognition).

Most problematic domestic activity (calculated at the household level).
The survey asked both women and men, *'Which domestic work or care activity is most problematic for your family (in terms of mobility, health, and time burden)?'*. We interpreted the naming of at least one care activity in response to this question as suggesting recognition of the problematic nature of domestic work. At a household level, we constructed a scale that took values from 1 to 3, with the following categories: 1=neither man nor woman recognizes problematic nature of care work; 2=either man or woman recognizes the problematic nature of care work; 3=both man and woman recognize the problematic nature of care work.

(iv) Women's decision-making ability and influence

Women's average decision-making ability, women's total decision-making ability (calculated for women only).
We adapted measures of women's decision-making ability from the Demographic Health Survey (Kishor and Subaiya 2008) and related research on agency (Ibrahim and Alkire 2007). The survey asked women whether they had a say in household-level decision-making in 10 areas (Questions 601 and 602 in survey). We calculated mean (and total) decision-making ability across these items, constructing two main scales: (1) decision making (who normally makes decisions in the household); and (2) decision-making and influencing (who normally makes decisions, and could women take decisions if they wanted to). The logic for computing both a mean and total score is that the mean score can be computed for all women, even if they answer the question for fewer than 10 items (some women had indicated that certain items in the survey did not apply to them); whereas a total score could be computed only for women who responded to all 10 items.

(1) Women's decision making (calculated for women only)
To construct the decision-making scales, we recoded eight out of 10 items in a binary manner: '1' if a woman is involved in decision making (either alone, or together with someone) and '0' if woman is not involved in decision making. We recoded the two remaining items (i.e. decisions over a woman's own health and when to go to the doctor; and decisions over how to spend her own time) following a different logic, because we judged that having decision-making ability required the woman herself to take these decisions. Accordingly, we coded each of these items '1' if woman takes the decision alone and '0' if not. The mean decision-making scale ranged from 0 to 1 – with 1 indicating the most decision-making ability.

(2) Women's decision making and influencing (calculated for women only)
To construct this scale, we recoded each of the 10 items in the following way:

0 = Woman is not involved and cannot influence
1 = Involved, but no influence
2 = Not involved, but can influence
3 = Involved and can influence

The mean decision making and influencing scale ranges from 0 (i.e. a woman is not involved and cannot influence decisions on any of the 10 items) to 3 (i.e. a woman is involved and can influence decisions on all 10 items). The scale ranged from 0 to 30, with higher levels indicating more decision making and influence.

(v) Relative autonomy index

We computed a measure of autonomy in carrying out care work that is based loosely on the relative autonomy index (RAI) that has been applied to measure individuals' autonomous motivation (Alkire 2005, Alkire et al. 2013). It consists of three sub-scales: external, introjected and autonomous motivation. RAI is the weighted sum of the person's scores in these three subscales. The scale ranges between -18 and +18. Positive scores indicate that an individual's motivation for his or her behaviour in a specific domain tends to be relatively autonomous; negatives scores indicate a relatively controlled motivation.

(vi) Data analysis

(i) Bivariate analyses

To test whether differences among women and men are statistically significant along a range of variables, we ran paired-sample T-tests on those households in which both a woman and a man were surveyed. Similarly, to test whether differences among girls and boys were statistically significant, the paired-sample T-test was also applied, but only to those households with a boy-girl pair (i.e. excluding households which have only boys or only girls).

(ii) Multiple regression analyses

The data were collected within households which in turn were located within communities in the five countries. But although the structure is hierarchical, observations are nested within only five countries. Given Hox's 30/30 rule (Hox 2010), this number of levels is insufficient for multilevel analyses. Accordingly, we conduct single level multiple regression analyses that pool the data across all the communities that were surveyed, and apply country fixed effects and country-clustered robust standard errors. The use of fixed effects models accounts for average differences across countries (i.e. coefficients account for all possible cross-country differences), while country-clustered robust standard errors account for the possible correlation of observations within countries.

One issue that we encountered requires particular acknowledgment. To account for the non-normal distribution of the time-use variables, we transformed the dependent variables (i.e. ratio of men/women hours on care as a primary activity, and ratio of men/women hours on any care responsibility) using natural log transformation. However, even after the log transformation, residuals are non-normally distributed (as demonstrated through the Shapiro-Wilk test for normal data and Skewness/Kurtosis tests for Normality) – which violates one of the regression assumptions. In other words, our models are highly susceptible to estimation bias, and, therefore, results of multiple regression analyses are to be interpreted with great caution. Along similar lines, the distribution of some of the binary variables in the analysis was highly uneven – e.g. when the ratio of male to female care was coded in binary fashion. As a result, the risk of bias estimates increased substantially and we refrained from using binary outcomes in final regression models.

ANNEX 4 TABLES OF DESCRIPTIVE STATISTICS

Table 1 Demographic characteristics of survey respondents in the five communities [Table 1 in online Annex]

	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Number of households	85		240		225		369		204		1,123	
Sample												
Resurveyed household	60	71%	201	84%	194	86%	76	21%	173	85%	704	63%
Reserve list-household	0	0%	5	2%	6	3%	33	9%	4	2%	48	4%
New household	25	29%	34	14%	25	11%	259	70%	27	13%	370	33%
Gender												
Female	85	61%	240	50%	225	57%	369	50%	204	50%	1,123	52%
Male	54	39%	240	50%	169	43%	369	50%	204	50%	1,036	48%
Total	139	100%	480	100%	394	100%	738	100%	408	100%	2,159	100%
Sample												
Households with women only	31	36%	0	0%	56	25%	0	0%	0	0%	87	8%
Households with both women and men	54	64%	240	100%	169	75%	369	100%	204	100%	1,036	92%
Total	85	100%	240	100%	225	100%	369	100%	204	100%	1,123	100%
Number of family members												
Mean (SD)	3.7 (1.4)		7 (2.3)		7 (3)		6 (2.7)		5 (1.9)		6.3 (2.7)	
Min-Max	1 - 8		2 - 13		2 - 17		2 - 17		2 - 10		1 - 17	
Households with children age<=6												
No child age<=6	67	79%	43	18%	69	31%	77	21%	57	28%	313	28%
Has child age<=6	18	21%	197	82%	156	69%	292	79%	147	72%	810	72%
Number of children age<=6/per household												
Mean (SD)	1.1 (0.2)		2.1 (1)		2.1 (1.1)		2(1)		1.4 (0.6)		1.96 (1)	
Min-Max	1-2		1-5		1-7		1-7		1-5		1-7	

Table 2 Time use of adult women and men [Table 2 in online Annex]

TIME ALLOCATION	COLOMBIA			ETHIOPIA			PHILIPPINES			UGANDA			ZIMBABWE			TOTAL		
	Mean F	*Mean M*	*T-test*	*Mean F*	*Mean M*	*T-test*	*Mean F*	*Mean M*	*T-test*	*Mean F*	*Mean M*	*T-test*	*Mean F*	*Mean M*	*T-test*	*Mean F*	*Mean M*	T-test
Care work as primary activity	4.93	1.17	**7.74*** **	6.45	0.29	**31.93*** **	6.58	1.04	**22.77*** **	4.12	1.15	**20.13*** **	5.75	1.44	**16.53*** **	5.42	0.99	**41.89*** **
Leisure as primary activity	4.00	4.78	**-2.15***	5.13	6.47	**-6.33*** **	4.62	5.78	**-4.11*** **	3.66	5.57	**-10.14*** **	5.66	6.83	**-3.79*** **	4.57	6.02	**-12.64*** **
Sleep as primary activity	7.35	8.31	**-2.64****	8.17	7.58	**3.46*** **	7.83	7.75	0.5	9.85	9.36	**3.61*** **	9.03	8.77	1.3	8.84	8.51	**4.01*** **
Care work as primary or secondary activity	6.07	1.46	**8.44*** **	9.03	0.72	**27.92*** **	8.46	1.5	**23.8*** **	5.14	1.56	**21.2*** **	7.35	1.87	**15.77*** **	7.06	1.41	**40.54*** **
Any care responsibility (includes care as primary, care as secondary, supervision: child, and supervision: adult)	15.87	8.74	**5.66*** **	15.22	2.9	**22.38*** **	16.41	3.04	**23.12*** **	13.06	6.02	**19.06*** **	10.84	2.75	**17.07*** **	13.82	4.31	**38.14*** **
Productive / paid work (as primary)	5.74	7.87	**-3.01****	2.92	6.83	**-13.86*** **	1.6	5.92	**-12.34*** **	5.6	6.27	**-2.89****	2.44	5.94	**-10.88*** **	3.71	6.36	**-17.87*** **
Total work (includes productive work and care)	10.67	9.04	**2.81****	9.37	7.12	**7.7*** **	8.18	6.96	**3.74*** **	9.72	7.42	**10.34*** **	8.19	7.38	**2.34***	9.14	7.35	**12.74*** **
Leisure, personal care (as either primary or secondary)	4.98	5.67	-1.93	20.89	21.08	-0.47	7.1	8.27	**-2.77****	16.53	17.81	**-5.99*** **	19.77	21.51	**-3.94*** **	16.04	17.11	**-6.45*** **
Hours in which at least two care activities (includes care as primary, care as secondary, supervision: child, and supervision: adult)	5.93	1.87	**5.21*** **	7.26	0.66	**16.09*** **	8.95	1.33	**19.48*** **	4.53	1.5	**16.21*** **	5.06	0.81	**11.69*** **	6.06	1.16	**29.64*** **
	F Col %	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*
In the past 24 hours, have you been responsible for looking after a child (<18 years old)			3.01			**41.34*** **			**84.18*** **			**33.46*** **			**70.97*** **			**205*** **
No	28.3	44.4		13.8	39.7		16.6	65.7		24.9	45.3		27	68.6		21.5	51.9	
Yes	71.7	55.6		86.3	60.3		83.4	34.3		75.1	54.7		73	31.4		78.5	48.1	
In the past 24 hours, have you been responsible for looking after a dependent adult			0.13			**9.14****			**8.77***			1.29			0.54			**4.51***
No	94.3	92.6		87.1	95		84	94.1		89.4	86.7		91.2	93.1		88.6	91.4	
Yes	5.7	7.4		12.9	5		16	5.9		10.6	13.3		8.8	6.9		11.4	8.6	
Is there any activity that you did not do yesterday but that you usually do?			2.09			**9.97****			**3.99***			**4.32***			0.36			0.75
No	45.3	59.3		71.7	83.7		63.9	74		60.2	52.6		58.8	55.9		62.4	64.3	
Yes	54.7	40.7		28.3	16.3		36.1	26		39.8	47.4		41.2	44.1		37.6	35.7	
Is there any activity that you did yesterday but that you usually do not do?			1.57			0.96			2.74			1.77			0.01			0.18
No	49.1	61.1		93.3	95.4		72.2	79.9		71.5	66.9		75.5	76		76.3	77.1	
Yes	50.9	38.9		6.7	4.6		27.8	20.1		28.5	33.1		24.5	24		23.7	22.9	

*** p<0.001, ** p<0.01, * p<0.05. **Boldface** type indicates statistically significant results.
Note: Table shows results of **paired-sample t-test.** This test runs only for paired samples, and automatically excludes observations (i.e. households) where no woman-man pair is available (i.e. no men were interviewed for this household).

Table 3a Value and skills attributed to 12 types of care tasks (6) and productive tasks (6) [Table 3a in online Annex]

PERCEPTION OF TYPES OF WORK	COLUMBIA			ETHIOPIA			PHILIPPINES			UGANDA			ZIMBABWE			TOTAL		
	Mean F	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*
ABSOLUTE MEASURES																		
Value																		
How valuable is meal preparation?	3.02	4.58	**-2.91****	2.74	5.58	**-10.65*****	2.83	6.5	**-12.69*****	4.3	6.06	**-7.73*****	3.81	5.96	**-6.48*****	3.53	5.92	**-17.76*****
How valuable is planting/harvesting crops?	6.72	4.98	**3.27****	4.86	3.82	**4.95*****	6.12	4.79	**4.43*****	5.53	4.89	**2.79****	5.95	5.29	1.96	5.61	4.71	**7.03*****
How valuable is cleaning house or compound?	3.81	5.77	**-3.7*****	6.24	8.44	**-8.74*****	4.8	7.33	**-8.25*****	5.63	5.95	-1.47	6.04	7.16	**-3.68*****	5.62	6.98	**-10.33*****
How valuable is drying/processing an agricultural product?	6.62	6.08	1.01	6.36	5.62	**3.29****	6.56	5.75	**2.45***	5.46	5.52	-0.26	6.59	6.61	-0.06	6.13	5.82	**2.4***
How valuable is caring for children?	4.17	4.94	-1.36	4.79	5.59	**-3.59*****	5.07	7.12	**-6.31*****	4.33	3.89	**2.13***	4.55	4.78	-0.81	4.59	5.04	**-3.61*****
How valuable is carpentry/making furniture?	10.43	8.42	**3.85*****	9.26	7.32	**8.6*****	9.35	6.58	**8.68*****	9.72	9.42	1.56	8.73	7.78	**3.11****	9.39	8.1	**10.57*****
How valuable is caring for elderly, ill, disabled?	8.11	8.91	-1.41	10.11	9.78	1.65	8.09	8.37	-1.03	7.18	6.49	**3.11****	5.99	5.95	0.16	7.82	7.57	**2.05***
How valuable is house construction/repair?	9.85	7.57	**3.9*****	6.02	4.56	**5.48*****	8.82	5.9	**8.72*****	8.18	7.62	**2.42***	7.45	6.11	**4.13*****	7.72	6.33	**10.07*****
How valuable is fuel or water collection?	7.13	7.08	0.11	8	9.04	**-4.27*****	7.19	6.34	**2.49***	6.85	7.54	**-3.02****	6.27	6.03	0.86	7.07	7.37	**-2.28***
How valuable is selling products/trading?	6.91	6.55	0.62	8.4	7	**5.23*****	5.83	5.95	**-0.32**	7.51	7.66	-0.67	7.87	7.98	-0.38	7.48	7.23	1.91
How valuable is taking care of farm animals?	5.83	5.06	1.6	3.72	2.26	**6.76*****	8.21	4.94	**9.26*****	6.05	4.94	**4.97*****	7.64	5.8	**5.76*****	6.17	4.5	**12.72*****
How valuable is washing, ironing, mending clothes?	5.4	8.08	**-5.35*****	7.5	9	**-6.05*****	5.13	8.43	**-11.86*****	7.29	7.99	**-3.42*****	7.1	8.56	**-4.97*****	6.85	8.41	**-12.56*****
Perception of skills required for tasks																		
How much skill needed for meal preparation?	4.74	5.72	-1.44	5.16	6.06	**-2.84****	5.02	6.26	**-3.65*****	5.79	7.28	**-6.95*****	6.78	7.61	**-2.42***	5.66	6.82	**-8.15*****
How much skill needed for planting/harvesting crops?	5.4	5.38	0.04	5.01	4.82	0.85	5.3	5.14	0.47	5.16	4.9	1.23	5.7	6.05	-0.96	5.26	5.17	0.72
How much skill needed for cleaning house or compound?	5.08	6.68	**-2.74****	8.77	9.02	-1.17	7.7	8.05	-1.17	7.93	8.39	**-2.22***	7.54	7.77	-0.8	7.86	8.27	**-3.39*****
How much skill needed for drying/processing an agricultural product?	6.11	5.08	1.71	6.83	6.1	**3.39*****	5.31	5.7	-1.23	5.08	5.03	0.27	6.24	6.55	-1.06	5.81	5.69	0.95
How much skill needed for caring for children?	5.08	5.36	-0.4	4.6	4.97	-1.55	7.68	7.37	0.97	5.68	5.3	1.74	5.09	5.36	-0.93	5.61	5.57	0.28
How much skill needed for carpentry/making furniture?	9.58	7.58	**3.52*****	6.09	6.09	0	5.96	4.78	**3.89*****	6.38	5.82	**2.27***	6.21	5.54	**2.28***	6.38	5.75	**4.58*****
How much skill needed for caring for elderly, ill, disabled?	8.43	8.04	0.58	9.07	8.97	0.45	7.76	8.5	**-2.43***	7.36	7.04	1.59	5.35	5.57	-0.73	7.48	7.49	-0.04
How much skill needed for house construction/repair?	8.36	5.98	**4.31*****	3.37	3.24	0.62	6.43	3.96	**7.73*****	6.08	5.05	**4.53*****	5.51	4.38	**3.56*****	5.52	4.37	**8.78*****
How much skill needed for fuel or water collection?	6.75	7.13	-0.63	9.74	9.05	**3.42*****	8.47	8.55	-0.28	8.19	8.74	**-2.72****	7.05	6.86	0.7	8.3	8.32	-0.24
How much skill needed for selling products/trading?	6.55	6.23	0.54	6.91	6.87	0.13	3.54	4.63	**-3.62*****	6.61	6.48	0.6	7.26	7.43	-0.64	6.3	6.44	-1.12
How much skill needed for taking care of farm animals?	5.55	5.87	-0.51	3.46	3.41	0.19	6.43	6.21	0.65	5.75	5.47	1.38	6.99	6.14	**2.8****	5.56	5.27	**2.38***
How much skill needed for washing, ironing, mending clothes?	6.38	8.96	**-4.12*****	8.99	9.39	-1.92	8.4	8.86	-1.63	7.98	8.51	**-2.94****	8.27	8.74	-1.91	8.26	8.84	**-5.29*****
Combined value of care work	31.06	39.52	**-6.21*****	39.38	47.22	**-13.31*****	33.11	44.1	**-14.4*****	35.51	37.96	**-4.63*****	33.77	38.43	**-6.73*****	35.44	41.28	**-18.25*****
Combined skills of care work	35.78	41.93	**-3.75*****	46.32	47.27	-1.69	45.03	47.58	**-3.3****	42.93	45.25	**-4.66*****	40.09	41.9	**-2.37***	43.13	45.27	**-6.94*****
RELATIVE MEASURES																		
Value of care work relative to paid work	0.71	1.1	**-6.04*****	1.09	1.66	**-14.31*****	0.8	1.44	**-13.05*****	0.9	1.03	**-4.53*****	0.81	1.05	**-6.65*****	0.9	1.25	**-18.58*****
Skills of care work relative to paid work	0.93	1.26	**-3.67*****	1.53	1.66	**-2.81****	1.52	1.68	**-2.69****	1.37	1.51	**-3.89*****	1.17	1.27	**-2.16***	1.37	1.51	**-6.5*****
	F Col %	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*	*F Col %*	*M Col %*	*Pearson chi2*
Which domestic work or care activity is most problematic for your family																		
None	37.7	51.9	6.65	2.5	16.3	**79.18*****	4.7	3.6	**15.86***	5.1	6	**20.17****	12.3	11.8	1.76	7.5	11.5	**40.37*****
Water collection	3.8	3.7		3.3	5		3.6	3.6		14.9	10.8		17.6	19.1		10.3	9.6	
Fuel collection	7.5	7.4		17.1	14.6		11.2	16.6		22.5	14.4		44.6	46.6		23	20.8	
Meal preparation	7.5	7.4		48.8	34.3		11.8	11.8		7.3	5.7		4.4	4.4		17.1	13.1	
Cleaning the house or compound	22.6	9.3		0	2.1		8.9	10.1		0.8	0.3		1.5	1.5		3.2	3	
Washing, mending, ironing clothes	9.4	7.4		6.7	1.3		24.9	17.8		3.5	4.6		3.4	3.4		8	5.9	
Caring for children	5.7	11.1		20.8	13		27.2	18.9		30.1	41.5		8.8	7.8		22	23	
Caring for elderly	3.8	1.9		0.8	1.3		3.6	13		15.2	15.2		6.9	4.4		7.7	8.8	
Caring for community members	1.9	0		0	12.1		4.1	4.7		0.5	1.6		0.5	1		1.1	4.3	

*** p<0.001, ** p<0.01, * p<0.05. **Boldface** type indicates statistically significant results.
Note: Table shows results of **paired-sample t-test.** This test runs only for paired samples, and automatically excludes observations (i.e. households) where no woman-man pair is available (i.e. no men were interviewed for this household).

Table 3b Recognition of women's contribution to household and potentially problematic nature of care work [Table 3b in online Annex]

RECOGNITION	COLOMBIA		ETHIOPIA		PHILIPPINES		UGANDA		ZIMBABWE		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Who makes the most significant contribution – response by woman												
Wife or other woman in the household	35	41%	32	13%	187	83%	94	25%	99	49%	447	40%
Husband or other man in the household	7	8%	186	78%	34	15%	193	52%	80	39%	500	45%
Who makes the most significant contribution – response by man												
Wife or other woman in the household	14	22%	123	51%	144	85%	108	29%	106	52%	495	48%
Husband or other man in the household	4	6%	116	48%	22	13%	179	49%	53	26%	374	36%
Which domestic work or care activity is most problematic for your family (in terms of mobility, health and time burden)?												
Woman's and man's responses are different	69	81%	178	74%	166	74%	246	67%	127	62%	786	70%
Woman's and man's responses are identical	16	19%	62	26%	59	26%	123	33%	77	38%	337	30%
Total	85	100%	240	100%	225	100%	369	100%	204	100%	1,123	100%
Recognition of woman's contribution to the household (1)												
No recognition	0	0%	85	35%	5	2%	110	30%	32	16%	232	21%
Some recognition	35	41%	129	54%	83	37%	142	38%	67	33%	456	41%
Highest recognition	7	8%	13	5%	124	55%	30	8%	69	34%	243	22%
Recognition that domestic work can possibly be problematic (2)												
No recognition	12	14%	0	0%	2	1%	3	1%	10	5%	27	2%
Some recognition	42	49%	45	19%	13	6%	35	9%	29	14%	164	15%
Highest recognition	31	36%	195	81%	210	93%	331	90%	165	81%	932	83%
Total	85	100%	240	100%	225	100%	369	100%	204	100%	1,123	100%

Note (1): No recognition means neither man nor woman named wife or other woman in the household as making the most significant contribution to the household's well-being. Some recognition means either woman or man named wife or other woman in the household as making the most significant contribution. Highest recognition means both woman and man named wife or other woman in the household as making the most significant contribution to the household's well-being.

Note (2): No recognition means neither man nor woman named any care task as problematic for the family. Some recognition means either woman or man named at least one care task as being problematic for the family. Highest recognition means both woman and man named at least one care task as being problematic for the family.

Table 4 Women's decision making, relative autonomy, satisfaction with the division of household labour, and acceptance of violence and criticism [Table 6 in online Annex]

REPRESENTATION	COLOMBIA		ETHIOPIA		PHILIPPINES		UGANDA		ZIMBABWE		TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%
DECISION MAKING												
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Decision-making score (1)	0.9	(0.1)	0.8	(0.1)	0.8	(0.2)	0.7	(0.2)	0.8	(0.2)	0.8	(0.2)
Min-Max	0.3 - 1		0.1 - 1		0 - 1		0 - 1		0 - 1		0 - 1	
N	84		240		223		368		204		1,119	
Decision-making and influencing score (2)	1.2	(0.3)	2.1	(0.65)	1.6	(0.6)	1.7	(0.8)	2.0	(0.7)	1.8	(0.7)
Min-Max	0.5 - 2.3		0.2 - 2.9		0.3 - 2.9		0 - 2.9		0.5 - 2.9		0 - 2.9	
N	84		240		223		368		204		1,119	
Decision-making score - TOTAL	9.2	(0.98)	7.7	(1.4)	7.7	(1.8)	7.3	(2.15)	7.8	(1.0)	7.7	(1.9)
Min-Max	5 - 10		1 - 10		0 - 10		0 - 10		0 - 10		0 - 10	
N	70		234		177		272		164		917	
Decision-making and influencing score - TOTAL	12.1	(3)	21.6	(6.5)	17.3	(5.9)	18.5	(8)	19.3	(6.9)	18.7	(7.2)
Min-Max	5 - 23		2 - 29		3 - 29		0 - 29		5 - 28		0 - 29	
N	70		234		177		272		164		917	
RELATIVE AUTONOMY INDEX	3.9	(2.9)	3.6	(4.8)	3.7	(5.5)	5.2	(5.2)	6.4	(6.4)	3.6	(5.3)
Min-Max	-2 - 12		-6 - 18		-18 - 18		-8 - 18		-8 - 18		-8 - 18	
N	84		240		225		368		204		1,121	
SATISFACTION WITH DIVISION OF TASKS	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
How satisfied are you with this division of tasks?												
Unsatisfied	6	7%	20	8%	8	4%	102	28%	12	6%	148	13%
Fairly satisfied	29	35%	39	16%	11	5%	51	14%	10	5%	140	12%
Satisfied	45	54%	109	45%	108	48%	152	41%	119	58%	533	48%
Very satisfied	4	5%	72	30%	98	44%	63	17%	63	31%	300	27%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
ACCEPTABILITY OF VIOLENCE												
Accepts beating in at least one situation												
No	82	98%	194	82%	151	77%	182	50%	191	95%	800	74%
Yes	2	2%	43	18%	45	23%	185	50%	11	5%	286	26%
Total	84	100%	237	100%	196	100%	367	100%	202	100%	1,086	100%
Accepts criticism in at least one situation												
No	83	99%	184	78%	66	34%	160	44%	175	87%	668	62%
Yes	1	1%	53	22%	130	66%	207	56%	27	13%	418	38%
Total	84	100%	237	100%	196	100%	367	100%	202	100%	1,086	100%

Note 1: To calculate the **decision-making score**, all 10 items excluding item #2 and item #10 were coded "1" if woman is involved in decision making (either alone, or together with someone) and "0" if woman is not involved in decision making. Items #2 and #10 were coded "1" if woman makes decision alone, and "0" otherwise. Then mean score was calculated across all 10 items. We calculated mean to account for missing (99=not applicable) on some items. According to this score, the **least powerful woman has score 0 (she is not involved in any of the 10 items)**; the **most powerful woman has score 1 (she is involved in all 10 items)**.

Note 2: To calculate the decision-making and influencing score, we recoded all 10 items as follows:

0 = Woman is not involved and cannot influence
1 = Involved, but no influence
2 = Not involved, but can influence
3 = Involved and can influence

Then mean score was calculated across all 10 items. According to this score, the **least powerful woman has score 0 (she is not involved and cannot influence decisions on any of the 10 items); the most powerful woman has score 3 (involved and can influence decisions on all 10 items).**

Table 5 Infrastructure available to households in our sample and its source [Table 9 in online Annex]

EXTERNAL SUPPORT AND INFRASTRUCTURE	COLOMBIA		ETHIOPIA		PHILIPPINES		UGANDA		ZIMBABWE		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Do you use an improved water source (not a natural source like a river or spring)?												
No	23	27%	115	48%	57	25%	46	13%	12	6%	253	23%
Yes	61	73%	125	52%	168	75%	322	88%	192	94%	868	77%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Is it usually government-provided?												
No	37	61%	103	82%	33	20%	8	2%	18	9%	199	23%
Yes	21	34%	22	18%	127	76%	280	87%	136	71%	586	68%
I don't know	3	5%	0	0%	8	5%	33	10%	38	20%	82	9%
Total	61	100%	125	100%	168	100%	321	100%	192	100%	867	100%
Do you use electricity in your house?												
No	2	2%	142	59%	49	22%	368	100%	204	100%	765	68%
Yes	82	98%	98	41%	176	78%	0	0%	0	0%	356	32%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Is it usually government-provided?												
No	14	17%	78	80%	60	34%					152	43%
Yes	68	83%	20	20%	114	65%					202	57%
I don't know	0	0%	0	0%	2	1%					2	1%
Total	82	100%	98	100%	176	100%					356	100%
Does your family usually use health facilities when household members are ill?												
No	2	2%	9	4%	14	6%	11	3%	3	1%	39	4%
Yes	82	98%	231	96%	211	94%	345	97%	201	99%	1,070	96%
Total	84	100%	240	100%	225	100%	356	100%	204	100%	1,109	100%
Is it usually government-provided?												
No	15	18%	218	94%	0	0%	0	0%	4	2%	237	22%
Yes	67	82%	13	6%	208	99%	345	99%	191	95%	824	77%
I don't know	0	0%	0	0%	3	1%	3	1%	6	3%	12	1%
Total	82	100%	231	100%	211	100%	348	100%	201	100%	1,073	100%
Does your family usually use childcare facilities?												
No	76	90%	209	87%	182	81%	312	85%	157	77%	936	83%
Yes	8	10%	31	13%	43	19%	56	15%	47	23%	185	17%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Is it usually government provided?												
No	1	13%	12	39%	14	33%	17	30%	2	4%	46	25%
Yes	7	88%	19	61%	26	60%	29	52%	42	89%	123	66%
I don't know	0	0%	0	0%	3	7%	10	18%	3	6%	16	9%
Total	8	100%	31	100%	43	100%	56	100%	47	100%	185	100%

Table 6 Time- and labour-saving equipment available to households in our sample [Table 11 in online Annex]

TIME AND LABOUR-SAVING EQUIPMENT	COLOMBIA		ETHIOPIA		PHILIPPINES		UGANDA		ZIMBABWE		TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%
Transport for fetching water (e.g. bicycle, cart)												
No			193	80%	185	82%	215	58%	101	50%	694	67%
Yes			47	20%	40	18%	153	42%	103	50%	343	33%
Total			240	100%	225	100%	368	100%	204	100%	1,037	100%
Rainwater-harvesting system/water reservoir/storage tank												
No	19	23%	214	89%	171	76%	343	93%	189	93%	936	83%
Yes	65	77%	26	11%	54	24%	25	7%	15	7%	185	17%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Water tap on compound												
No	14	17%	203	85%	156	69%	365	99%	202	99%	940	84%
Yes	70	83%	37	15%	69	31%	3	1%	2	1%	181	16%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Firewood- or charcoal-efficient stove												
No			163	68%	11	5%	236	64%	110	54%	520	50%
Yes			77	32%	214	95%	132	36%	94	46%	517	50%
Total			240	100%	225	100%	368	100%	204	100%	1,037	100%
Flask for liquids/food												
No	23	27%	11	5%	104	46%	312	85%	191	94%	641	57%
Yes	61	73%	229	95%	121	54%	56	15%	13	6%	480	43%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Dustbin/compost pit												
No	14	17%	127	53%	141	63%	104	28%	23	11%	409	36%
Yes	70	83%	113	47%	84	37%	264	72%	181	89%	712	64%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%
Solar energy system/biogas system												
No	223	93%			214	95%	341	93%	134	66%	912	88%
Yes	17	7%			11	5%	27	7%	70	34%	125	12%
Total	240	100%			225	100%	368	100%	204	100%	1,037	100%
Generator												
No	65	77%	240	100%	225	100%	366	99%	191	94%	1,087	97%
Yes	19	23%	0	0%	0	0%	2	1%	13	6%	34	3%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1,121	100%

Table 7 Participation in norms-related, fuel/energy-related and water-related training projects [Table 14 in online Annex]

PARTICIPATION IN OXFAM PROJECTS	COLOMBIA		ETHIOPIA		PHILIPPINES		ZIMBABWE		TOTAL	
	No	%	No	%	No	%	No	%	No	%
Woman in the household participated in project										
NORMS-RELATED PROJECTS										
No	58	69%	124	52%	166	74%	141	69%	489	65%
Yes	26	31%	116	48%	59	26%	63	31%	264	35%
Total	84	100%	240	100%	225	100%	204	100%	753	100%
Man in the household participated in project										
No	47	87%	72	30%	129	76%	123	60%	371	56%
Yes	7	13%	167	70%	40	24%	81	40%	295	44%
Total	54	100%	239	100%	169	100%	204	100%	666	100%
WATER-RELATED PROJECTS										
Woman in the household participated in project										
No	12	14%	111	46%	211	94%	204	100%	538	71%
Yes	4	5%	129	54%	14	6%	0	0%	147	20%
Total	84	100%	240	100%	225	100%	204	100%	753	100%
Man in the household participated in project										
No	11	20%	45	19%	132	78%	204	100%	392	59%
Yes	2	4%	194	81%	37	22%	0	0%	233	35%
Total	54	100%	239	100%	169	100%	204	100%	666	100%
FUEL/ENERGY-RELATED PROJECTS										
Woman in the household participated in project										
No	12	14%	137	57%	216	96%	194	95%	559	74%
Yes	4	5%	103	43%	9	4%	10	5%	126	17%
Total	84	100%	240	100%	225	100%	204	100%	753	100%
Man in the household participated in project										
No	13	24%	93	39%	141	83%	199	98%	446	67%
Yes	0	0%	146	61%	28	17%	5	2%	179	27%
Total	54	100%	239	100%	169	100%	204	100%	666	100%

Note: Due to data collection error, no data are available for Uganda.

Table 8 Time use of girls and boys (reported by mothers) [Table 17 in online Annex]

TIME ALLOCATION	COLUMBIA			ETHIOPIA			PHILIPPINES			UGANDA			ZIMBABWE			TOTAL		
	Mean F	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*	*Mean F*	*Mean M*	*T-value*
Ages 0–17																		
Sleep	9.55	9.25	0.44	10.43	10.6	-0.9	9.73	10.16	**-2.44***	10.44	10.58	-1.1	10.94	10.97	-0.11	10.34	10.53	**-2.16***
Paid work	1.5	0.3	1.1	0.17	0.21	-0.58	0.14	0.58	**-3.52*****	0.5	0.65	-1.74	0.07	0.31	**-2.06***	0.28	0.46	**-3.48*****
Education	5.13	6.35	-2.07	2.18	1.93	1.5	4.86	3.75	**4.2*****	2.56	2.37	0.88	5.08	4.77	0.67	3.37	2.96	**3.26****
Care work	0.54	0.37	1	0.49	0.13	**12.57*****	0.38	0.25	**3.7*****	0.47	0.34	**4.37*****	0.37	0.26	**2.14***	0.44	0.25	**10.94*****
Leisure	3.22	3.83	-0.6	6.09	6.6	**-2.29***	4.61	5.27	**-2.48***	6.66	7.06	-1.71	5.3	5.5	-0.48	5.8	6.26	**-3.49*****
Number of households	10			187			156			242			100			695		
Ages 0–4																		
Sleep				13.51	13.51	-0.01	12.39	12.83	-0.8	11.84	11.98	-0.42	13.92	13.92	0	12.73	12.89	-0.68
Paid work				0	0	.	0	0	.	0.1	0.24	-1.41	0	0.67	-1	0.03	0.13	-1.6
Education				0.14	0.13	0.05	0.53	0.3	0.82	0.93	0.16	**2.37***	0	0.5	-1	0.48	0.21	1.83
Care work				0.03	0.02	0.09	0.03	0.06	-0.72	0.15	0.19	-0.69	0.03	0	1	0.06	0.08	-0.76
Leisure				9.15	9.12	0.08	6.46	6.78	-0.47	9.95	9.56	0.65	9.75	8.75	0.99	8.77	8.64	0.43
Number of households	No observations			56			40			50			12			158		
Ages 5–8																		
Sleep				10.42	10.33	0.43	9.47	9.97	-1.8	10.85	10.34	**2.21***	10.55	9.9	1.95	10.36	10.22	1.09
Paid work				0	0.19	-1	0	0	.	0.02	0.35	-1.78	0	0	.	0.01	0.19	**-2.02***
Education				1.53	1.45	0.25	5.33	4.83	0.68	1.96	2.32	-0.72	7.45	7.9	-1.71	3.03	3.06	-0.09
Care work				0.29	0.14	**2.08***	0.3	0.21	1.23	0.43	0.34	1.2	0.13	0.2	-0.96	0.33	0.24	**2.38***
Leisure				6.8	6.58	0.44	4.9	5.02	-0.2	7.22	7.3	-0.13	4.85	4.7	0.29	6.36	6.35	0.06
Number of households	No observations			43			34			54			10			141		
Ages 9–12																		
Sleep	9	9		9.14	9.11	0.19	8.62	8.91	**-2.17***	9.36	9.54	-1.6	9.73	9.64	1	9.13	9.25	-1.5
Paid work	0	0		0.07	0.37	-1.37	0	0.29	-1.44	0.78	0.68	0.72	0	0	.	0.3	0.42	-1.35
Education	7.17	7	1	3.66	3.04	1.48	7.29	6.9	1.06	3.38	3.87	-1.37	5.91	5.82	0.22	4.74	4.62	0.57
Care work	0.47	0.4	0.5	0.88	0.25	**6.35*****	0.54	0.32	**3.45****	0.76	0.49	**3.34****	0.29	0.15	2.03	0.7	0.35	**7.45*****
Leisure	3.33	4	-0.5	4.13	5	**-2.21***	2.78	3.76	**-2.37***	4.72	5.76	**-2.27***	5.55	6	-1.24	4.1	5.02	**-4.07*****
Number of households	2			38			34			47			11			132		
Ages 13–17																		
Sleep	9	8		8.53	9.13	**-2.06***	8.38	8.82	**-2.03***	9.1	9.59	**-2.52***	9.17	9.19	-0.14	8.8	9.23	**-3.64*****
Paid work	1	1		0.66	0.66	0	0.38	2.53	**-4.11*****	1.41	1.44	-0.1	0	0.86	-2.07	0.81	1.46	**-3.02****
Education	4	7	-1	3.88	3.72	0.48	7.06	3.7	**4.18*****	3.61	2.39	**2.69****	6.31	5.5	0.7	4.87	3.46	**4.31*****
Care work	0.7	0	1.4	0.88	0.26	**8.9*****	0.64	0.51	1.77	0.73	0.53	**2.7****	0.9	0.6	1.78	0.76	0.47	**6.42*****
Leisure	2	2	0	3.72	4.34	-1.81	2.89	3.65	**-2.29***	3.87	5.52	**-3.66*****	3.19	3.72	-0.64	3.49	4.52	**-4.42*****
Number of households	2			32			36			57			18			145		

*** p<0.001, ** p<0.01, * p<0.05. **Boldface** type indicates statistically significant results.

Note 1: Numbers reflect average hours per person. In other words, numbers account for differences in numbers of boys and girls within households.
Note 2: Table shows results of **paired-sample t-test.** This test runs only for paired samples, and automatically excludes observations (i.e. households) where no boy-girl pair is available (i.e. households that have only girls or only boys).

Table 9 Social norms – responses to vignettes, perceptions of who should help with care, and acceptability of shaming men involved in care Table 22 in online Annex]

SOCIAL NORMS	COLOMBIA		ETHIOPIA		PHILIPPINES		UGANDA		ZIMBABWE		TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%
Disapproval of vignette that describes couples where woman man is engaged in paid work while woman does all the care work												
WOMEN												
Strongly approve	1	1%	99	41%	98	44%	24	7%	15	7%	237	21%
Approve	32	38%	75	31%	81	36%	174	47%	108	53%	470	42%
Disapprove	46	55%	34	14%	24	11%	96	26%	60	29%	260	23%
Strongly disapprove	5	6%	32	13%	22	10%	74	20%	21	10%	154	14%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1121	100%
MEN												
Strongly approve	0	0%	61	26%	61	36%	50	14%	14	7%	186	18%
Approve	27	50%	146	61%	56	33%	160	43%	89	44%	478	46%
Disapprove	25	46%	11	5%	30	18%	79	21%	73	36%	218	21%
Strongly disapprove	2	4%	21	9%	22	13%	79	21%	28	14%	152	15%
Total	54	100%	239	100%	169	100%	368	100%	204	100%	1034	100%
Approval of vignette that describes couples sharing work												
WOMEN												
Strongly disapprove	3	4%	22	9%	34	15%	6	2%	3	1%	68	6%
Disapprove	2	2%	7	3%	51	23%	18	5%	13	6%	91	8%
Approve	42	50%	74	31%	67	30%	127	35%	101	50%	411	37%
Strongly approve	37	44%	137	57%	73	32%	217	59%	87	43%	551	49%
Total	84	100%	240	100%	225	100%	368	100%	204	100%	1121	100%
MEN												
Strongly disapprove	1	2%	17	7%	28	17%	22	6%	3	1%	71	7%
Disapprove	1	2%	64	27%	44	26%	54	15%	11	5%	174	17%
Approve	32	59%	84	35%	54	32%	99	27%	115	56%	384	37%
Strongly approve	20	37%	74	31%	43	25%	193	52%	75	37%	405	39%
Total	54	100%	239	100%	169	100%	368	100%	204	100%	1034	100%
From whom should women mainly receive help with caring for people and domestic work?												
Woman should not receive help from men	19	22%	87	36%	65	29%	31	8%	12	6%	214	19%
Woman should receive help from men	66	78%	153	64%	160	71%	338	92%	192	94%	909	81%
Total	85	100%	240	100%	225	100%	369	100%	204	100%	1123	100%
Woman accepts mocking/shaming a man in at least one situation												
No	84	100%	182	77%	152	78%	272	74%	184	91%	874	80%
Yes	0	0%	55	23%	44	22%	95	26%	18	9%	212	20%
Total	84	100%	237	100%	196	100%	367	100%	202	100%	1086	100%
Man accepts mocking/shaming a man in at least one situation												
No	53	98%	170	74%	102	70%	256	70%	191	95%	772	78%
Yes	1	2%	59	26%	43	30%	109	30%	11	5%	223	22%
Total	54	100%	229	100%	145	100%	365	100%	202	100%	995	100%

Table 10 Number of hours spent on tasks by women and men in communities in Ethiopia and Zimbabwe 2014 and 2015 [Table 26b in online Annex]

HOURS	ETHIOPIA (n=141)				ZIMBABWE (n=162)				TOTAL (n=303)			
	Mean: 2014	Mean: 2015	T-value	% of change	Mean: 2014	Mean: 2015	T-value	% of change	Mean: 2014	Mean: 2015	T-value	% of change
WOMEN												
As primary activity												
Water collection	0.65	0.58	0.87	-11	0.31	0.77	**-4.26*** **	148	0.47	0.68	**-3** **	45
Fuel collection	0.43	0.28	1.77	-35	1.17	0.56	**4.03*** **	-52	0.83	0.43	**4.36*** **	-48
Food preparation	2.79	2.89	-0.53	4	0.79	2.28	**-8.68*** **	189	1.72	2.56	**-6.34*** **	49
As either primary or secondary activity												
Water collection	0.73	0.69	0.5	-5	0.33	0.96	**-5.15*** **	191	0.52	0.83	**-4.01*** **	60
Fuel collection	0.65	0.38	**2.53***	-42	1.24	0.62	**4.05*** **	-50	0.97	0.51	**4.76*** **	-47
Food preparation	3.18	3.13	0.24	-2	0.84	2.67	**-10.3*** **	218	1.93	2.88	**-6.62*** **	49
MEN												
As primary activity												
Water collection	0.04	0.04	0.28	0	0.1	0.35	**-3.72*** **	250	0.07	0.2	**-3.39*** **	186
Fuel collection	0.06	0	**2.09***	-100	0.03	0.42	**-4.7*** **	1300	0.05	0.22	**-3.7*** **	340
Food preparation	0.18	0	1.88	-100	0	0.13	**-3.58*** **		0.09	0.07	**0.33**	-22
As either primary or secondary activity												
Water collection	0.06	0.04	0.47	-33	0.1	0.4	**-4.2*** **	300	0.08	0.23	**-3.69*** **	188
Fuel collection	0.09	0	**2.49***	-100	0.03	0.46	**-5.01*** **	1433	0.06	0.25	**-3.76*** **	317
Food preparation	0.23	0	**2.28***	-100	0	0.15	**-3.89*** **		0.11	0.08	0.44	-27

*** p<0.001, ** p<0.01, * p<0.05. **Boldface** type indicates statistically significant results.
Note: Table shows results of paired-sample t-test.

Table 11 Distribution of care hours among women and men in communities in Ethiopia and Zimbabwe, 2014 and 2015 [Table 29 in online Annex]

INEQUALITY: RATIO MEN'S HOURS/WOMEN'S HOURS	ETHIOPIA					ZIMBABWE					TOTAL				
	Mean: 2014	Mean: 2015	T-value	N	% of change	Mean: 2014	Mean: 2015	T-value	N	% of change	Mean: 2014	Mean: 2015	T-value	N	% of change
Hours spent on care work as primary activity	0.28	0.07	**4.47*** **	136	-75	0.17	0.34	**-2.74** **	156	100	0.22	0.21	0.31	292	-5
Hours spent on care work as primary or secondary activity	0.29	0.1	**4.55*** **	134	-66	0.17	0.37	**-2.78** **	158	118	0.22	0.25	-0.46	292	14
Hours spent on any care responsibility(a)	0.31	0.24	0.89	132	-23	0.21	0.4	**-2.24***	157	90	0.26	0.33	-1.2	289	27
Hours multitasking(b)	1.22	0.17	**3.82*** **	133	-86	1.21	0.37	**3.84*** **	156	-69	1.22	0.28	**5.41*** **	289	-77
Leisure, personal care (as either primary or secondary activity)	1.18	1.11	1.05	131	-6	1.15	1.26	-1.16	160	10	1.16	1.19	-0.44	291	3
Hours spent on sleep as primary activity	1.02	1	0.26	131	-2	1.01	1.05	-0.93	161	4	1.01	1.03	-0.42	292	2
Hours spent on productive/paid work (as primary activity)	2.7	3.07	-0.69	69	14	1.41	1.65	-0.97	70	17	2.05	2.35	-1.04	139	15
Hours spent on total work (includes productive work and care)	0.88	0.83	0.62	128	-6	0.89	1.12	-1.95	154	26	0.89	0.99	-1.31	282	11

*** p<0.001, ** p<0.01, * p<0.05. **Boldface** type indicates statistically significant results.
(a) Includes care as primary activity, care as secondary activity, supervision: child, and supervision: adult.
(b) Hours in which at least two care activities (includes care as primary activity, care as secondary activity, supervision: child, and supervision: adult).
Note 1: Table shows results of paired-sample t-test.
Note 2: Analyses exclude households where woman hours = 0 while men hours >0

Table shows average change in inequality (measured as ratio of men's hours to women's hours) from year 2014 to year 2015.

Table 12 Participation in training activities in communities in Ethiopia and Zimbabwe, 2014 and 2015 [Table 33 in online Annex]

PARTICIPATION IN TRAINING 2014	Ethiopia (n=141)	Zimbabwe (n=162	Total (n=303)
	Col %	Col %	Col %
TRAINING ON WATER			
Neither woman nor man participated in training	29	67.3	50.2
Either woman or man participated in training	51.9	25.9	37.5
Both woman and man participated in training	19.1	6.8	12.3
TRAINING ON FUEL			
Neither woman nor man participated in training	54.3	53.1	53.6
Either woman or man participated in training	38.6	32.7	35.3
Both woman and man participated in training	7.1	14.2	11.1
TRAINING ON INCOME			
Neither woman nor man participated in training	18.8	58	40.7
Either woman or man participated in training	59.4	30.2	43.1
Both woman and man participated in training	21.9	11.7	16.2
TRAINING ON HEALTH			
Neither woman nor man participated in training	6.7	32.1	20.5
Either woman or man participated in training	45.2	35.2	39.7
Both woman and man participated in training	48.1	32.7	39.7
TRAINING ON GENDER			
Neither woman nor man participated in training	22.9	72.7	50.3
Either woman or man participated in training	58.8	23.6	39.4
Both woman and man participated in training	18.3	3.7	10.3

PARTICIPATION IN TRAINING 2015	Ethiopia (n=141)	Zimbabwe (n=162	Total (n=303)
	Col %	Col %	Col %
TRAINING ON WATER			
Neither woman nor man participated in training	12.1	35.8	24.8
Either woman or man participated in training	38.3	35.2	36.6
Both woman and man participated in training	49.6	29	38.6
TRAINING ON FUEL			
Neither woman nor man participated in training	24.8	31.5	28.4
Either woman or man participated in training	47.5	30.2	38.3
Both woman and man participated in training	27.7	38.3	33.3
TRAINING ON INCOME			
Neither woman nor man participated in training	7.1	33.3	21.1
Either woman or man participated in training	40.4	34.6	37.3
Both woman and man participated in training	52.5	32.1	41.6
TRAINING ON HEALTH			
Neither woman nor man participated in training	2.8	16.7	10.2
Either woman or man participated in training	23.4	24.7	24.1
Both woman and man participated in training	73.8	58.6	65.7
TRAINING ON GENDER			
Neither woman nor man participated in training	12.1	22.2	17.5
Either woman or man participated in training	48.9	26.5	37
Both woman and man participated in training	39	51.2	45.5

CHANGE FROM 2014 TO 2015	Ethiopia (n=141)	Zimbabwe (n=162	Total (n=303)
	Col %	Col %	Col %
TRAINING ON WATER			
Negative change: participated in 2014, didn't participate in 2015	8.4	10.5	9.6
No change	65.6	47.5	55.6
Positive change: didn't participate in 2014, but participated in 2015	26	42	34.8
TRAINING ON FUEL			
Negative change: participated in 2014, didn't participate in 2015	10.2	15.4	13.1
No change	49.6	47.5	48.4
Positive change: didn't participate in 2014, but participated in 2015	40.2	37	38.4
TRAINING ON INCOME			
Negative change: participated in 2014, didn't participate in 2015	4.7	11.1	8.3
No change	78.1	53.1	64.1
Positive change: didn't participate in 2014, but participated in 2015	17.2	35.8	27.6
TRAINING ON HEALTH			
Negative change: participated in 2014, didn't participate in 2015	3	9.9	6.7
No change	90.4	64.8	76.4
Positive change: didn't participate in 2014, but participated in 2015	6.7	25.3	16.8
TRAINING ON GENDER			
Negative change: participated in 2014, didn't participate in 2015	8.4	5.6	6.8
No change	71.8	37.9	53.1
Positive change: didn't participate in 2014, but participated in 2015	19.8	56.5	40.1

NOTES

[1] The districts were: Boyacá, Colombia; Adamitulu Jiddo Kombolcha and Arsi Negele, Ethiopia; Balindong, Saguiaran and Bubong in the island of Mindanao in the Philippines; Lilongwe and Michinji, Malawi; Lamwo in Uganda; and Bubi, Umzingwane and Zvishavane, Zimbabwe.

[2] Malawi is not discussed in this report for this reason.

[3] For details of the baseline research findings, see Rost et al. (2015).

[4] This section builds on the literature review of the 2014 HCS research report (Rost et al., 2015).

[5] DFID Call to Action: 'Governments will prioritize investments in infrastructure and essential services, including water, sanitation and energy that reduce and redistribute women's burden of unpaid care and work. Employers will recognize women's burden of unpaid care work and take measures to support women and men in fulfilling care duties. Donors and international institutions will invest in the evidence base and scale up initiatives to reduce and redistribute women's burden of unpaid care and work. All stakeholders will work to improve data for measuring and recognizing unpaid work, for example through investment in time-use surveys.'

[6] In two countries, Uganda and Ethiopia, comparison communities were also surveyed but not subject to programme interventions, in order to give additional insights into whether Oxfam activities were having the intended effect. However, owing to contextual changes, the implementation of project activities did not happen in the intended communities, so the comparison analysis was not carried out.

[7] In analysis of the 2014 data, analysis was completed for each of the data sets separately. To look at a large range of potential determinants of care patterns, the team built linear regression models using forward and backward stepwise methods.

[8] On the latter, it should be noted that further work on the measurement instrument is likely to be needed beyond that used in the 2015 survey. In qualitative and quantitative work undertaken alongside this survey, Rost et al. (forthcoming) finds that in Uganda, mothers' reports of the time their children spent on paid and unpaid work were far lower than those of children. On the one hand, children may not be accurate reporters of the amount of time that they spend at work; on the other hand, mothers' reports may understate actual time spent, reflecting a social desirability bias.

[9] Names were changed to reflect male and female names in each context.

[10] The 2014 HCS is available in Rost *et al*. 2015.

[11] It is possible too that migration itself, especially where induced by drought as in Ethiopia, may have induced behavioural changes in the communities, but we defer this important question for future research.

[12] Key descriptive statistics are included in Annex 4 of this report (the references to these tables are underlined), while the full set of tables – including all descriptive statistics and results of the multivariate analysis – are available online at www.oxfam.org.uk/care.

[13] This difference was statistically significant ($t(1035)=41.89$; $p<0.001$).

[14] Male-female differences were strongly statistically significant in all countries.

[15] This male-female difference was statistically significant ($t(1035)=40.54$; $p<0.001$).

[16] This male-female difference was statistically significant ($X2$ (1, N=2,070)=205, $p<0.001$).

[17] This male-female difference was statistically significant ($X2$ (1, N=2,070)=4.51, $p<0.05$).

[18] This male-female difference was statistically significant ($t(1035)=38.14$; $p<0.001$).

[19] Across all five countries, the male-female difference was statistically significant.

[20] This male-female difference was statistically significant ($t(1035)=29.64$; $p<0.001$).

[21] Across all countries, the male-female difference was strongly statistically significant.

[22] As a primary activity, (B= -0.05; 95%CI= -0.08, -0.02; $p<0.05$); on any care responsibility, (B= -0.12, 95%CI= -0.15, -0.08; $p<0.001$).

[23] For households with a child below age six: (B=3.67, 95%CI= 2, 5.33; $p<0.01$). For households with a dependent adult: (B=2.10, 95%CI= 1.07, 3.13; $p<0.01$).

[24] The analysis combined productive and paid activities: agricultural work (for marketing or subsistence), other production and services for sale, work in family businesses and waged work. For brevity, we use the term 'paid work'.

[25] The difference was statistically significant ($t(1035)=- -17.87$; $p<0.001$).

[26] Across all countries, the male-female difference was strongly statistically significant.

[27] This difference was statistically significant: ($t(1035)=12.74$; $p<0.001$).

[28] In this analysis, 'leisure' includes activities such as personal care, eating, socialising, religious activities and rest.

[29] The difference was statistically significant across all countries ($t(1035)=-12.64$; $p<0.001$).

[30] See data from the Young Lives survey, for instance (presented in Samman et al. 2014, p. 38).

[31] The difference was statistically significant at the 1% level: $t(694)=10.94$, $p<0.001$.

[32] The difference was statistically significant at the 10% level: $t(694)=3.26$, $p<0.01$.

[33] The difference was statistically significant at the 1% level: $t(694)=-3.49$, $p<0.001$.

[34] The difference was statistically significant at the 1% level: $t(694)=-3.48$, $p<0.001$.

[35] For household size: (OR=0.76; 95%CI=0.7, 0.8; $p<0.001$). For household wealth: (OR=0.96; 95%CI=0.9, 0.99; $p<0.01$).

[36] Meal preparation: $t(1033)= -17.76$, $p<0.001$; care of farm animals: $t(1033)= 12.72$, $p<0.001$; washing, ironing and mending clothes: $t(1033)= -12.56$, $p<0.001$; house construction and repair: $t(1033)= 10.07$, $p<0.001$; cleaning house or compound: $t(1033)= -10.33$, $p<0.001$.

[37] House construction and repair: $t(1033)=8.78$, $p<0.001$; meal preparation: $t(1033)= -8.15$, $p<0.001$; carpentry and furniture making: $t(1033)=4.58$, $p<0.001$.

[38] Combined value: (t(1033)= -18.25, p<0.001); Combined skill: (t(1033)= -6.94, p<0.001); Relative value: (t(1033)= -18.58, p<0.001); Relative skill: (t(1033)= -6.5,p<0.001).

[39] Regression models with absolute and relative measures of value and significance were run separately – due to high collinearity (i.e. tolerance value less than 0.1 and a variance inflation factor greater than 10 (Lin 2008, Curto and Pinto 2011) between the absolute and relative measures.

[40] (B=0.25; 95%CI=0.05, 0.45; p<0.05).

[41] For men who valued care work (more), in absolute terms: B= -0.06; 95%CI=-0.11, -0.01; p<0.5) and relative to paid work: B=-1.1; 95% CI= -1.86, -0.34; p<0.05). For women who valued care work (more), in absolute terms: (B= -0.05; 95%CI=-0.09, -0.0004; p<0.5) and relative to paid work (B= -0.97; 95% CI= -1.81, -0.13; p<0.05).

[42] In absolute terms (B=0.04; 95% CI= 0.02, 0.06; p<0.01). Relative to paid work (B=0.45; 95% CI= 0.06, 0.84; p<0.05).

[43] To account for the non-normal distribution of care hours among young people, we transformed the outcome variable using natural log transformation. However, even after the log transformation, residuals were non-normally distributed (as demonstrated through Shapiro-Wilk test for normal data and Skewness/Kurtosis tests for Normality). This means that our OLS model is highly susceptible to estimation bias. We also conducted a logistic regression with a binary outcome variable which indicated whether boys or girls performed more care work.

[44] (B=-0.5, 95%CI= -0.95, -0.06; p<0.05).

[45] (OR=1.19, 95%CI=1, 1.42; p<0.05).

[46] The standard deviations were 0.3 and 0.65 respectively.

[47] For decision-making ability: (B=1.68, 95%CI= 0.63, 2.73; p<0.05). For decision-making and influencing ability: (Model 1: B=1.62, 95%CI=0.6, 2.6; p<0.05; Model 2: B=1.7, 95%CI=0.68, 2.7; p<0.01).

[48] (B= -0.24; 95% CI= -0.48, -0.001; p<0.05).

[49] (B= -0.51; 95%CI= -0.59, -0.43; p<0.01).

[50] Additional quantile regressions provided more detailed examination by testing the association between women's decision-making power and the redistribution of care hours at the 25th, 50th, 75th and 95th percentiles, but there was no significant association at any percentile.

[51] (B=0.02; 95%CI=0.002, 0.03; p<0.05).

[52] Controls included household characteristics (i.e. household size, the presence of a child below age six and/or a dependent adult), the woman's age, her decision-making and influencing ability, household assets, and the perceived value of care work by the woman and man in the household relative to paid work. Including other measures of recognition reduced the model's goodness of fit.

[53] As a primary activity: B= -1.24, 95%CI= -1.53, -0.96; p<0.001. For any care responsibility: (B= -0.89, 95%CI= -1.59, -0.19; p<0.05).

[54] On care work in general: (B=1.12, 95%CI=0.31, 1.94; p<0.05). On water and fuel collection: (B=1.11; 95%CI=0.54, 1.68; p<0.01).

[55] (B=0.59; 95%CI=0.04, 1.15; p<0.05).

[56] (B=0.51; 95%CI=0.16, 0.86; p<0.05).

[57] These included a woman's age and decision-making and influencing ability, and selected household characteristics (i.e. household size, the presence of a child below age six and/or a dependent adult, and household assets).

[58] (B= -1.07; 95%CI= -2.09, -0.05; p<0.05).

[59] (B=0.23; 95%CI=0.03, 0.43; p<0.05).

[60] (B=0.91, 95% CI=0.24, 1.57; p<0.05). But note this relationship is not significant when model is run for all five countries and excludes 'transport for fetching water'. Moreover, the model with significant association explains only 10% of variation in men's hours spent on any care responsibility. In other words, this finding needs to be interpreted with great caution. The poor goodness of fit may be partially due to the skewed distribution of the outcome variable, as more than half (59.6%) of all men in our sample reported spending zero hours on care as a primary activity.

[61] These included household-level recognition of care work, household access to public water and electricity services, and household characteristics.

[62] For care work in general: (B=-0.7, 95%CI= -1.2, -0.21; p<0.05. For water, B= -1.19, 95%CI= -2.18, -0.21; p<0.05).

[63] (B=0.52; 95%CI=0.04, 1; p<0.05).

[64] (B= -0.57, 95%CI= -1.1, -0.05; p<0.05).

[65] For boys: (B= -0.85, 95%CI= -1.27, -0.44; p<0.01); for girls: (B=-0.37, 95%CI= -0.7, -0.04; p<0.05).

[66] These included women's decision-making power and age, and household characteristics (size, assets and the presence of a child below age six or a dependent adult).

[67] (B= -0.36; 95%CI=-0.65, -0.08; p<0.05).

[68] (B=0.59; 95%CI=0.07, 1.12; p<0.05).

[69] For value: (B=-0.79; 95%CI=-1.56, -0.03; p<0.05); for skill: (B= -0.46; 95%CI=-0.82, -0.10; p<0.05).

[70] (B=0.05; 95%CI=0.02, 0.07; p<0.01).

[71] (B=0.18; 95%CI=0.1, 0.3; p<0.01).

[72] hours (B=-0.80; 95%CI=-1.58, -0.03; p<0.05).

[73] (B=-0.73; 95%CI=-1.34, -0.13; p<0.05).

[74] (OR=1.16; 95%CI=1.05, 1.29; p<0.01).

[75] (OR=1.34; 95% CI=1.18, 1.52; p<0.001).

[76] Controls included household access to other resources (i.e. water, electricity, healthcare and childcare), household assets, household structure (household size, the presence of a child below age six and/or a dependent adult), the woman's age, and her decision-making and influencing ability. Note that the uneven distribution of participation in the activities may cause estimators to be biased.

[77] (B= -0.71; 95%CI= -0.9, -0.5; p<0.01).

[78] For water: B=2.06; 95%CI=1.23, 2.89; p<0.01. For fuel: B=2.39; 95%CI=1.67, 3.12; p<0.01.

[79] (B=0.65; 95%CI=0.3, 0.99; p<0.01).

[80] (B=0.4; 95%CI=0.23, 0.57; p<0.001).

[81] (B=0.59; 95%CI=0.48, 0.7; p<0.001).

[82] B=1.46; 95%CI=0.14, 2.78; p<0.05).

[83] (B=2.65; 95%CI=0.86, 4.45; p<0.05).

[84] These included the participant's age and education level, household characteristics (size, the presence of a child below age six and/or dependent adult, and household assets) and other social norms. No risky collinearity was detected among social norms measures (as judged by variance inflation factor and the tolerance value).

[85] As noted in the introduction, the WE-Care programme was integrated into a broader programme conducted by host organizations in each country; in the communities in both Ethiopia and Zimbabwe, the wider host programme included training on health and on income, in addition to gender, fuel and water, so we analyse the effects of participating in all these trainings.

[86] For women: (t(302)=18.27; p<0.001); for men: (t(302)=17.86; p<0.001).

[87] Results are statistically significant for care as a primary activity, care as a primary or secondary activity, and any care responsibility.

[88] (t(288)=5,41; p<0.001).

[89] (B=-0.33; 95%CI= -0.35,-0.31; p<0.001).

[90] On care as a primary or secondary activity: (B=-0.56; 95%CI=-1.11, -0.01; p<0.05). On multitasking: a(B=-1.73; 95%CI=-2.95, -0.51; p<0.01).

[91] (B=-0.54; 95%CI=-1.05, -0.03; p<0.05).

[92] (B=-1.51; 95%CI=-2.5, -0.52; p<0.01).

[93] On food preparation: (B=0.41; 95%CI=0.16, 0.66; p<0.01); on fuel collection (B=0.12; 95%CI=0.01, 0.23; p<0.05).

[94] The term 'productive' is used in contrast to 'reproductive' activities, without intending to imply that care activities are 'unproductive'.

Women's Economic Empowerment and Care (WE-Care) is Oxfam's initiative in 10 countries that supports women's empowerment by addressing excessive and unequal care work – building evidence, promoting positive norms, new investments and policy advocacy.

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Front cover: Grace Aloyo, 23 and Mark Olara, Uganda.
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