FACTORS AND NORMS INFLUENCING UNPAID CARE WORK

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

EXECUTIVE SUMMARY

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WE-CARE
WOMEN'S ECONOMIC EMPOWERMENT AND CARE

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EXECUTIVE SUMMARY

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 has increased, there remains a lack of understanding of the full spectrum of women's work, paid and unpaid. 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 to raise recognition of care work, advocating for investments to reduce the unnecessary drudgery of care, and redistributing care responsibilities more equitably.

Building on these 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 the design of development initiatives and policy. The project involves research and interventions in selected communities in districts of six countries: 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. The aim is to generate evidence that helps local organizations address problematic aspects of care work, contributing to women's ability to participate, lead and benefit from development initiatives. This 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).

In 2014, Oxfam and its partners implemented a baseline Household Care Survey (HCS) in five of the six countries in which the project was active (i.e. all but Malawi, where separate activities took place), and in November/December 2015, a revised version of the HCS was carried out in these same communities. As a follow-up survey, the 2015 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, new questions were introduced on social norms and children's time use. Moreover, the survey was designed as a panel in order to enable a robust examination of how participating in different types of WE-Care programme activities in the intervening year had affected respondents' care workloads. 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 in 2014. However, the panel remained mostly intact only in the Ethiopia and Zimbabwe samples – where 85% of households interviewed in 2014 were re-interviewed in 2015 – therefore the analysis of change over time focuses on these countries.

Across the communities in the five countries, 1,123 households were interviewed in 2015 – the same number as in 2014. Almost equal numbers of women and men were surveyed – 1,123 women (52%) and 1,036 men (48%) – though some female-headed households were included in the samples in Colombia, and in the Philippines many men were not present at the time of the survey. Across the five countries, the average household consisted of six people, and nearly three-quarters of households had at least one child under the age of six.

The survey analysis focuses on several possible levers for change at the household level – namely recognition of the importance of care work and women's role in carrying it out; women's ability to take decisions in several aspects of household life; access to public services and to time- and labour-saving equipment; progressive social norms about care and gender roles; and participation in WE-Care programmes aimed at energy-related, water-related and norms-related change. The analysis sought to examine the extent to which these factors were associated with the amount of time women (and men) spent on unpaid care work, and the distribution of care work within households. The positive relationships that emerge in the analysis could potentially inform programme activity that seeks to diminish the problematic aspects of unpaid care work in women's lives.

TIME SPENT ON CARE AND ITS DISTRIBUTION

Care work is often underreported partly because participants may not perceive it as work, and partly because people often undertake care work alongside other activities. A key innovation of this study is the granular analysis of how much time is spent on care, by distinguishing 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 probed the extent of multitasking – i.e. carrying out two or more care activities at once.

Time use of women and men

Across the five contexts, women spend large amounts of time on care. Compared with men, they spend more hours on care as a primary activity, as a primary or secondary activity, and on any care responsibility. Women also spend much more time multitasking. In particular:

- On average, women spent 5.4 hours on care as a primary activity in the day before the survey, compared to just under 1 hour (0.99) for men.
- Women spent an average of 7.0 hours on care as a primary or secondary activity, compared with an average of 1.4 hours for men.
- Over one-third of all men in our sample reported spending no time on any care activity.
- On average, 78% of women had been responsible for a child compared to 48% of men, and 11% of women had been responsible for a dependent adult compared to 9% of men.
- Women reported an average of 13.8 hours in the previous day when they had at least one care responsibility, including supervision, compared to 4.3 hours that men reported having any care responsibility.
- On average, women spent 6.1 hours on multitasking compared to 1.2 hours for men.

Women also spent relatively more time on total paid and unpaid work – 9.1 hours compared to 7.3 hours for men – while spending less time on leisure and personal care.

At least three facts stand out from these data. First, our approach of carefully probing different types of care responsibilities significantly expands our understanding about 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 spend 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 this 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. Third, when we add the amount of time spent on secondary care and supervision of dependants, inequality in time spent on care between men and women is slightly less acute.

The analysis considered the relationship between the amount of care work that women undertook and their education, relative household assets, income and savings, and household access to time-saving equipment such as water taps and fuel-efficient stoves. None of these factors was consistently associated with the amount of care work that women undertook. And while a significant minority of women reported negative consequences related to unpaid care work, such as exhaustion, headaches or a lack of time for personal care and rest, there were no consistent patterns in the relationship between the amount of care work and women's reported well-being.

Time use of boys and girls

Patterns of time use among women and men were echoed in the analysis of patterns among youth. Among children aged 0–17, 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. On average, girls had spent 0.44 hours on care work in the previous day compared to 0.25 hours for boys. In larger households and in wealthier households, boys were likely to spend fewer hours on care work than girls did, while youth care work tended to be more equally distributed in households with children below age six than in households without young children.

FACTORS CONDITIONING TIME SPENT ON CARE WORK AND ITS DISTRIBUTION

Having documented patterns of time use, our analysis sought to determine which factors, at the household level, were more likely to be aligned to fewer care hours for women and a more equal distribution of care within households. The factors we explored included recognition of care work, women's decision-making ability, access to time- and labour-saving equipment and public services, social norms and participation in Oxfam-supported WE-Care programmes.

Recognition of care work

The HCS asked men and women who they felt made the most significant contribution to their household's well-being – on average, across the five countries, a minority of men or women identified a woman, and both the man and woman identified a woman in just 22% of households. Perhaps counterintuitively, in households with greater recognition of women's contribution, women spent more hours on care as a primary activity. This measure of recognition may in fact be capturing the status quo, i.e. that in these households, women do indeed spend more hours on 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, which both men and women valued equally. Men valued paid tasks relatively more than women. Our analysis of the associations between the value assigned to care work and distribution of care hours showed that, 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. However, the findings on associations between the perception of skills required and distribution of care hours showed a different pattern: in households in which men believe care work required greater skill, primary care hours are less equally distributed. Further research is needed to understand whether men 'justify' their non-involvement in care work by reporting that it requires special skills that only women possess, or whether they truly believe that care tasks require particular skills and thus shy away from them. The recognition of care was also linked with equality of youth care hours: in households in which care work is valued more than paid work, boys spent more hours doing care work than girls. Our results suggest that women with greater relative autonomy experience more equal primary care hours – one possible explanation is that more autonomous women select into more gender-equal households.

Women's decision making within households

Across the five countries, on average, women were involved in eight out of the 10 decisions in aspects of their own and household life that the survey covered. But this did not necessarily translate into lower or more equal care burdens. In fact, some of our models show that women with greater decision-making power spent more hours on care, while some of our results point to a negative association between women's decision-making ability and the distribution of care hours. Moreover, we found no association between women's decision-making ability and distribution of care hours between boys and girls.

Access to public services

Access to public services varied substantially depending on the service and country – some 17% of households used a childcare service, one-third could access electricity, nearly three-quarters had an improved water source and nearly all (96%) could access a health facility. Compared to households with no electricity, in households with electricity women spent fewer hours on care. We did not uncover any associations between any other services (e.g. improved water, healthcare and childcare facilities) and women's care hours.

Access to time- or labour-saving equipment

Three types of equipment were most related to care loads – having a water tap on the compound (on average, 16% of households), a charcoal or fuel-efficient stove (50%) and dustbin/compost pit (64%) – though ownership varied widely across communities. 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, while 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. 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. The negative association between households' access to an efficient stove and reduced care hours could be due to the tendency of households with heavy care workloads to self-select to participate in the improved stoves project in programme communities. 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.

More encouragingly, the results suggest that these three types of equipment had some potential to alleviate care workloads and to redistribute care work amongst boys and girls. In households with a water tap on the compound, girls spent fewer hours on care work in general and on water collection in particular, compared to households with no water tap in their compound. In households with a fuel-efficient stove, boys spent more hours collecting water and fuel. Finally, in households with a dustbin/compost pit, boys spent less time on care work and both boys and girls spent less time on water and fuel collection, compared to households that did not have a dustbin/compost pit.

Social norms

One aim – and innovative aspect – of the survey was to develop robust quantitative measures of norms. We included eight experimental measures of norms in an effort to gain a richer understanding of people's attitudes toward the care work they do, what they believe others do, and how they understand societal expectations.

The data point to both acceptance of the status quo alongside a preference among women and men for a more gender-equal distribution of care work. In addition to the measures already reviewed that shed light on norms (recognition of women's contribution, the perceived value and skill embedded in care work, and relative autonomy in carrying out care), additional indicators suggested:

- Most women reported some degree of satisfaction with the division of labour in their households – some 87% overall, and as many as 94% of women in Zimbabwe and 96% in the Philippines.
- About 25% of respondents considered it acceptable to beat or harshly criticize women for at least one type of perceived failure to perform care tasks. In Uganda, where levels were highest, the share of women who reported it being acceptable (50%) was much higher than that of men (32%). The lowest levels of acceptance were in Colombia – under 4% for men and under 3% for women. One-fifth (20% of women, 22% of men) found it acceptable to shame or mock men in at least one instance of carrying out care tasks.
- 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. However, in every sample except for the Philippines, a higher share of women and men (66% of women and 76% of men) approved of a vignette describing a routine in which paid and care work were shared equally.

- Across the five countries, 80% of women expressed the desire that their husbands would help with one or more care activities – but about 50% of women who wanted their husbands to help 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.

Taken together, this evidence suggests an openness to the idea of a more equal distribution of care work. Our analysis points to some evidence that in households where social norms were more progressive, care work was more equally distributed, for example, in households in which men strongly disapproved of an unequal gendered distribution of care, and in households in which both the woman and the man considered care work to be more important than paid work. Among youth too, in households where care work was valued more than paid work, boys spent more hours than girls doing care work. And in households which registered greater disapproval of criticizing a woman for a perceived failure to carry out care tasks, boys carried out an equal amount or more care work than girls. All this evidence suggests that changing social norms has the potential to impact upon the care loads of women and of girls.

Participation in Oxfam projects

On average, across the five countries, 20% of women and 35% of men reported participating in Oxfam's water-related projects; for energy-related projects, the figures were 17% and 27% respectively; and for norms-related projects, the figures were 35% and 44% respectively. For all these programmes, cross-country variation was substantial. There was no clear relationship between participation in the water- and energy-related projects and either a reduction or a redistribution of women's unpaid care hours. However, participation in Oxfam's norms-related projects was associated with two outcomes: men's relative autonomy in carrying out care, and household-level disapproval of the vignette that describes a couple where the man is engaged in paid work while the woman does all the care work. The strength of the effect was greater in households in which both the woman and man participated in these projects. We do not know to what extent this finding is conditioned by selection bias – i.e. if participants with more progressive social norms chose or were selected to participate in Oxfam activities. Both factors, in turn, were associated with a more equal distribution of care work.

Changes between 2014 and 2015 in the Ethiopia and Zimbabwe samples

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. The two countries present a contrasting situation in terms of time use. A key finding is that women in the Ethiopian communities reported spending less time on care in 2015 (although male-female inequalities in time use increased) while the converse occurred in the Zimbabwean communities (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.

Second, we probed the effects of having had access to certain types of equipment or services in 2014 – or acquiring equipment or service provision in the course of the year – and patterns of time use. Numerous households reported acquiring equipment such as a fuel-efficient stove (e.g. one-third of households in Ethiopia and 43% in Zimbabwe), unsurprisingly, given relatively high levels of participation in WE-Care water- and energy-related programmes. However, a surprisingly high share of households reported the loss of equipment (e.g. water-related equipment in Ethiopia and electricity-related equipment in Zimbabwe), although it is not clear what happened in these cases – e.g. if equipment fell into disrepair, was sold or given away, etc. With infrastructure too, some reports are difficult to interpret. In Ethiopia, for example, 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, 23% of households in Ethiopia and 35% in Zimbabwe reported the loss of childcare services.

The introduction of infrastructure and time- and labour-saving equipment does not have a straightforward association with reduced hours or reduced inequality. In households which acquired water-transport equipment (e.g. wheelbarrows), fuel-efficient stoves, access to childcare and/or electricity, men reported spending either the same amount or more time on care in 2015 than they had in 2014. But in households that acquired a solar 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 than in 2014. More research will be needed to understand why access to different types of equipment and services had such mixed effects.

Training was widespread and appears to have had several positive results. In households in which at least one adult participated in water-related activities, both men and women spent fewer hours on care. 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.

Comparing change in time use also raises an important methodological consideration: it could be that the time spent on care was reported more accurately in 2015, because respondents became more aware of care as work following the baseline survey and subsequent programme activity focused on gendered norms around care work. 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 than those in the Ethiopian communities at increasing men's participation in care work.

Emerging lessons

WE-Care programme activity had been in place for just a year at the time of the follow-up HCS. While it is too early to assess long-term effects and their durability, the results point to some suggestive findings as well as many areas in which follow-up research is needed. So far, emerging lessons include:

- The research approach which analyses multitasking (6 hours per day on average for women) and supervision of dependants (13.8 hours per day with any care responsibility) expands our understanding of the reality of care in women's lives. The findings challenge development and employment strategies which only consider care tasks reported as a primary activity. Research focused on time use is well advised to take into account these additional dimensions of time use and their implications for gender equality.
- Although some equipment and service access – notably the provision of electricity – seemed to have a positive effect on women's care loads, our results also make clear that a focus on only one dimension of care, such as childcare provision or stoves or water systems, cannot be expected to significantly 'free up' these rural women's time. Further analysis is needed to understand the joined-up impact of having access to different types of equipment and services – and seemingly contradictory findings, such as the positive relationship between having (and acquiring) a fuel-efficient stove and women's primary care hours.
- Our analysis of social norms points to the coexistence of some conservative attitudes around the gendered division of care, but also to openness to a more shared distribution of paid and care workloads. The focus on social norms around care appears to be merited, for several reasons. First, women's higher levels of decision-making power, education and income do not appear to be associated with lower care workloads, pointing to the need to shift social norms that may constrain the ability to negotiate on care even among otherwise 'empowered' women. Second, progressive norms do appear to be associated with fewer care hours for women and a more gender-equal distribution of care within households. Third, the provision of labour-saving equipment or access to infrastructure and services is not consistently related to lower care hours for women, suggesting the need for further research on what improves their effectiveness – and whether combining these interventions with efforts to shift social norms would help. Moreover, participants in Oxfam programme activities focused on norms change reported more gender-equal norms – though it is difficult to know whether they self-selected (or were selected) into these programmes for that reason.
- Some types of equipment – water taps on the compound, a fuel-efficient stove and a dustbin/compost pit – had some potential to alleviate care workloads and to redistribute care work amongst boys and girls. Our results also suggest that a focus on social norms may facilitate more gender-equal care loads among the younger generation, given that in households where care work is valued more than paid work, and in those in which respondents did not approve of criticising women for perceived failures in carrying out care, boys did equal or more care work than girls.

This report has pointed to some emerging findings from the project and also to numerous areas in which more research is required to understand 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, gendered norms, access to services and time- and labour-saving equipment is critical to make future programme work even more effective. Likewise, 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.

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 photo: Lamwo district, Uganda: Grace Aloyo, 23 and Mark Olara,30, share care work and farm work, after WE-Care training with Women and Rural Development Network (WORUDET)

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