5 How can public services address women's unpaid care work?

This chapter discusses the impact of gender-sensitive approaches to the provision of public services on women's unpaid care work. It begins with a look at the care need figures for different population groups, the largest of which is children. It then describes provision of care services – to children, the elderly, carers themselves – by different classes of social actors: the state as a direct provider, the market, and third sector organisations. The focus then turns to approaches to unpaid caregiving under the umbrella of public services that have been attempted in the case countries of Brazil, Kenya and Nepal; examples are given of NGOs and other, newer actors (e.g. social enterprises) stepping in to specifically address this burden when public health systems have not. Childcare services – especially preschool provision (ECD) – are explored, with Nairobi City Council furnishing an instructive example of collaboration with other actors to extend and upgrade provision of these services in the market.

Connecting public services and unpaid care work

This chapter examines the role of the state in recognising and reducing care, as well as redistributing it among women and men, the family, and itself. In all societies, infants and young children, elderly persons with reduced intrinsic capabilities, the ill or injured, and those with disabilities need care (ActionAid ([1]), 2013 for a description of the scope and content of unpaid caregiving). In general, state provision of public care services is designed with the priority accorded to persons needing care; scant attention is given to the unpaid caregiving burden undertaken to support them, typically by women.

Caregiving needs vary across regions and countries. Children are the largest population group in need of care in many low and middle-income countries, reflecting high fertility rates (Table 5.1). In sub-Saharan Africa, there are 79 children aged 0-14 years for every 100 people of working-age (15-64 years) and 40% of the total population is under 15 years old.[1] Latin America has the lowest share after OECD countries, with a ratio of 38 children for every 100 working-age adults and 25% of the total population under 15 years old. Elderly people form a much smaller, though increasing, proportion of the population, comprising for example 4% of the total population in sub-Saharan Africa, 6% in South Asia and 8% in Latin America.

Table 5.1. Dependency ratio, children and older people as shares of the total population, by region, 2016

Region/Group	Dependency ratio children (0-14 yrs-old) to working-age population (15-64 yrs-old)	0-14 yrs-old to total population (%)	65+ yrs-old to total population (%)
Middle East and North Africa	46	30	5
Latin America and the Caribbean	38	25	8
Sub-Saharan Africa	79	40	4
South Asia	45	29	6
Least developed country	71	40	4
OECD	28	18	16

Source: World Bank (n.d.[2]), World Development Indicators http://datatopics.worldbank.org/world-development-indicators/.

The care needs of persons with illness and disabilities are rising due to ageing populations and increasing numbers of people with disabilities who are living longer (Global Burden of Disease, 2015[3]). Disability prevalence is higher in lower-income countries and among women, the elderly and people from the poorest wealth quintile. Mental health conditions are widespread and have associated care needs. Suicide is the second most common cause of death among young people worldwide, and depression is among the largest single causes of disability, particularly for women (WHO, 2013[4]).

HIV-AIDS is the leading cause of illness and disability in three African countries and a major cause in many others. Although the rate of new infections has fallen worldwide, the level remains high[2] and HIV-AIDS care needs are rising as new medical treatments reduce the number of deaths. A range of "contextual" (non-medical) care and support services are required for HIV-AIDS patients, including repeated clinical visits, physical care, social support, pain and symptom management, and end-of-life care (UNAIDS, 2016[5]). Support groups offering a range of services were vital to the initial response to the epidemic (UNAIDS, 2016[5]) which gave rise to many third sector activities and "home-based care" activist groups (UN Women, 2015[6]).

Information on the extent to which care needs are met outside the household in developing countries is limited. Support for childcare is the most widely documented service: on average, 39% of children in developing countries make use of non-household care services. Much higher levels of coverage (70% or above for 3-5 years-old, on average) are found in Ghana, Vietnam, Thailand, Trinidad and Tobago, and

Jamaica (UN Women, 2018[7]). However, coverage through early childhood development/education focuses mainly on the older age groups (4-6 years-old) (UN Women, 2018[7]).

Public health systems in developing countries focus primarily on infectious diseases and mother and child health (HelpAge International, 2017[8]). In general, they are not sufficiently well resourced, from either national or supplementary donor sources, to support care needs or provide medical treatment. Sexual and reproductive health and rights are another key issue related to the provision of health services and women's unpaid care work. This includes their ability to choose the number and spacing of children; however, the World Health Organization (WHO) estimates that 214 million women in developing countries are not using modern contraceptive methods (WHO, 2018[9]). Lack of or uneven access to health facilities increases the extent to which care must be provided by household members, affecting poorer households and those in more remote or rural areas, especially in low-income countries.

Older people's care needs (usually referred to as long-term care) comprise a range of essential services and cash benefits – including nursing services at home or in institutions; cash benefits to cover services and related costs for equipment; adaptation of living environments; and cash benefits. In this regard, only 6% of the world's population is entitled by law to some level of coverage of these needs by the state, while 48% of the population have no LTC entitlements from the state at all. Nationwide services for institutional and/or home-based care are only available in countries that provide universal coverage for LTC (Scheil-Adlung, 2015[10]). At the other end of the spectrum, nationwide services are non-existent in countries where families are formally responsible for LTC, and even where eligibility rules foresee long-term care services for elderly people without any family members. India, People's Republic of China ("China"), Russian Federation, Algeria, Argentina, Brazil, Chile and Mexico have established by law that families bear the sole responsibility for the long-term care of their members (Scheil-Adlung, 2015[10]).

Across all types of caregiving, unpaid care is by far the predominant form of support (WHO and World Bank, n.d.[11]), with women providing the largest share of unpaid caregiving for children and the elderly, sick and disabled. In urban China, Mexico, Nigeria and Peru, women are the principal caregivers for care-dependent older people in 67-89% of households (WHO, 2015[12]). In Latin America, women account for more than 9 out of 10 unpaid caregivers in Argentina, and more than 4 out of 5 in Chile, Cuba and Uruguay (Armstrong, n.d.[13]).[3] Similarly, a survey of caregivers of elderly persons in Brazil found that 88% were women (Roquete, 2017[14]).

In addition to women providing care as mothers, many providers of childcare are grandparents. This is especially relevant in countries with high current or past HIV prevalence, resulting in "skipped-generation" families where grandparents raise their grandchildren due to the death of the parents (HelpAge International, 2017[8]). As of 2013, 18 million children had lost one or both parents to AIDS-related causes (UNDP, 2016[15]). In Zambia, due to internal migration and the impact of AIDS, 30% of older women are at the head of skipped-generation households (WHO, 2015[12]). Besides families, public health services often use "volunteer" community health workers who are either unpaid or receive very little compensation. This reinforces the undervaluation of care work and is reflected in the gendered distribution of paid workers in the labour market.

Women's unpaid caregiving burden has multiple negative effects. First, caregiving – especially long-term caring for the elderly – affects carers' own health, due to the stress and burden of the work (HelpAge International, 2017[8]; WHO, 2015[12]), which makes it difficult for carers themselves to access health services (Appleford, G et al, n.d.[16]). Effects are exacerbated for carers who are themselves elderly.

Second, there are strong negative intergenerational effects within families. In the absence of acceptable or affordable public services, mothers in low-income households who need to work for pay may bring their children with them to work, often in hazardous settings. In Pakistan, Peru, and 10 African countries, 40% of mothers resort to bringing young children to their place of work (World Bank, 2018[17]). Alternatively, they may leave their children at home uncared for or inadequately supervised. Older siblings, especially sisters, are often diverted into care work to support or substitute for their mothers to the detriment of their education

(ODI, 2016[18]); (Perlman, Wodon and Adamu, 2018[19]). In Egypt, an increase in the number of preschool-aged siblings has an adverse effect on schooling attainment for girls and rural children, while boys see a significantly higher likelihood of school attendance and better educational outcomes (Dancer and Rammohan, 2007[20]).

Third, women's economic status is affected by their care responsibilities in terms of ability to take paid work and the type of work that is feasible. The quality of their labour force engagement suffers, through higher rates of absenteeism and inability to work long hours continuously; the resulting discontinuous employment can eventually affect pension contributions upon retirement (see Chapter 5 on social protection). These effects further undermine the incentive for girls' families and for women themselves to invest in their own education, skills and training – thus perpetrating gender segregation of the labour market, leading to a longer-term macroeconomic impact (see Chapter 1).

Provision of care services can enable women's economic empowerment

In both developing and developed countries, providing quality and accessible care services is associated with a decrease in women's unpaid care work and increased women's labour force participation (OECD, 2011[21]); (O'Neill, Chopra and Vargas, 2017[22]); (Schlosser, 2011[23]); (World Bank, 2018[17]). In the Netherlands, for example, provision of childcare facilities led to increases in women's labour force participation, which in turn contributed to changes in the sharing of unpaid domestic work (OECD, 2018[24]). In Kenya, working mothers who received subsidised childcare were 17% more likely to be employed than mothers who did not (Clark et al., 2017[25]). In addition, working mothers in Kenya who were provided with subsidised childcare were able to work fewer hours overall than mothers without childcare, and this had no impact on their earnings (Clark et al., 2017[25]). There is also some evidence of the positive impact of long-term care provision and a consequent reduction in unpaid caregiving for older persons. Korea's insurance programme for the elderly intends to improve access to long-term care and reduced the share of care provision that family members (predominantly women) provided on an unpaid basis by 15% within two years (UN Women, 2016[26]).

While the effect of improved childcare provision on mothers' labour force participation is consistently positive and significant, it is not large (UN Women, 2016[26]); (O'Neill, Chopra and Vargas, 2017[22]); (Schlosser, 2011[23]). This may be partly because of limited opportunities for women in the local labour market, and partly because childcare outside the household reduces the intensity but not the extent of unpaid care work. Taking away one component of women's unpaid work burden, such as direct care, for part of the day does not alleviate the obligation to fulfil the remainder, domestic work.

Public services options for unpaid care work

This section describes care services provision by different classes of social actors: the state as a direct provider, the market, and third sector organisational providers. The state not only provides care services directly in a number of ways, but also shapes the distribution of caregiving among these different actors through the legislative and regulatory framework, fiscal policies, public investments and social protection policies (see Chapter 4 on social protection). Public policy is also the primary mechanism for alleviating individuals' unpaid caregiving burden, because it can shift care provision away from households towards those other social actors.

Table 5.2. Approaches to public services that address unpaid care work across different intervention areas

Intervention area	Approaches	Examples
Childcare provision: Early childhood development and publicly provided childcare	Provides for and delivers childcare services for 0-3 and 4-6 age groups: extended or improved quality of provision can redistribute care from households to the state; no direct impact on male engagement (though maybe spill over) Adapting to parents' needs to reduce unpaid care is possible in terms of hours and location of services, e.g. locating services near workplaces, within primary school compounds or mobile services, or providing services that better accommodate working hours and provision of meals Subsidised/ free access important for lower income groups.	Cambodia, Chile, Costa Rica, Ghana, Guatemala, Mexico, Mozambique, Thailand, Uruguay. India (SEWA, mobile crèches)
Employment policy, market provision of childcare and third sector organisations	Legislating for and regulating employer childcare can support redistribution of unpaid care from households to market Parental leave provision supports redistribution of childcare from women to men (see Chapter 4 on social protection); mainly applicable to those in formal employment	At least 19 countries out of 100 economies reviewed by World Bank/IFC – various
Health services and care provision for the elderly	Extended or improved services reduce unpaid care burden, including though reduced travel time and via impact on health outcomes Increased provision and improvements in quality of geriatric and/or disabled care through professionalisation may redistribute care from households to state mother and child health services can incentivise men's involvement in ante-/postnatal care and care of children Subsidised/ free access important for lower income groups.	Nigeria, Kenya (extension of mother and child health services) Costa Rica, India, Nepal (Chapter 4), Peru, Zanzibar Rwanda, South Africa (See Chapter 2 on shared household responsibilities)
Services for carers through social protection/cash transfers	Child benefits, childcare vouchers, cash-for-care payments or conditional cash transfers that enable access to childcare or other services, provision of childcare within wider social protection programmes: supporting redistribution of care from households to market or state Health and social insurance/pension programmes can improve safeguarding and access to long-term care; Potential impacts on reducing/redistributing care dependent on monetary amount (which may enable services to be bought in by households; or purchase of equipment – particularly relevant for care of elderly/ disabled)	Costa Rica (Chapter 4)

Source: OECD Best Practice Matrix; (Cassirer and Addati, 2007[27]); (HelpAge International, 2017[8]); (IFC, 2017[28]); (IFS, 2018[29]); (Martinez, Pereira and Naudeau, 2012[30]); (ODI, 2016[18]); (O'Neill, Chopra and Vargas, 2017[22]); (UN Women, 2016[26]).; (World Bank, 2018[17])

With the exception of the very few countries that have created a coherent policy framework on care (see Box 4.1 on Uruguay in the social protection chapter), most governments do not have a "care services policy" as such, but rather address the issue indirectly across government ministries and agencies, with varying degrees of co-ordination. This is most evident in respect of childcare through, for example, cash transfer programmes to poor households that are conditional on spending on childcare, preschool, or health facility attendance. Although most CCT programmes focus on the demand side for health and education interventions, in El Salvador the programme includes the supply side of infrastructure investments in schools, health centres and water and sanitation (de la Briere and Rawlings, 2006[31]). In general, however, there is a lack of co-ordination of programmes in different policy areas, and these are rarely designed, monitored or evaluated with the objective of alleviating women's unpaid caregiving burden (as opposed to care needs).

Care service provision by the state is implemented across a number of sectors, depending partly on the population group that makes use of the services. Table 5.2 provides an overview of key policy and intervention areas where public services can have an impact on unpaid care and work; how they do so; and relevant examples or evidence where available.

Childcare provisions

There are many alternative forms of non-homebased childcare emerging worldwide (UNICEF, 2008[32]), including in developing countries. Care service providers can be public, market-based (whether supplied by individuals, corporate service providers or employers), co-operatives or social enterprises, NGOs, or community-based self-help groups (Razavi, 2007[33]). The level and composition of provision varies considerably across countries, with implications for quality and access for different social groups.

Publicly provided childcare

There is widespread public provision of childcare across countries, concentrated in the preschool age group (3-5 years). Access to pre-primary school in developing countries ranges from a low of 17% in sub-Saharan Africa to a high of 65% in Latin America and the Caribbean (Devercelli and Neuman, 2013[34]) Children aged 3-5 in the richest households are almost six times more likely to attend an early childhood education programme than children from the same age group in the poorest households (UN Women, 2018[7]). There is no comparable information on childcare service provision for children below the age of three years, but provision is assumed significantly lower.

An example of a recent governmental intervention is the National Network for Childcare and Development in Costa Rica (Red Nacional de Cuidados y Desarrollo Infantil). This programme primarily serves children under seven years of age from poor and vulnerable families.[4] Other childcare projects have been provided by the state in Ecuador, Chile, Mexico, Uruguay, Ghana (IFS, 2018[29]), Chile, Guatemala and Mozambique (Cassirer and Addati, 2007[27]). Cambodia operates crèches at public sector workplaces under a national strategy for the poor and vulnerable; Argentina has a nationwide programme targeted at young parents that helps them complete their education.

Public preschool childcare provision recognises and reduces the amount of unpaid care work by carers of this age group, mostly women; yet the extent of reduction depends on hours of provision. It can promote redistribution of unpaid care within the household if fathers are encouraged to bring their children to the centre or participate in parenting support groups.

Market provision of childcare

Market-based provision of childcare is provided by employers (for the children of employees), and by market providers on a commercial basis. Childcare provision is obligatory for employers in 19 out of the 100 countries for which information is available (World Bank, 2018[17]). Moreover, provision can at times refer only to the children of female workers, which makes it easy for businesses to bypass the requirement – for example, by keeping the total workforce, or the number of female employees, below the threshold. There is no comprehensive information on the extent to which employers fulfil statutory leave and childcare support obligations in practice, although evidence suggests that larger companies are more likely to comply (IFC, 2017[28]). Given that these provisions may apply only to formal sector employers, in low-income countries where women's paid work opportunities are predominantly outside the formal sector, the reach of employer-provided childcare for equal childcare service access is limited in scope.

Formal childcare providers comprise privately owned and managed primary schools (which sometimes extend their services for preschool children), free-standing crèches, childcare centres and online platforms. These operate in many countries but are affordable only to medium- to high-income families. To the extent that they are formal and registered enterprises, they may also offer higher-quality care, as they are subject to mandatory service quality standards set by governments. Little information is available on the coverage of this market or the actual quality of care it provides in developing countries.

Informal childcare provision includes small local providers, operating informal (but fee-charging) childcare centres or babysitting services. Individuals, such as domestic workers providing childcare and other services, are also in this category. The actual numbers of those involved as caregivers are not known, but

some observers indicate that millions of such jobs exist worldwide (Cassirer and Addati, 2007[27]). Employment of this kind is largely informal and unregulated in both commercial and domestic settings, and the quality of care is variable: in many countries, it involves female migrant workers who can be exceptionally vulnerable to ill treatment (Cassirer and Addati, 2007[27]).

Third sector organisations

NGOs, communities, co-operatives and working parents themselves (directly or through trade unions) are also involved in childcare provision in Costa Rica, India and Thailand (Moussié, n.d.[35]).; (Cassirer and Addati, 2007[27]), Mozambique, Ghana and Colombia. Building on the pioneering work of organisations such as the Self Employed Women's Association (SEWA) in India and Women in Informal Employment Globalizing and Organizing (WIEGO), these programmes often serve poorer communities and parents, particularly women, in informal jobs in areas such as street vending, waste recycling, domestic work, seasonal labour in agriculture, fishery, seafood processing and home based work. Collective childcare programmes match the working hours of the parents and many take children even from a very young age (Peñalolén childcare in Chile and SEWA childcare in India). Many provide meals and health services to children in the centres (Cassirer and Addati, 2007[27]).

Long-term care for the elderly

In most low- and middle-income countries, there is limited development of public, formal long-term care services for older people. The provision of long-term care is a low policy priority given the extended belief that "families" are better placed to provide care (HelpAge International, 2017[8]). Ageing populations have pushed governments to introduce this on the agenda, especially in Latin America. In general, governments' main approach to supporting elder care is indirect, through social protection policies and programmes, notably pensions. Publicly funded pensions allow older persons to pay for health services and relieve other family members from the care role (HelpAge International, 2017[8]) to some extent, depending on their monetary value. The Government of Korea, for example, recently introduced an insurance plan to increase the affordability of privately provided care services for the elderly (UN Women, 2016[26])

Other services for the elderly include government-run small residential care homes. These often target older people with no resources, but exclude those with challenging conditions such as dementia. In Brazil for example, the federal government runs a single residential home, located in Rio de Janeiro, with a capacity of 300 people (HelpAge International, 2017[8]). At the same time, there has been a rapid growth in private sector residential services as well as nursing agencies offering home care. These new sectors are weakly if at all regulated, raising concerns about the quality of care and the potential exposure of older people to abuse (HelpAge International, 2017[8]). The Government of Zanzibar provides free medical care and free transport to older people in both public and private commuter buses, as well as supporting elderly centres (HelpAge International, 2017b[36]).

Services for carers

Information provision, financial support and respite care all benefit informal carers, recognising and reducing their caregiving burden. An intervention offering support and education to carers of people with dementia in India led to improved well-being and health status for both the carers and their dependants (WHO, 2015[12]). Those services are now being replicated in a number of other countries, including Peru. Another option involves local health workers assessing when family carers need additional support (such as limited home care services or respite care). A number of countries are now experimenting with these integrated models, including Costa Rica, which has established a programme for 12 000 older people in poverty (HelpAge International, 2017[8]).

Evidence from Brazil, Kenya and Nepal on how public services can address women’s unpaid care work

This section discusses approaches to unpaid caregiving under the umbrella of public services that have been attempted in Brazil, Kenya and Nepal. It describes types of service provision and whether the motivation or effect is to alleviate the unpaid care work burden. “Public services” refers to any provision outside the household, including but not limited to direct service provision by the state. The discussion covers support for both caregivers and the different population subgroups requiring care (children, older people and people with disabilities). Programme interventions are divided along these lines, with few overlaps and little efforts at co-ordination.

In all three countries, policy attention and practical efforts to address unpaid caregiving through direct public service provision are most widespread in the field of childcare. This is consistent with the wider international picture described above. The Educaçao Infantil programme in Brazil operates large numbers of public preschool nurseries for this age group. Meeting professional standards, the nurseries have achieved high enrolment rates.

In Nepal, the government prescribes national-level preschool and early child development (ECD) centres, which local administrations are authorised to run. In 2007, it supported more than 7 000 community ECD centres, although this still falls far short of need. Start-up public funds are offered but local matching funding is required for operation, and many communities have not been able generate sufficient funds. In some cases, communities have taken charge of government centres (Key informant interview, ActionAid). At the time of a 2007 assessment, primary school attendance was not compulsory, and only 10% of the one-third of children entering primary school had any preschool experience (UNESCO, 2007[37]). Some welfare organisations have run ECD centres, mainly for orphans and destitute children. International third sector organisations have been active as providers, notably Plan International, UNICEF and Save the Children (UNESCO, 2007[37]). At the present time, ActionAid has 21 community-based childcare projects designed around community-level standards and concerns (Key informant interview, Nepal).

In the 2010 Kenyan Constitution, the mandate for ECD services was devolved to the local level. In Nairobi, the need for affordable public childcare is very high. Women heads of household have very high rates of labour force participation (80%) (Lokshin, n.d.[38]), and the presence of preschool-age children in a female headed household reduces the rate of girls’ enrolment in secondary school by more than 40% when alternative childcare is not available (Lokshin, n.d.[38]). Evidence also shows that caregiving responsibilities negatively impact women’s ability to access child health and nutrition services (Appleford, G et al, n.d.[16]). The City Council now oversees public ECD services and there are facilities in about half of all the wards in the city: it operates 205 preschool classes attached to primary schools, 24 ECD centres in primary schools and 24 independent standalone ECD centres in high-density areas. Fourteen thousand children aged 4-6 years are provided for out of a total estimated number of children of almost 300 000 in this age group (Nairobi City Council, n.d.[39]), which amounts to slightly under 5% of the total eligible age group. The Council targets poorer areas in Nairobi, with 60% of its facilities in informal settlement communities or “slums”, where there is a high proportion of female-headed households. It also accords priority to children with disabilities and special needs.

Beyond its role in direct provision, the Nairobi City Council is also required to regulate and enforce care standards in both its own and other childcare centres and nurseries, and has set out ECD standards in a number of guidance documents. However, it lacks the resources to enforce these and faces a major challenge in raising standards in its own facilities as well as in monitoring and enforcing compliance across the sector. One large USAID-funded programme, the Tayari project, concentrates on providing training for childcare centre staff. To date, however, there remain challenges with the quality of ECD services: public preschools are poorly resourced and managed, as demonstrated by inadequate play and learning materials, the shortage of trained teachers, and a lack of health and nutrition services or of a consistent, child-centred curriculum (Njagi, 2017[40]).

Public health systems in the three countries are largely unmindful of the unpaid caregiving burden. According to a key informant interview from the Brazil Women's Secretariat, the issue of care is said to be "completely hidden". Some third sector organisations are however working to change the situation. For example, Mothers and More is an NGO project in Brazil that improves the affordability and accessibility of public health services for mothers and children from poor households, alleviating the actual and potential care burden for caregivers (Key informant interview, Brazil). In Kenya, a child maternal health project reportedly increased the number of service locations in the project area when they realised that caregiving constrained female participants' ability to access services and remain in the programme (Appleford, G et al, n.d.[16]); (Key informant interview, Kenya IDRC).

Regarding long-term care of the elderly, there are a few scattered interventions of different types in the three countries, although in general LTC is very limited. In Brazil, there is no nationwide institutional care service for the elderly or home-based care services, and there is very limited capacity in communities (Scheil-Adlung, 2015[10]). Research has found that LTC institutions employ medical professionals who are unprepared to provide care, meaning that care for the elderly is restricted to the essentials[5] (Roquete, 2017[14]). In Nepal, availability of care from a spouse or child may be essential to the well-being of the very old or frail elderly; social norms (and residential patterns) are, however, changing – and the elderly are now one of the most neglected groups in Nepalese society (Chalise and Brightman, 2006[41]). HelpAge's programme provides technical assistance to ameliorate public health services by improving geriatric care and nursing skills among health professionals working in institutions (Key informant interview, Nepal).

In Kenya, there are a few government homes for the most destitute and for people with the most severe disabilities. Some private (corporate) businesses provide elder care services on a commercial basis, but at rates only affordable by well-off households (Key informant interview, Kenya). Charities are active in the sector, and there is growing private (market) provision of home-based nursing services. This results in some public services for elder care for the destitute and for high-income groups, but for almost nothing in between (Key informant interview, Kenya, African Population and Health Research Centre [APHRC]). In general, services are oriented toward reducing the need for and improving the quality of care for older people, rather than on recognising or addressing the burden of unpaid care on families. However, this unpaid care is often provided by other elderly people, a consequence of HIV/AIDS-related mortality and morbidity among working-age adults (Key informant interview, Kenya HelpAge International).

Care for people with disabilities (and their caregivers) seems to be limited to charitable and humanitarian relief programmes. A focus on disability is however integrated in some wider interventions. In Kenya for example, the Early Childhood Development programme in Nairobi also attempts to ensure that children with learning and other disabilities are included through community health worker referral (Key informant interview, Kenya). Most commonly, support for the elderly and disabled is realised through anti-poverty programmes, health services or education policies and programmes. As regards anti-poverty programmes, in countries with high HIV/AIDS prevalence and large numbers of orphans, much unpaid care work (for children, the sick and the elderly) is done by older people, and the well-being of the two groups is interlinked. In Kenya, which is not the worst HIV/AIDS affected country, 55-68% of orphans and vulnerable children are cared for by their grandparents (Key informant interview, Kenya HelpAge). Alongside vulnerable children and orphans themselves, caregiving grandparents in Kenya (mostly women) have been the core group of beneficiaries of the poverty-focused cash transfers for orphans and vulnerable children (CT-OVC) programme, discussed in Chapter 5 on social protection.

There was relatively limited evidence in the case study countries of initiatives in other policy areas that directly seek to impact on unpaid care work. Promundo's work in Brazil and globally, with health services to engage men in care work, is discussed in the Chapter 3 on shared responsibility in the household. More broadly, with respect to health services, these are often divided into single-issue programmatic silos in which donor funding is concentrated (Key informant interview, Kenya APHCR), which makes addressing cross-cutting issues like unpaid care work challenging.

Lessons learned in Brazil, Kenya and Nepal on addressing unpaid care work in public services

Across the three countries, there were very few examples of public service programmes or policies that address, or demonstrably impact upon, unpaid caregiving by recognising, reducing and/or redistributing it. As noted, the interventions that have been most widespread and greatest in scale have been in the field of childcare. Nursery school policies and programmes implicitly recognise and significantly reduce the unpaid caregiving burden for parents. Childcare interventions also permit parents (particularly mothers) to increase their paid work, to varying degrees depending on the costs and hours of provision. In Nairobi slums, improved access to childcare services was found to be associated with increased female employment (Key informant interview, Population Council). This makes it cost-effective for more mothers to pay for childcare, and has also led to demands for improved quality in that care (Key informant interview, Kenya Kidogo).

Policy advocacy and evidence on the impact of interventions may help explain the widespread adoption of ECD programmes in many countries; the expansion of childcare services has become official policy in many countries in the past 20 years or so, with considerable influence and support from UNICEF. Such advocacy has led to childcare policies of the type that have been adopted in Brazil and Kenya, though not yet in Nepal.

In Brazil, the central government required cities to support public childcare services from 1997 but gave no financial support until 2007, when resources from a national fund became available. Funding is now shared between central and local government. National funding is made available according to a formula demonstrating need, i.e. actual enrolment in the centres. It covers a range of non-staff requirements (equipment, courses, food for meals, transportation, etc.). Local governments have also sought national-level funding to construct new care centres: 4 700 are planned and 3 100 have been constructed to date.

Interventions addressing unpaid care work through fee-paying childcare services can only succeed where families have the financial resources to pay for them, where they have the skills and experience to undertake paid work, and where there is sufficient demand in the local labour market for women to have employment opportunities or the possibility of working as entrepreneurs. This means that women from poor households in impoverished rural areas with limited market opportunities are far less likely to have their unpaid caregiving burden alleviated by these means.

In recent years, international NGOs and other, newer actors (e.g. social enterprises) have built on or extended existing statutory provision, with a focus on groups or geographic areas poorly served previously, such as Action Aid’s support for rural childcare provision in Nepal and HelpAge interventions to promote better-quality elder care provision. ActionAid Nepal provides partial initial funding for its community childcare centres to cover equipment, meals, games and toys, etc., sharing costs not only with municipalities but also with clients and the community. Once a centre is running, small fees are charged to users and the centre does local fundraising as well. Homenet Nepal also contributes to cost of its childcare centres, sharing funding with the municipality and with volunteering staff, who presently provide 50-60% of total staffing effort.

Recent developments in childcare provision in Nairobi, Kenya provide an interesting case of collaboration between social enterprise, impact investment actors, informal providers and municipal government that may offer useful lessons for other municipal authorities. Since the 1990s, the Government of Kenya has held responsibility for training, supervision and inspections of childcare facilities for preschool services (the 4-6 year age group), but the coverage of publicly provided services remains very limited. There are also an estimated 300 private preschools and approximately 2 000 small-scale alternative providers (community schools, low-cost family schools, and so on) (Key informant interview, Nairobi’s City Council). Another estimate is that there are 3 700 childcare centres in the city, covering children from 0 to 4 or 5 years (Key

informant interview, Tinytotos). For the past few years, the City Council has worked collaboratively with established organisations, such as Action Aid or the Aga Khan Foundation, and with two new, innovative private sector actors whose aim is to upgrade services by supporting existing informal suppliers (see Box 5.1).

Box 5.1. Social enterprise and innovation in childcare provision in Nairobi: Collaboration between actors

Given the significant need and demand for childcare services in Nairobi, especially among less well-off groups such as women heads of household, Nairobi City Council has chosen to collaborate with other actors: 1) NGO Aga Khan, 2) a social enterprise (KIDOGO), and 3) an impact investor (TinyTotos), in attempts to extend and upgrade childcare services provision in the market.

KIDOGO seeks to raise standards by providing staff training and operating a small number of demonstration centres. It operates a "hub and spoke" model that acts like a franchise, encouraging participating centres to improve the quality of childcare provision, including through good nutrition, and giving them permission to use the KIDOGO label. Tinytotos facilitates impact investing focuses instead on the operational competence of the providers, seen as SMEs. Thus, it emphasises managerial competence as well as quality of care provision in small childcare centres. The two organisations both have good relations with the city government, and are respected for their innovative approaches and the additional resources they bring in the effort to improve standards across the sector.

Both have been very successful in terms of proving the value of their respective business models and meeting objectives. KIDOGO points to its good performance in terms of numbers of trained staff and of meals provided for the children and so on, whereas Tinytotos emphasises the revenues and profitability of the centres participating in its programme, providing training services on a commercial basis and access to viability gap financing. They share a belief in the market-based approach as the key to sustainability, contrasting it favourably with externally provided, donor-funded, time-limited interventions that tend to close down when the project ends.

This collaboration is fuelled by a genuine interest and confidence on the part of the local authority in market-based approaches to "proof of concept" and by enhancing demand through improving care standards. The authority trusts market actors to work within the regulatory framework it has set, and has a non-punitive approach to enforcement. It recognises that without the other actors' inputs, compliance with the quality standards they have drawn up could not be assessed, let alone assured. This also provides the local authority with a shield against the possibility that government ministries (e.g. industry or treasury) might demand closure of non-registered providers, and usher in corruption among official inspectors. This close collaboration is, however, heavily reliant on one individual inside the City Council who champions the policy; there are some concerns that attitudes and practices may change were they to leave their post (Key informant interview, Kenya Kidogo).

Both organisations charge fees to parents and to trainee caregivers, on the grounds that it is important to demonstrate value to both groups and not to distort the market by free provision. In both cases, they report that parents accept (small) increases in fees when the quality of care improves and meals are given, and suggest that this is possible because childcare is cost-effective and enables mothers to earn more. By contrast, NCC has decided to remove fees for its services, citing parents' complaints that they were "exploitative" and arguing that this allows it to reach the lowest income households in the city.

Source: Key Informant Interviews, Kenya

In general, however, childcare provisions do not promote redistribution of caregiving between men and women. Instead, it often tends to reinforce women's primary responsibility for undertaking care or organising access to it, thus perpetuating the "normal" pattern of specialisation in caregiving. There is scope for redistribution of the unpaid caregiving burden within families when childcare services introduce complementary measures such as encouraging more fathers to bring their children to nurseries and get involved in parent-infant teacher/care worker discussion forums. There are some exceptions where redistribution of caregiving is reported in conjunction with childcare provision. For example, some fathers and men are involved both in managing their children's participation in the Nairobi City Council (NCC) nurseries (Key informant interview, NCC) and as childcare providers (on an entrepreneurial basis) in the private sector (Key informant interview, Kenya NCC and Kidogo).

Health services usually only address unpaid care work by way of improving care and nursing services in institutional settings or with improved community outreach. The high level of demand for Age Nepal's project to train professional caretakers in geriatric care (Key informant interview, Nepal) suggests that such skills are at a low level in the health sector workforce in that country. In both childcare and elderly care, improvements in care service provision standards widen the options available to current caregivers. With some notable exceptions, health service interventions do not involve any explicit encouragement for a fairer gender division of unpaid caregiving. A counter-example is Brazil's Mother and More project, which has sensitised older children to their mother's caregiving burden; the children sometimes give voice to this understanding by encouraging other family members to share the load (Key informant interview, Brazil).

Two international NGOs, Oxfam and ActionAid, are working in both Nepal and Kenya to directly address unpaid care work in their strategic programming. Their chosen approach to policy implementation is through activities decided by women's groups and communities. However, caregiving burden does not consistently surface among women's primary concerns in women's groups or community assemblies; the focus is instead on other aspects of women's economic empowerment, such as increases in income-earning activity and political representation (Key informant interview).

Key findings

Governments have a leading role to play in providing and regulating care services

Governments have a key role to play in redistributing unpaid care from household to the state and the market, both through direct provision of care services (often at local or municipal government level) and through establishing linkages to wider social programmes (e.g. social protection programmes) and creating incentives for other actors – notably employers, NGOs, co-operatives – to provide such services outside the household. They also can play a key role in regulating the provision of care services, to ensure that they meet adequate standards of care. At the same time, making public service provision universal and accessible to all can ensure that these policies do not inadvertently increase inequality. This is central to the "leave no one behind" agenda and reaching women living in poverty or in informal employment, for example.

Some governments and donors have made important advances in subsidising early childhood care, most often for reasons of human capital development. It is also a proved effective strategy for increasing women's engagement in the paid labour force, and thereby for promoting women's economic empowerment and reducing gender inequalities. The relatively high level of commitment of some governments to public funding of childcare provision responds to long-standing research evidence and

advocacy about the social value of preschool support. A number of governments have made policy commitments to expanding preschool education, particularly for the 4-6 age group, while provision for younger children has received much less attention.

More broadly, a childcare transition is under way, with an evolving and growing spectrum of service provision by market, third sector and public actors. Multi-party co-ordination can promote innovation in services provision in unpaid care, improving both reach and quality. In all three case countries, examples were found of collaboration between state providers of national, publicly financed care systems (healthcare and childcare), third sector organisations and, in one case, private sector providers; the aim was to enhance and improve the quality of care services (some with donor funding), through standard setting, better training and regulation. Improved quality of services is likely to increase demand, or at least expand choices.

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Notes

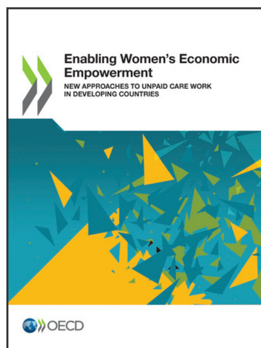
[1] Standard international data on the distribution of population by age does not distinguish smaller age groups among children within the overall 0-14 year range.

[2] http://www.unaids.org/en/resources/presscentre/featurestories/2016/december/20161202_HIV-care.

[3] Men spend a much higher portion of their unpaid workload outside their own households, according to data for 14 countries (all that is available): about half of their total caregiving effort. Even so, women spend about the same amount of time as men in this way.

[4] http://news.co.cr/costa-rica-initiates-public-early-childhood-education-program/51187/.

[5] That review covered a mix of private non-profit institutions, private for-profit institutions, public facilities and charitable institutions.



From:
Enabling Women's Economic Empowerment
New Approaches to Unpaid Care Work in Developing Countries

Access the complete publication at:
https://doi.org/10.1787/ec90d1b1-en

Please cite this chapter as:

OECD (2019), "How can public services address women's unpaid care work?", in *Enabling Women's Economic Empowerment: New Approaches to Unpaid Care Work in Developing Countries*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/4f87a336-en

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