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A "macro" view on equal sharing of responsibilities between women and men

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A "macro" view on equal sharing of responsibilities between women and men[1]

I am currently working on the analysis of time use data. However, these reflections will refer to this work only tangentially. The design of time use surveys and the analysis of time use data require clear-cut categories on what activities constitute housework, care of persons, or voluntary work. Responsibilities are a more slippery concept, because they might refer also to a "state of mind" (Folbre *et al* 2005). I will stick to focus on the activity content of "responsibilities" throughout this piece. I start

affordable), and when it is commodified by hiring paid domestic workers might have a "care of persons" component attached. Housework, care of persons and "community" work (which are referred to as *unpaid care work,* [Elson 2000]) all contribute to reproduce the labour force (the existing one and the future one [Picchio 2003]), all are prone to vary in order to accommodate for negative shocks originating in the market economy, and all are related to and influenced by the different ways paid work is organized and remunerated.

I will therefore refer to unpaid care work throughout this piece as comprising housework, care of persons and voluntary work. Technically, unpaid care work is the equivalent to "non-SNA work". This is the definition recently adopted by the UNRISD Project *"The Political and Social Economy of Care in a Development Context"* (Razavi 2007) and by the BRIDGE Care Pack (BRIDGE forthcoming).

Care work

Caring for others, providing care, working for pay in the care sector… women and men can do them all. Certainly, all of us need to be cared for at many stages of our lives: constantly, as it is the case of children or some old people; very intensively, as it happens with the ill; by professionals when our lives are at risk (if we are fortunate enough); on a daily basis, as able adults are cared for by other adults. *We all receive and provide care at some stage of our lives, as being vulnerable is part of our condition as human beings* (Tronto 2007: 39). However, not all of us become full-fledged carers: responsibilities for caring are ascribed on

and its commodification –along with a greater participation of women in the public sphere– the road to gender equality. In the socialist tradition, valuing care requires the reorganization of the gender division of labour and its sharing between women and men (Barker 2005). Clearly, greater commodification can sometimes change the very nature of care, as not all care can be transferred to the public or market spheres (Gardiner 1997: 240). And women's participation in labour markets is typically concentrated in poor quality/low pay sectors (often linked to care), particularly in developing countries (Chen *et al* 2005). On the other hand, the distribution of unpaid care work has proven extremely resistant to change, as time use studies around the globe attest (Benería 2003: 150).

The organization of care in developing countries: Some complexities

Through a myriad of laws, regulations, public provision of care services, and omissions, and lack of coverage, states define who receives care, who provides it and who bears the costs of care provision (both paid and unpaid). In doing so, states shape and reproduce gender relations by allocating tasks and obligations to the two sexes (Sainsbury 1999: 5). In practice, *care regimes* –the rules and norms that regulate care provision– are characterized by the "sites" of privileged care provision (family, market, community), the degree of state involvement in it, and the ways care provision is supported and eventually compensated for (Jenson 1997, cited by Razavi 2007: 20).

At the micro level, the organization of care mirrors that of the paid work. In developing countries, the "male breadwinner/female carer model" has historically had less influence, as it requires formal labour markets and sufficiently

forgone earnings) are immediate and palpable, and in some situations available resources might not suffice to provide adequate care. In such cases, it is the state that should bear some of the costs, and protect the rights of those made vulnerable by unfortunate circumstances.[2]

I worry that the emphasis on micro distributional issues *only* might contribute to maintain the status quo and discourage the voicing of demands through political organization.

Care can be thought of at the *macro level*, focusing on the *absolute levels of wellbeing that should be achieved in any given society,* on the one hand, and on who bears the costs, on the other. We could think of an aggregate amount of care that is required (out of a normative stance related to minimum standards of living), identify the resources needed to perform it and see who and to what extent different sectors provide the care needed. In this way, both gender inequalities in caring and care deficits (i.e., the situations in which care needs are not being met) can be made visible and policies to tackle them can be imagined and implemented[3]. The interplay of unpaid care work, and paid care work funded/provided by the market, the state, the families and the community can be clearly outlined if one proceeds in this way[4].

A macro focus is critically needed when analyzing care responsibilities in contexts of poverty and extreme poverty. Care deficits often go hand in hand with other dimensions of deprivation (employment; income; infrastructure; opportunities), reinforcing inequality. Undernourishment, deficits in sanitation infrastructure, absence of primary prevention can increase the incidence of several diseases. Deprivation also means tougher conditions for those who are responsible to care. And even when everyone in the family is healthy, coping with everyday care needs is harder and more time-consuming as compared to better-off households, which are usually smaller in size, better equipped and might resort to paid domestic work. Time use surveys show this imbalance between poor and better-off households. In the case of Buenos Aires, women and men in poor households spend longer times in unpaid care work than non-poor households, and poor women do more unpaid care work than poor men. It is not clear though that this hard work can fully compensate for the lack of income implied by being below the poverty line[5].

A macro focus does not dismiss the micro distributive conflict. As it was mentioned, the ways in which the state provides, funds, and regulates the provision of care bears immediate distributional results (between women and men, and between classes and generations). Ideally, states should guarantee minimum standards of care for all citizens, and "share" some of the costs of the carers by either reducing unpaid care work or compensating for some of their costs. The way in which this is done can reinforce or counterbalance gender differences in care burdens (see the policy section). Still, the important thing is that when the State deserts its role, families, the market or the community, struggle to fill the gaps in ways that in most cases *amplify existing inequalities.*

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[2] The "community" can also help. But again, there is not much role for the community when redistribution is not the solution (when resources other than time are required).
[3] For a proposal of how to measure these theoretical care needs, see Budlender (2008).
[4] These ideas resemble the "care diamond" laid out in Razavi (2007).
[5] Whether unpaid care work and income are substitutes or complements is a matter of debate. On the one hand, there are no market substitutes for some forms of care

government, the private sector, non-profits or other providers in the community. A similar argument could be made for including a range of questions on the availability of infrastructure and services such as piped water and electricity.

An analytical framework to evaluate policies

I would like to briefly define two broad categories of policies that could be put in place to fill care deficits and increase gender equality. These are "macro level" policies and policies for equal sharing of care responsibilities between women and men.

At the macro level, policies should be judged on whether they *strengthen citizenship.* If receiving care is considered a right, then entitlements supersede compensatory measures. Neither insufficiency in care (care deficits) nor unprotected and impoverished carers should exist. Alternative policy packages and "care models" can be contrasted through the lenses of citizenship. The "rights" perspective can be useful to take cases to Courts and also as a tool to legitimate political claims and build political consensus around care issues.

At the micro distributive level, Susan Himmelweit (2002: 64 – 65) established a set of criteria to evaluate policies, organized around three principles: a) the assessment of the effects of

should be clear that this has to be *decent* employment). Also, public policy should enhance the position of own account workers in terms of their "economic security" (Chen *et al* 2005).

Suggested policies: Policies to work towards equal sharing of responsibilities between women and men

***Reconciliation policies**:* in some contexts, introducing parental leaves and children allowances, and having good social security systems, ease the care burdens by providing resources for those in need of care, or by lowering the costs of those who provide care. In some other contexts, with pervasive levels of informality and low levels of labour law enforcement these measures might sound utopian (and are ineffective). In such contexts, direct provision of care services might perform much better (Benería 2008).

***Social policies that do not reproduce gender stereotypes**:* there is abundant literature on the fact that many "anti-poverty" programmes in Latin America have a "functional" approach to women's participation in them. They are based on the idea that cash transfers to women are better spent in "meritorious" goods and services than equivalent cash transfers to men; and exalt women's altruism and "care skills". In so doing, they perpetuate women's disadvantaged *position*, even if material conditions are improved (Chant, 2008; Molyneux 2007). Care becomes a duty for poor women and a "choice" for affluent women, whose households could eventually resort to different combinations of state provided and market provided care services. Social policies should be designed to contribute to tackle gender inequalities in care burdens, instead of taking them for granted and building on them[7]; and to truly *alter* the distribution of entitlements and income.

[7] For an example of such a programme, see Schmukler (2006)

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