IN BRIEF

LANDSCAPE OF CARE WORK IN ZIMBABWE

UN WOMEN

Photo credit: WFP/Claire Nevill

Introduction

Care work encompasses a diverse range of paid and unpaid activities dedicated to providing care, support, and assistance to individuals, households and communities. Care work is an essential public good that benefits society. It is critical for realising human rights for all and for strengthening human capabilities. Care work is disproportionately carried out by women and girls in Zimbabwe just like it is the case globally. Within the 2030 Agenda for Sustainable Development adopted by world leaders in 2015, Sustainable Development Goal (SDG) 5 aims to achieve Gender Equality. SDG 5.4 specifically pertains to the care agenda and underlines the importance of recognising and valuing unpaid care and domestic work, with the target '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'.

Definitions

Care work consists of activities and relations to meet the physical, psychological, and emotional needs of adults and children, old and young, frail and able-bodied.[1] It includes direct caregiving activities related to caring for children, the elderly, people with illnesses, and people with disabilities, as well as indirect or domestic work such as cooking, cleaning and collecting water, food and firewood.[2] It should be noted that feminist analysts have argued that direct and indirect care are fundamentally interconnected because both direct and indirect care work are often performed simultaneously in the global south.[3]

Unpaid care work refers to the services provided by individuals within a household or community without receiving any monetary compensation for the benefits of its members. Most unpaid care work takes place within families. Unpaid care work also occurs at the community level for people outside the home (friends, neighbours, and community members).[4]

Paid care *work* provides direct care for individuals in a household or institutional setting in exchange for monetary compensation. Paid care is provided in various public and private settings, in both formal and informal economies, including paid domestic work, social care work, healthcare, education and childcare.[5]

Establishing ***comprehensive care systems*** that consider the varied needs of individuals with disabilities, the elderly, people with illnesses, and children while adopting an intersectional approach is crucial. A **comprehensive care system** is defined as "...a set of policies aimed at implementing a new social organisation of care with the purpose of caring for, assisting and supporting people who require it, as well as recognising, reducing, and redistributing care work – which today is performed mainly by women – from a human rights, gender, intersectional, and intercultural perspective, these policies must be implemented based on inter-institutional coordination from a people-centered approach..[6]

Zimbabwe is a lower-middle-income country located in southern Africa. Since 2000, it has experienced a deteriorating economic, political and social environment, which has led to a weakened social welfare system.[7] The female HDI value for Zimbabwe was 0.580, compared to 0.604 for men in 2021, resulting in a Gender Development Index[8] of 0.961. This places Zimbabwe in Group 2, indicating that the country is close to gender parity. Yet, structural inequalities are deeply rooted in Zimbabwe's society, evident in the high rates of gender-based violence, limited representation of women in decision-making bodies, and women's lower access to economic opportunities and resources.[9] Such inequalities also manifest in the distribution of care work and the extent to which care needs are met in the country.

Achieving SDG 5.4 calls for appropriate investments in care infrastructure, social protection systems and public services to promote shared responsibility for this essential work amongst the government, private sector, households, and communities. Policy emphasis on care work is crucial for addressing gender disparities, promoting women's empowerment, and preventing the feminisation of poverty. Further, investments in the care economy can contribute to inclusive growth and human development by addressing the interlinked issues of poverty, health, education, decent work, and gender equality.

The overall purpose of this brief is to present an overview of the existing care services, systems and infrastructure in Zimbabwe. Using this analysis, the study aims to demonstrate gaps in data and policy on care. A mixed methods research approach consisted of a desk review of existing publications and academic records, combining quantitative and qualitative data sources. The review was light-touch and did not allow in-depth exploration of all legislation and policies. To this end, section 2 discusses Zimbabwe's historic and contextual backdrop. Section 3 explores the extent of care work and care needs in the country. Section 4 dives into the relevant legislative, institutional and policy environment and gaps. Finally, Section 5 concludes and provides policy recommendations.

Country background

Zimbabwe is a landlocked lower-middle income country in Southern Africa, with a population of 16.3 million in 2022.[10] Its GDP grew by 3.0 per cent in 2022, down from 8.5 per cent in 2021.[11] Although agriculture contributed to only 8.8 per cent of the GDP in 2021, it employed 62 per cent of the total employed population in the same year. Over one-third of the country's population lives in rural areas.[12] Zimbabwe has one of the largest informal sectors in the world, and about 76 per cent of total employment was estimated to be informal in 2019.[13] Extreme poverty (44 per cent headcount ratio in 2022) remains challenging.[14] Structural transformation has been slow, and low agricultural productivity remains a consistent problem. However, the economy has high human capital, especially compared to other countries in sub-Saharan Africa.[15] The country is also vulnerable to climate change, especially droughts and floods, and ranked 44th most vulnerable per the Climate Change Vulnerability Index (CCVI) in 2021.[16]

Gaining independence from British colonial rule in 1980, Zimbabwe enjoyed relative stability and economic growth under the leadership of Robert Mugabe for the first decade of independence. However, political unrest and economic decline escalated in the late 1990s and early 2000s. Hyperinflation reached unprecedented levels in Zimbabwe during the late 2000s and early 2010s, leading to the abandonment of the Zimbabwean dollar. The country adopted a multi-currency system, where foreign currencies, including the US dollar and South African rand, became the primary means of exchange. In recent years, there have been attempts to reintroduce a local currency, and in 2019, the Zimbabwean government launched a new currency, the Zimbabwean dollar. The political landscape witnessed significant changes in 2017 when Emmerson Mnangagwa assumed the role of president. Efforts to revive the economy and address long-standing issues are ongoing.

Traditionally, Zimbabwe is a patriarchal society where men have more power and status than women. Culturally, men are taught to view themselves as 'breadwinners' while women are taught to be obedient housekeepers.[17] Although Zimbabwe's legal and policy frameworks are progressive and largely support gender equality, structural barriers to women's empowerment and gender-based discrimination are persistent across the country. For instance, the radical land redistribution reforms introduced in 2000 increased women's access to land over time.[18] However, women still have limited access to assets and resources, and they are overrepresented in the informal sector, where vulnerable employment affects 74.6 per cent of women compared to 54.6 per cent of men.[19] Furthermore, the use of formal financial products

and services by women in Zimbabwe is low at 43 per cent compared to that of men, which is 50 per cent.[20]

Overview of the extent of care work and care needs

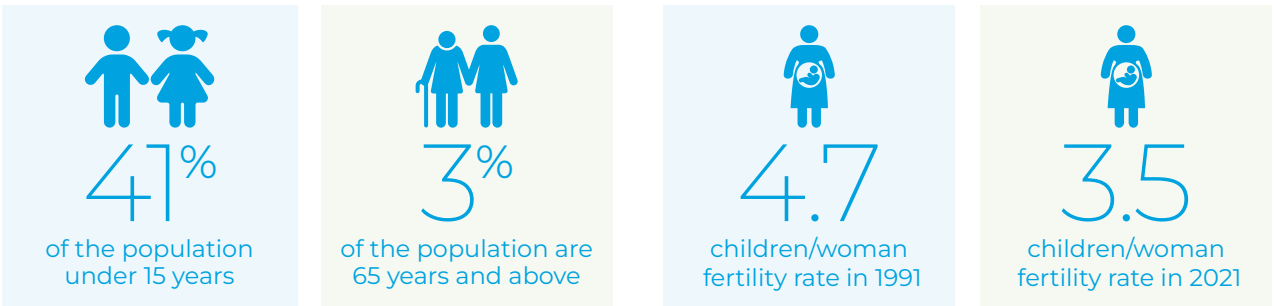
There is limited availability of up-to-date information and data on indicators that reflect gender issues in Zimbabwe, although there is momentum to improve gender statistics. Specifically, data on unpaid care work through time use surveys are lacking, while data on areas such as gender and the environment lack comparable methodologies for monitoring over time. Zimbabwe National Statistics Agency is the country's main source of official statistics. A Gender Statistics Committee, chaired by the Ministry of Women Affairs, Community, Small and Medium Enterprises Development, was set up by the agency to promote the production and use of gender statistics. With this caveat in mind, this section presents data from the latest nationally representative surveys, international data sources, and smaller studies to present an overview of the extent of care work and care needs in the country.

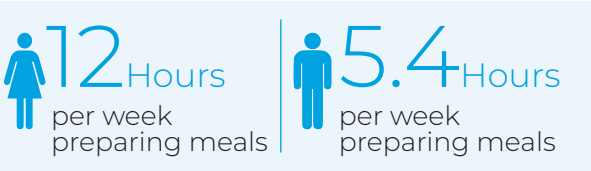
Care needs and unpaid care work

With 41 per cent of the population under 15 years old and 3 per cent aged 65 years or older, [21] the number of dependents with high care needs in the country is substantial. About 9.5 per cent of the population also had at least one type of disability in 2022[22] Zimbabwe's population is transitioning as fertility rates have been dropping over time, from about 4.7 children/woman in 1991 to 3.5 children/woman in 2021.[23] On the other hand, the estimated life expectancy was 58 years in 1991, saw a dip till the late 2000s and rose again to 59 years in 2021. [24] Based on these demographic statistics, the number of dependents is set to decrease in the coming years. However, this does not mean that care needs in the country will decrease with time. For instance, Zimbabwe is undergoing rapid urbanisation like many African countries (urban growth rate of 2.2 per cent between 2015 and 2020[25]), and its family structures are slowly changing.[26] This is leading to difficulties in meeting the care needs of the elderly and persons with disability, especially in rural areas. The elderly in urban spaces are living in resource-scarce conditions with little care and support, although they are often providers of crucial caregiving services to their households.[27]

Women in sub-Saharan Africa spend 3.5 times more time on unpaid care work daily than men (263 minutes vs 78 minutes). Domestic services, as opposed to direct care for dependents, make up much of the time spent on unpaid care work.[28] The Labour Force and Child Labour Survey (LFCLS) 2019[29] corroborates these findings in Zimbabwe.

Women in Zimbabwe spend, on average, 25.9 hours per week on unpaid caring activities for children under five years and ill adults, compared to only 16.1 hours per week spent by men. Women spend 12 hours per week preparing meals, almost twice what men spend (5.4 hours per week) on the same.





Women also spend much more time on other domestic duties such as:

Cleaning the house.

Fetching water

Fetching firework

Research also finds that women are primary caregivers for the elderly in households.[30] Thus, overall, women bear disproportionate household responsibilities for unpaid care work.

Oxfam's 2017 Household Care Survey (HCS)[31] found that this unequal distribution of unpaid care work begins in childhood and persists over time. Girls aged 8-12 years spend 1.7 hours a day more than boys of the same age group on unpaid care activities, and girls of 13-17 years spend 1 hour more than boys of the same age group. This comes at the cost of less time girls spend on leisure and sleep for girls between the ages of 8 and 12 years (about half an hour less). If overall work hours are added – paid and unpaid – then girls between the ages of 8 to 17 years spend 30 minutes to one hour more on work every day than boys. Interestingly, global research similarly finds that if both unpaid and paid work are added, working women spend more hours per day on work than working men.[32]

Traditional norms and beliefs and the dearth of care services, are important contributors to upholding the unequal division of unpaid care work in the country. For instance, although 86 per cent of men in the HCS reported that they approved of men doing care work, only 47 per cent of men thought that other men in their community would approve of men doing care work.[33] HCS also found that marriage is associated with greater inequality in primary care hours, with married men spending less time on primary care.[34] Although the exact reason cannot be established, marriage might reinforce the gendered division of labour within households. Having at least one child under six was significantly associated with higher care hours for women. This suggests a shortage of formal childcare provisions in the country, due to which household women bear primary responsibility for young children's care.

Zimbabwe also grapples with the effects of climate change, which is expected to increase the total burden of unpaid care work. Droughts, heatwaves, heavy rains with flash floods, strong winds and hailstorms are some of the extreme events that are becoming increasingly common.[35] Due to a lack of economic diversification and significant dependence on rainfed agriculture, climate change affects agricultural production and food security. Such changes would affect people's health, thus increasing healthcare needs and the time taken to complete domestic work like collecting water. Global research shows that climate change disproportionately increases women's and girls' responsibilities for providing care work.[36]

HIV remains an important health crisis in the country. As of 2022, the prevalence rate was 11.0 per cent among adults,[37] and HIV/AIDS was the leading cause of disability and death in Zimbabwe in 2017.[38] Significant improvements have been made in decreasing the infection count since the peak of the crisis in 2008, when the prevalence rate was 33 per cent. Social stigma against the LGBTQIA+ population worsens the HIV burden in the country. The welfare system in the country has been overwhelmed in the last two decades, in large part due to the economic crisis and has struggled to provide adequate care to people with HIV/AIDS. Vulnerable groups, including the elderly and persons with disability, face difficulty accessing health care for HIV/AIDS. Older adults also struggle with the burden of a "skipped generation" as their adult children get sick and die and foster orphaned children.[39,40]

Labour force and paid care sector

Collating data from the labor force and household surveys from 27[41] African countries shows that the most important reason cited by women for being out of the labour force was unpaid care work (34.4 per cent of women cited this).[42] Women's employment rate in Zimbabwe is lower than men's (61 per cent vs 72 per cent in 2022), and thus, women experience a gender employment gap of 11 percentage points.[43]

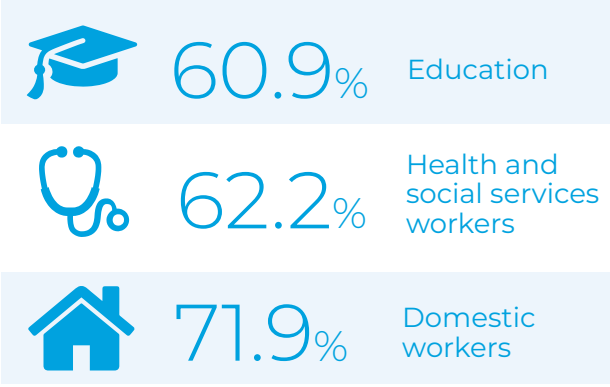
Employment rate in Zimbabwe, 2022.

Women also spend less time on economic activities than men. About 53 per cent of women and 47 per cent of men spent less than 20 hours on paid work activities every week.[44]

This is on work per week. [45] While there are many reasons for women's lower participation in economic activities, women's disproportionate responsibilities for unpaid care work are an important contributor in sub-Saharan Africa. Furthermore, the Interim Poverty Reduction Strategy Paper (I-PRSP) (2016-18) found that women earned only two-thirds of men's income on average due to sectoral and occupational segregation. Such a gender pay gap is directly associated with women's responsibilities for unpaid care work.[46]

Care sectors – education, health and social services, and domestic workers – make up only 14.5 per cent of total employment in Zimbabwe, according to LFCLS 2019.[47] This shows that the size of the care sector is small and largely inadequate to meet the care demands in the country.

Representation of women across the care sectors



Women are overrepresented in care sectors.

In addition, about 1.5 per cent of all children between the age of 5-17 years are child domestic workers, with more girls than boys engaged in this profession (56.4 per cent girls and 43.4 per cent boys).[48] These sectors are characterised by vulnerable employment, such as casual, part-time and fixed-term contracts.[49] Although labour migrants in many countries are overrepresented in care sectors, this is not the case in Zimbabwe. Agriculture and retail trade are the biggest sources of employment for migrants, with 45.5 per cent in agriculture and 13.9 per cent in retail trade.

Legislative, institutional and policy environment and gaps

Public policies play a crucial role in shaping the dynamics of care work. They can reinforce or alleviate the care responsibilities of individuals, particularly women and households. Care-sensitive policies that support a care society contribute to gender equality, support women's safety and empowerment, and the overall well-being of communities. They are essential in addressing inequalities in unpaid care work and inequalities in the labour force, including paid care sectors. With this context, this section examines legislation, institutions and policies on care in the country against the four pillars of a purple economy – universal social infrastructure, labour market regulations, physical infrastructure, and enabling macroeconomic environment.[50]

Zimbabwe's Vision 2030 guides its development trajectory. It seeks to "transform Zimbabwe into an Upper Middle-Income Economy by 2030 with a per capita gross income of between US$3 500 and US$5,000". Furthermore, the government

recognises the challenges of unpaid care and women's lack of decent paid care work. It has undertaken a rapid assessment to understand women's responsibilities for unpaid care work, but no concrete interventions have followed.[51] At the time of writing this snapshot, the rapid assessment could not be found online.

Universal Social Care Infrastructure

Collectively, socialised childcare, elderly care, and care for people living with disabilities are called social care infrastructure and are the principal source of care when unpaid care is insufficient to meet care demands. More provision of socialised care infrastructure and services can also reduce unpaid care work undertaken by households and communities. For instance, HCS found that access to healthcare facilities was associated with increased leisure hours for men, more sleep hours for women, less paid work hours, and equal distribution of caring labour between women and men in Zimbabwe.[52] Adequately financed social care infrastructure that pays living wages to its workers is important for valuing, rewarding and redistributing care work. There is a lack of socialised care infrastructure in Zimbabwe, as well as sparse regulation of privately provided care services.

Healthcare

Zimbabwe's healthcare system is currently working towards the National Health Strategy (2021–2025)[53] under the stewardship of the Ministry of Health & Child Care. Despite recent gains such as high coverage of family planning and antiretroviral therapy (ART), the healthcare system has declined for over a decade due to various interconnected political and economic reasons.[54,55] Antenatal care and maternal mortality are high, and there is poor treatment coverage for conditions such as cancer, stroke, and asthma.[56] Largely driven by the economic crisis, government healthcare expenditure declined from 10.5 per cent of GDP in 2010 to 9 per cent in 2024.[57] Access to healthcare services in Zimbabwe is especially difficult in rural areas due to long travel distances of up to 10 to 50 km and lack of adequate road and transport infrastructure.[58] There are also medical personnel and drug shortages.[59,60] Several HIV/AIDS programmes exist for prevention, treatment and care, but they are not systematically integrated into the primary health care system.[61]

Community involvement in health remains a sustained tradition in the country, especially in the absence of public healthcare services. Community and home-based practices are actively encouraged to allow communities to take responsibility for their health. Community health workers are also important to the health system, especially in rural areas. Village Health Workers (VHWs) in rural areas and Health Promoters in urban areas provide basic services and promote preventative health behaviours. Driven partially by shortages in medical personnel, some individuals seek traditional healers, and the government has tried to integrate traditional medicine into the broader healthcare system.

The Friendship Bench is an interesting example of community engagement in healthcare provision.[62] Under this model, local community members receive basic cognitive behavioural therapy training to offer services on a bench outside district clinics in Zimbabwe. This approach has proven highly successful, as evidenced by a clinical trial demonstrating a significant reduction in rates of depression and common mental disorders. Additionally, it incorporates income-generating activities to enhance financial independence among patients and implements community awareness initiatives. The program is in the process of nationwide scaling and integration into rural health systems, with careful consideration given to cultural and linguistic adaptations.

Childcare

The Education Act 1987 is the guiding Act for establishing, maintaining and regulating public educational facilities and establishing and administrating private schools. The Act explicitly prevents discrimination on the grounds of gender, pregnancy, and marital status. It also provides menstrual health. Zimbabwe's education system consists of seven years of primary education, four years of secondary education and two years of high school. The Basic Education Assistance Module (BEAM) programme, introduced in 2001, assists orphans and vulnerable children with primary and secondary education.

With over 99 per cent gross enrolment rate in primary schools in 2022,[63] gender parity in enrolment and literacy rates of 89.8 per cent,[64] one of the highest in sub-Saharan Africa, Zimbabwe's primary school education system has made significant strides in

ensuring education for all.[65] However, the system faces many challenges, including funding, infrastructure, and access issues, particularly in rural areas.[66] Economic challenges in the country have affected the quality of education facilities.[67] There is also a substantial shortage of care workers in the education sector, including primary schools, with a deficit of as much as 25,000 educators in 2022. In addition, poor teacher remuneration is a widespread concern.[68] The shortage worsens in rural areas and affects those already disadvantaged even more. Nearly half of all science teachers in rural areas lack adequate training, which is much higher than about one-quarter in urban areas.[69]

Early childhood development (ECD) is a care-intensive period in the development stage of a child's life and is thus of particular importance to how care work is socially organised. The government of Zimbabwe has recognised the importance of early childhood education. ECD is offered in various settings, including government-established ECD centers, community-based ECD centers, and private preschools. Moreover, all primary schools are required to attach at least two early childhood education classes since 2004. In 2015, 98 per cent of all primary schools successfully implemented this rule,[70] and the gross enrolment rate was 81.80 per cent in 2022.[71] However, most ECD centres are managed by para-professionals with limited training and lack adequate and appropriate resources such as play materials.[72]

Care for Persons with Disability

Zimbabwe's Disabled Persons Act of 1992 provides for the welfare and rehabilitation of persons with disability. It also establishes a National Disability Board and overlooks related matters. In 2019, the Department for Disability under the Ministry of Public Service, Labour and Social Development was established. The National Disability Policy and National Coordination Committee, which will implement the policy, were launched in 2021 and 2022, respectively. The policy set standards for persons with disability inclusion across all sectors – public, private and development sectors. It domesticates the provisions of the Convention on the Rights of Persons with Disabilities, which Zimbabwe ratified in 2013. Unfortunately, the policy is not binding since existing laws do not support it, and no budgetary support from the government has been made as of 2022 to ensure the full realisation of the policy.[73]

A national Disability Rights bill was developed in 2019 but hasn't been adopted since 2023.

Persons with disability in Zimbabwe struggle to access public spaces and facilities, especially transportation and mobility systems.[74] Access to health services is also limited by important information barriers, especially in rural areas, as reported by the national disability survey 2013.[75] Furthermore, persons with disability face barriers to employment due to environmental barriers, leading to high levels of poverty and vulnerability.[76] Social support is limited, and only 26 per cent of persons with disability have access to social welfare programmes.[77]

Zimbabwe aims to provide inclusive education and is a signatory to the Salamanca Statement and Framework for Action on special needs education. Women trained in inclusive education display more positive attitudes towards children with disabilities than men in their position and are perceived to be better teachers due to cultural motherhood roles.[78] Quality healthcare services for children with disabilities are difficult to access, with challenges in infrastructure and equipment provision, inadequate financing, gaps in monitoring and unattractive teaching conditions. Illustratively, 92 per cent of caregivers of CWD report turning to traditional healers in the country.[79]

Elderly care

Older Persons Act (2012) enshrines the rights of older adults to receive health care and social security from the state. Zimbabwe is a leader in promulgating policies for the elderly, and the Zimbabwe National Healthy Ageing Strategic Plan of 2017–2020 was recognised for promoting healthy ageing by the UNFPA Asia and Pacific report.[80] However, there are significant implementation challenges.[81] Besides cash transfer programmes targeting vulnerable people, the Assisted Medical Treatment Order (AMTO) is an example of a social assistance programme directly targeted to the elderly. It provides a medical voucher to facilitate healthcare access for elderly people in public hospitals. Unfortunately, social protection reaches only a fraction of the elderly in the country. For instance, only 44 per cent of the population aged 65 years and above received monthly pension and social security benefits.[82]

Social care services are underfunded.[83] Institutional care or old people's homes, as they have come to

be known in Zimbabwe, are mainly owned and operated by private or voluntary organisations. There are no consistent statistics on how many old-age homes exist. For example, Zimbabwe Pensions and Insurance Rights Trust reported 71, and the Parliamentary Portfolio Committee[84] reported 29.[85] These institutions have access to some government grants, although they are irregular.[86]

Many of the elderly rely on family and community support for care. Part of the traditional care ethos and food security system for the elderly, orphans and other vulnerable groups in indigenous rural set-ups involves a traditional practice called *zunde ramambo* (king/chief's granary).[87] Under this practice, community members who fall under the jurisdiction of a specific chief work on communal land once a week. The harvest from the communal land is stored and distributed to those in need, often including the elderly. However, this practice is in decline and/or changing in some parts of the country.[88]

Labour Market Regulation

Labour Market regulations can promote work-life balance so that women and men can balance their paid employment and care work responsibilities. Furthermore, policies that discourage gender-based discrimination and encourage women's participation in labour force can shift social norms and lead to redistribution of care work. It should be noted that such labour market regulations are less effective in addressing women's unpaid care needs in countries like Zimbabwe, where a very small percentage of the population is employed in the formal sector as wage employees. The Labour Act 1985 has an extensive non-discrimination clause which prohibits discrimination based on gender and pregnancy, amongst other things. Although the Constitution compels the state to implement "measures such as family care that enable women to enjoy a real opportunity to work", the Labour Act does not make any appropriate provisions.

Labour Relations Act covers the provision of maternity leave. Women are guaranteed 98 days of maternity leave with full pay. Women are also guaranteed the right to return to work. Parental leave is important for redistributing care work since it doesn't limit early infant care responsibilities to the mothers. However, no laws and policies exist regarding parental or paternity leave. Men can take up to 12 days of unpaid leave.

Legislative protection for paid care workers can include the right to collective bargaining, minimum wage laws, and laws regulating working conditions. There is some protection for domestic workers with specific minimum wage legislation that sets domestic workers' wages to between USD 85 and USD 100 per month. In addition, workers not residing with their employers are entitled to accommodation, transport, electricity and fuel/cooking allowances.[89] The Zimbabwe Congress of Trade Unions is the country's main trade union. Trade unions have faced difficulties organising informal sector workers and workers in rural areas, a key issue for care workers such as domestic workers and community health workers with poor working conditions and low remuneration.[90]

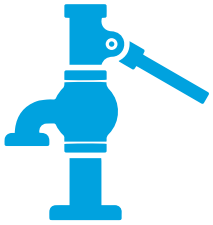
Enabling Macroeconomic Environment

Although macroeconomic policies are a large area of concern regarding care work, this sub-section focuses on social protection systems. Social protection measures can be a powerful tool to redress women's socio-economic situation. The National Social Protection Policy Framework[91] for Zimbabwe (2016) outlines government aspirations on social protection in Zimbabwe. The National Social Security Act guides social insurance through pensions to the elderly, amounting to USD 30-35 monthly payments.[92] Unfortunately, it does not cover the informal sector, thus leaving out the majority of the country. Harmonised Social Cash Transfer programme (HSCT) and BEAM are some of Zimbabwe's most important social protection programmes.

HSCT, launched in 2011, provides an unconditional cash transfer of USD 10 to 25 per month to

food-poor and labour-constrained households. By February 2014, HSCT reached 55,509 households in 20 districts.[93] The programme is gradually being rolled out in all 65 districts of Zimbabwe and aims to reach approximately 250 thousand households.[94] As discussed, BEAM provides educational assistance to orphans and vulnerable children. It covered about 530 thousand out of the 1.3 million children in need. Social safety net programmes in the country have been criticised for being fragmented and poorly targeted.[95] There is limited coordination and integration among the programmes.[96] Lengthy application process, lack of awareness, and high transport costs to accrue the benefits are other challenges associated with public assistance in the country.[97]

Physical Infrastructure



Zimbabwe made significant progress in infrastructure development after independence. This included building an electricity network with regional interconnections, an extensive road network and a water and sewer system. However, this has not been maintained adequately due to the political and economic crisis since the 2000s.[98] Caregivers, particularly women, would benefit from essential care-supportive infrastructure. Traditional cooking methods often not only have negative health and environmental impacts; are also time-consuming and physically demanding. However, in 2021, only 7 per cent of rural Zimbabwe had access to clean fuel and technology for cooking.[99] In rural areas, women and girls are central in fetching water, requiring them to cover long distances and encounter associated security risks. HCS found that access to public water sources reduces women's primary care hours by about 2 hours per day in Zimbabwe.[100] However, in 2022, only 66 per cent of the population had access to basic drinking water services.[101] Climate change and extreme weather events further challenge access to clean water.

About half of the population has access to electricity,[102] and power cuts are frequent.[103] Interestingly, HCS found that access to electricity is associated with more primary care hours and fewer sleep hours for women. Qualitative interviews by the study found that several care tasks did not need to be conducted intensively before dark with electricity. This suggests that changing social norms is important alongside providing care-supportive infrastructure to ensure that it doesn't further disadvantage women.[104]

Informational and communication technology can also reduce domestic care work responsibilities and offer various communication, information and organisational benefits that can help both caregivers and care receivers. For example, they allow access to e-commerce platforms in urban areas and access to Hospital Cash Plan. In Zimbabwe, 85.4 per cent own a mobile phone, while internet penetration stands at 34.8 per cent.[105]

Conclusion and recommendations

In conclusion, this snapshot of care systems in Zimbabwe reveals a complex landscape shaped by various factors, including economic challenges, climate change, and resource limitations. Households, specifically women and girls, bear disproportionate responsibilities for care work. Care sectors are also an important source of employment for women but are relatively small relative to care needs in the country. A few recommendations that emerge from this analysis are as follows:

The gender statistics infrastructure in the country needs to be strengthened. There are significant gaps in data on gender issues. Most importantly, time use surveys need to be conducted at regular intervals to measure and monitor the social organisation of care work as well as the impacts of care work on individuals and the economy. A harmonised information system across agencies and government departments would benefit research on topics related to the care agenda, such as ageing, maternal care, and regulation of institutional care.

Research and understand policy initiatives and how they affect care givers and redistribute care work within households and between the household, market, society and government. Programmatic interventions should also collect data to understand how they affect the distribution of care work.

Additional research is needed on numerous aspects related to the care agenda in the country. For example, there is an insufficient understanding of the connection between unpaid care work and poverty and inequality in the region. Furthermore, the impact of different macroeconomic policies and austerity measures on the social organisation of care work remains poorly understood.

The country's social protection programmes and policies only cover a small percentage of the population, leaving out most care workers as a target group. This has led to human capital flight on the part of many professional social workers who have since left for the United Kingdom and other countries over decades, thereby increasing the care burden on members of the nuclear and extended families, especially women. The programmes and policies also do not adequately support the care needs of persons with disability and older people. Social protection policies in the country should consider the needs of these groups. When the economy achieves enough growth and stability, it might be commendable for Zimbabwe to effectively implement an institutional redistributive model of social policy, which allows the country to prioritise social welfare as an important institution that is part of the society, providing Universalist services outside of the market on the principle of need and universal rights.

Gender and disability should be mainstreamed in all infrastructure projects and climate change mitigation and adaptation strategies. Infrastructure and other time-saving technologies are very important for reducing domestic work and allowing access to care services, especially as climate change, conflict, and other regional crises have affected care services provision, food security and livelihoods.

Labour laws in the country should be amended to introduce paternity leave. Flexible and other care-friendly working arrangements may also be encouraged to promote the participation and retention of people with caring responsibilities.

References

1 Feminist scholars have argued that care for the environment, including women's care for animals, plants and shared spaces, should also be considered care work. For further reading, refer to Oxfam Policy & Practice. 'Caring in a Changing Climate: Centering Care Work in Climate Action'. Accessed: 27 March 2024. https://policy-practice.oxfam.org/resources/caring-in-a-changing-climate-centering-care-work-in-climate-action-621353/.

This paper recognises that the boundaries between paid labour contributing to household income and unpaid caregiving tasks within households are porous. For instance, caring for animals and selling animal products from these animals in the marketplace could be called subsistence work as well as care work. In the interest of harmony with international standards, this paper does not include such activities in its definition of care work.

2 UN System Policy Paper on Care – Forthcoming, 2023, UN Women, UNDP, ILO, ECLAC, OHCHR

3 FEMNET (2022). *The Africa Care Economy Index.* Accessed: 5 May 2024 https://www.undp.org/sites/g/files/zskgke326/files/2022-09/The%20Africa%20Care%20Index%202022_E-version_14%20Sept%202022.pdf

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