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THE AFRICA CARE ECONOMY INDEX

DR. SALIMAH VALIANI

for FEMNET – The Africa Women's Development and Communication Network

May 2022

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by Dr. Salimah Valiani

In Africa, the care economy has long been unrecognised. At least since the last pandemic — HIV-AIDS — caring work has been severely undervalued in the continent, and the redistribution of caring work, from females in the home and communities, next to nonexistent. The COVID-19 pandemic has renewed attention to the care economy globally. The Africa Care Economy Index offers a concrete evaluation of African state performance in the recognition, support and redistribution of caring work. Based on a definition of care economy and related concepts relevant in Africa, the Index uses ten metrics to evaluate the 54 states of the continent. Demonstrating longstanding neglect of the care economy by all states in Africa, recommendations are made around broad policy and in depth research required to begin supporting and redistributing caring work. Social recognition and state support for caring work are shown to be central to building holistic development that benefits the majority in Africa.

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Acknowledgments

The African Women's Development and Communication Network (FEMNET) and the United Nations Development Programme (UNDP) acknowledge and are grateful for the contribution and support of the following individuals and teams towards the compilation and production of the African Care Economy Index.

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FEMNET TEAM
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UNDP TEAM
- Odette Kabaya, Cleopatra Phiri Hurungo, Dr. Sandrine Koissy-Kpein, Marie-Claire Nishimwe, Peter Mokwe, Therese Niyondiko and Tatiana Prokhorova

FUNDING PARTNERS
- UNDP and Government of Canada

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Introduction

> Jane, a licensed massage therapist in Africa travelled overseas to support her country's team in a world competition of mobility impaired sports. On arrival, Jane was given the responsibility of providing medical care — something she was not trained for nor told about in advance. One player, Sylvia, suffered from recurring wounds that needed regular dressing. Taught from a young age to dress her own wounds by nurses over the years, Sylvia gave tips to Jane on what to do. Attempting to learn fast on the job and under pressure to assist several players, Jane supplemented Sylvia's tips by watching youtube videos.
>
> Sylvia lost a limb after enduring a burn by boiling water as an infant. Daughter of a single working mother who lacked funds for a child minder, Sylvia was in the care of two other children when the accident happened. The details of how the burn occurred were never known.
>
> On returning from the competition, overwhelmed by the trying experience, Jane cried for two days. Sylvia's remaining limb was amputated as it came to be understood that the recurring infections were due to tissue that had never healed after the burn. After the amputation, Sylvia felt liberated, though she never played for the national team again.[2]

Much has been written about Africa's demographic dividend (Bloom, Canning et al. 2007; World Bank 2007; Bloom, Humair et al. 2013; Drummond, Thakoor and Yu 2014; May and Turbat 2017). An enlarging global share of working age population is seen as the basis for transformed economic growth in Africa in the coming decades. Linked to this potential for economic growth is adequate human capital investment, with education and healthcare most frequently mentioned as policy targets.

Drummond, Thakoor and Yu (2014, 4), for example, estimate that between 2010 and 2100, working age population will increase in Africa by 2.1 billion, while the rest of the world combined will see an increase of 2 billion. Africa's productive potential is contrasted with ageing populations of advanced economies. As in other studies, a shift from agriculture to labour intensive manufacturing is the scenario envisioned for Africa to harness this productive potential.

[1] The author acknowledges the extensive research assistance of Lethabo Mailula, whose work and diligence were crucial to this project. Important feedback was offered by feminist activists Siphokazi Mthathi, Odette Napina, Phumi Mtetwa; feminist academics Dzodzi Tsikata and Randy Albelda; and Dr. Sandrine Koissy-Kpein and her team at the UNDP's Advancing Gender Equality and Women's Empowerment in Africa Program. Correspondence may be directed to the author: valianisalimah@gmail.com

[2] An account of real events, with names and other identifiers removed to protect anonymity. Though exceptional in parts, the account reflects experiences typical of many African contexts.

Omitted from equations of the demographic dividend is consideration of the caring work that underpins the effectiveness of investment in education and healthcare to transform children into productive workers. As the above account of Jane and Sylvia illustrates, without policy attention to affordable, quality childcare, accessible healthcare, adequate training for various types of care workers, and a culture of caring for those providing care — the development of society's young is put at risk.

In some detail, without adequate care, the mental, physical and psychological development of children is curtailed, ultimately affecting the productivity of individuals and capacity of society as a whole. Without adequate recognition, respect, training and support, caregivers are prevented from supplying the high levels of care needed to build and replenish the workforce, particularly in contexts where histories of impoverishment present numerous challenges in processes of production.

Central to recognising and respecting care and realising Africa's demographic dividend is making women's wellbeing a reality. The COVID-19 pandemic has recast light on an extensive economy of care whose invisibility in Africa is near proportionate to the extent of need in African populations. This is due to the normalisation of female unpaid labour as the response to all major human needs: from the supply of fuel, food and water, to tending to depression and other outcomes of violence, to caring for children, the elderly, and those suffering the array of ailments arising from impoverishment. Africa is identified as the world region with the most "unshared system of care", with 70 percent of care provided by women within the family (Rogero-Garcia 2012). Outside the family, volunteer or scantly remunerated women are employed by public, private and non-profit institutions to provide the remaining, 30 percent of care, with very limited resources.

The Africa Care Economy Index is grounded in the argument that a socialised, public sector response is crucial to reverse the gendered distribution and extreme undervaluing of caring work normalised in the continent. Building a culture of respect and redistributing caring work are urgent to achieve two, interrelated goals. First, as per the 2007 ***African Feminist Charter***[3], to significantly improve the wellbeing of women and girls that provide the bulk of care and realise their right to sustainable, just livelihoods. Second, to materialise Africa's demographic dividend into greater collective wealth.

The purpose of the Africa Care Economy Index is to measure and map current social recognition and state support for the care economy in Africa and begin defining gaps. Given the geographic, demographic, and political expanse of the continent, this is done through ten categories or metrics. Legislation, policy, or/and government spending data related to the care economy are examined, by metric, for each of the continent's 54 countries.

The paper is divided in three major sections: a) a theoretical discussion of care economy, related concepts, and their relevance for Africa; b) measuring social recognition and state support for the care economy through the ten index metrics, including highlights from country-specific data and key questions for in depth, policy oriented research; and c) presentation of the index results and interpretation.

[3] See https://awdf.org/the-african-feminist-charter/ for *The African Feminist Charter* translated into several major languages of the continent.

SECTION A

Care Economy and Related Concepts

In the late 1960s and early 70s, socialist feminist thinkers offered a critique of Marxian notions of economic production by elaborating the role of unpaid female labour and defining it as the principal source of women's oppression. Mariarosa Dalla Costa and Selma James (1972, 7) wrote of a "community of housewives" forming "the other half of capitalist organisation" and "the hidden source of surplus labour." Isabel Lerguia and John Dumoulin (1972, 44) delineated the functions of housework in the maintenance of capitalist society, arguing housework to be the "invisible" economic base of "visible" producers of commodities. These invisible functions are biological reproduction, education and caring for children, the elderly and the ill, and reproduction of the labour power consumed daily in capitalist production (Lerguia and Dumoulin 1972, 42).

Connecting the oppression of women underlying unpaid female labour in the home, and the "super exploitation" of wage-earning women working outside the home, Terry Fee (1976, 8) hypothesised that the historical stamp of wage-less housework as trivial, laid the roots for women's secondary place in the paid labour force. Shifting the lens to agrarian societies of Africa and Asia, Ossome and Naidu (2021) elevate these socialist feminist insights to a global scale, arguing that where productive investment and capital formation have focused mainly on cash crops and livestock, female unpaid labour sustains both rural food production and capitalist production.

Reproductive labour

In the 1980s, the term *reproductive labour* was taken up in policy circles. Some of the first international policy discussions of reproductive work figured in the ***Nairobi Forward-looking Strategies for the Advancement of Women***. Devised by member countries of the United Nations (UN) in 1985, the Strategies followed from an appraisal of the achievements and challenges remaining after the UN-declared International Decade for Women (1976-1985). Framed as "parental and domestic responsibilities", reproductive labour featured as the shared domain of "women and men" (UN 1986, 35). Employers were called upon to allow flexible work hours without penalty to workers so they could perform reproductive labour. Similarly, employers and the state were urged to provide parental leave for both women and men to care for newborns.

Cecilia Fraga Utges (2018) locates the 1995 ***Fourth World Conference on Women Beijing Declaration and Platform for Action*** as the beginnings of efforts to measure reproductive labour, which in various

countries took the form of data collection on time spent by women and men performing reproductive tasks. As Folbre (2013) points out, the purpose of the resulting, time use surveys, was not only measurement, but the development, implementation and evaluation of policies aimed at reducing and redistributing women's unpaid caring work. Little policy development, much less implementation, have resulted from the collection of time use data in the majority of countries globally.

Taking the perspective of agrarian societies, where capitalism has unfolded differently from Western Europe and North America, Ossome and Naidu (2021) argue for a shift of focus. Given the tendency of high unemployment and underemployment in much of Africa, Asia and Latin America, and the largely female role in assuring the survival of all, Ossome and Naidu underline the essentiality of gendered labour in sustaining "life", not only past, current and future workforces.

Care, interdependence, ubuntu

Along the lines of Ossome and Naidu (2021), feminists have been discussing *care*, a much broader concept, since the 1990s. Philosopher Eva Kittay underlines the fundamental role of caring labour in human societies, starting with the idea that human beings are mutually dependent rather than self-contained, self-centred equals voluntarily interacting with one another, as portrayed in mainstream economics (Kittay 1999, Preface). Given the long maturation process of humans, the common phenomena of illness and old age, and the "decidedly human capacities" for moral feeling and attachment, Kittay underlines interdependency and interconnectedness, and in turn, the act of providing care, as foundational to the development of culture itself (Kittay 1999, 29).

Relating care and interdependence to similar, African notions, Kanyhama Dixon-Fyle (2002, 5) writes:

> in Africa, all that lives tends to be seen as the physical, visible manifestation of a transcendent reality or principle. Previously, this led often enough to a treasuring of the living, borne out in all relationships; so much so, that every day, mundane affairs — family life, village life, productive activities, contacts with nature — were carried out in a way that recognised this sacred, underlying dimension.

Ubuntu, the web of life, or interdependence in human community and between humans and other beings, is a Southern African rendering of these notions. Chisale (2018) argues that due to the porousness of the concept, ubuntu has been used to enforce patriarchy and gender binary social constructions, including around care. Chisale bases this on oral history gathered from elderly females and males of Kwa Zulu Natal province, South Africa, where ubuntu is presented as non-gendered. One of the first critiques of ubuntu (*unhu*, in Shona) as a notion of patriarchy appeared in Tsitsi Dangarembga's 1988 novel, ***Nervous Conditions***. In it, the intelligent, female protagonist, Tambudzai, is expected to end her schooling before completion and begin working to allow for her brother to attend school. Tambudzai reflects on how, in the lexicon of reciprocity in unhu, sacrifice — in the name of the whole — is cultivated in female individuals far more than in males.

Carework, care economy, human infrastructure

Feminist economists and sociologists, largely in the early 21st century, have linked notions of care to the nature of work performed predominantly by females in capitalist production, conceptualising the notion of *carework*. Carework broaches the complexity of caring work within both the private and public spheres, paid as well as unpaid. Encompassing the breadth of caring work required for human survival at various points in the life cycle, carework also captures the particularity of the skills entailed in caring labour.

As Emily Abel and Margaret Nelson (1990, 9) explain, carework involves "a distinctive pattern of thought that can be learned and practiced, but which differs sharply with scientific rationality." They argue that it is due to this distinction from male dominated forms of work that carework is valued differently. The concept of carework allows for theorisation around the historic undervaluing of carework in the world capitalist economy, a process which can be traced with specificity in different national contexts as well as between world regions.[4]

Drawing from models in Scandinavian countries, Shahra Razavi (2007) proposes the social organisation of various facets of carework between households (family members), the market (employers), the state, and the community (nongovernmental organisations and religious groups). While employers and the state are envisioned as the key financiers, the state is also responsible for regulating care, while households and the community participate in providing care. In turn, the *care economy*, as Valeria Esquivel (2011, 9) puts it, is a concrete term used mainly in policy circles to articulate a host of demands around the social organisation of care. This ranges from childcare and services to care for the elderly, labour market regulations recognising workers' unpaid care duties, and pension coverage and salaries for homemakers, to mention a few.

Bringing the conceptual discussion to the empirical realm, Michael Fine (2007, 146-147) underlines the need for "a dynamic mapping of the division of care between different actors." Building on this, Duffy, Albelda and Hammonds (2013, 150) argue the collective benefits of paid caring work make it a public good requiring the support of the state, not unlike physical infrastructure, such as bridges and roads. They offer the concept of *human infrastructure* as the basis of sustained economic growth and societal wellbeing. Mapping and quantifying the human infrastructure of the US American state of Massachusetts, Duffy and co-authors (2013) include hospitals, old age homes, schools, home healthcare services, and social service organisations.

Adding to theories around the historical undervaluing of carework, Duffy and co-authors (2013, 150) explain that in the provision of care, "increases in productivity are hard to achieve without sacrificing quality." They give the examples of increasing the size of school classrooms or nurses' caseloads. While such increases can raise productivity, as traditionally defined, beyond a certain point, larger classes or

[4] Though a notable feature of the world economy as a whole, analysis of the undervaluing of carework on a country basis captures specificities which, in turn, feed back into unequal relations between various countries/regions in the global economic hierarchy. For analysis of the continuum of undervaluing between unpaid and paid carework in Canada with international comparisons, see Valiani, S. (2011) "Valuing the Invaluable – Rethinking and respecting caring work in Canada", Ontario Nurses' Association, Research Paper No.1. For analysis of the dynamics of undervaluing of one form of carework within selected countries, and between the global North and South, see Valiani, S. (2012), *Rethinking Unequal Exchange – The global integration of nursing labour markets*, University of Toronto Press.

caseloads lessen the quality of teaching and nursing. These examples are also relevant for Africa. Another is that of agricultural productivity. Female agricultural productivity in Africa is seen as low relative to male agricultural productivity, because women engage less in the cash crop and export crop production that carry greater value in nominal terms (UN Women, UNDP-UNEP PEI and World Bank 2015). What is unaccounted for in the standard notion of productivity is the value of female agricultural production for family food supply and the sustenance of significant proportions of African populations. Given such particularities, Hilary Wainwright (2010) argues for a distinction between *social efficiency* and *economic efficiency*, in questions regarding the organisation of carework and other public services.

In order to compensate for the particularities of carework, Duffy et al. (2013) propose that the cost of carework be collectivised, through the state, so that wage levels in the care sector and the quality of care do not suffer. Paralleling John Kenneth Galbraith's 1958 argument that inadequate expenditures on public transport and communication infrastructure negatively affect private company production, Duffy, Albelda and Hammonds (2013, 150) argue that human infrastructure deficits limit economic growth.

Though originating in countries of the North around the crisis of care resulting from the growing proportion of the elderly in the population, and inadequate social organisation of care, Valeria Esquivel (2011, 9) argues the concept of care economy is nevertheless fruitful for Latin America. As Esquivel (2011, 10) states, "the great potential" of care economy is it helps make care a public policy issue, removing it from the private sphere of the home and inherently associated with women.

Recognising the overlap between discussions of social protection and discussions of care economy, Esquivel (2011, 17) underlines differences in the "logic of social protection" and the "logic of care." The logic of social protection is consistent with traditional economic notions of *welfare* as equivalent to minimum levels of consumption, and fails to account for unpaid caring labour in the home. At best, the logic of social protection allows only for paid care, for example, providing funds for paid care in disability grants while leaving unaddressed the unpaid care needed by people living with disabilities.

Making the same point at the macro level, Hassim and Razavi (2006, 2) argue that women's unpaid caring work forms "the bedrock on which social protection is subsidised." Adding another layer to this subsidising is the erosion of public services due to austerity and privatisation. Hassim and Rasavi (2006), Bezanson and Luxton (2006), and others, point out that public service erosion impacts most on women because it redistributes carework back into the unpaid sphere of the home and communities.

Working from a logic of care allows for a tracking of the various spheres of care provision, as well as of the gender, class and generational differences among those providing and accessing care (Daly and Lewis 2000; Razavi 2007; Esquivel 2011). Esquivel (2011, 18) underlines that the increasing role of markets in care provision in Latin America means that some households can access care while many cannot, which deepens inequality. In contrast, public provision of universal care services would have a powerful equalising force: not only would it allow for the majority of women to seek work outside the home, it would assure decent wages for crucial carework in which female workers are typically overrepresented.

SECTION B

Measuring Social Recognition and State Support for Care in Africa

Esquivel's analysis has resonance for Africa. Public financing and provision of universal care services in Africa would significantly increase the participation of women and girl children in formal education and the economy, altering income distribution and advancing women's wellbeing throughout the continent. Rather than being limited to caring work, agricultural production, and food processing mainly for the household, women and girl children would be enabled to make yet greater socio-economic contributions. Rising quality of care resulting from political commitment to build human infrastructure would optimise the development of capabilities of all household members. Africa's demographic dividend could then materialise into economic growth and greater collective wealth.

The COVID-19 pandemic has magnified the links between unpaid caring work, human infrastructure, economic growth, and development — underscoring the need to fortify the care economy globally. Such a fortification would be the basis for socio-economic rejuvenation and human development, rather than revived economic growth driven by intensified inequality and precarity.

From the onset of the global COVID-19 pandemic, the United Nations Economic Commission on Latin America (ECLA) pointed out that COVID-19 "has brought to light, in an unprecedented way, the importance of care for the sustainability of life" (ECLA 2020, 1). The ECLA (2020, 4) stresses that as a result of the pandemic, "women's time should not become, as has happened throughout history, an adjustment variable in states' efforts to address the health crisis and new economic scenarios."

Along the same lines, writing on state responses to the first wave of the pandemic in Africa, Lyn Ossome (2020, 6) notes that across the Horn of Africa, services considered essential by the state were mainly those consisting of caring labour, defined broadly. Ossome gives the example of the predominantly female food sellers of Uganda required by the state to continue trading, but only inside market locations, and hence the requirement that they sleep in the markets. Ossome's example embodies ECLA's warning around women and their time becoming an adjustment variable in the COVID-19 pandemic.

Also from the onset of the global pandemic, the United Nations Economic Commission on Africa (ECA) made connections between collective health crises and deepened gender inequality. Underlining increased unpaid care demands due to school closures and caring for the ill, the ECA (2020, 22) warned of women being more likely to forgo economic activities and this feeding into financial inequality.

In both popular and policy perspectives in Africa, recognition of care as an aspect of economy is in its nascent steps. This helps explain why few African countries have conducted nationally representative surveys of time spent on unpaid caring work. Where nationally representative surveys have been conducted, evidence shows that the vast majority of unpaid caring work is performed by women and girls, and that females spend less time on education, paid work, and leisure than males (see tables and figures below).

Methodologically, it is important to note that while time use surveys conceptualised in the global North draw a distinction between direct care and indirect care (housecleaning and other domestic work), feminist analysts maintain the two are fundamentally intertwined in the global South, and often include subsistence agriculture as well as food processing (Kes and Swaminathan 2006; Razavi 2007; Esquivel, Budlender, Fobre and Hirway 2008; Esquivel 2011). The data below reflect the more inclusive notion of caring work.

Table 1. Minutes and hours spent per day on unpaid caring work by gender, various countries and years (Source: Charmes 2006)

	Benin (1998)		South Africa (2000)		Madagascar (2001)		Mauritius (2003)	
	♀	♂	♀	♂	♀	♂	♀	♂
Unpaid domestic and caring work	3h 28min	1h 7min	3h 48min	1h 15min	3h 41min	47min	4h 37min	1h 13min
Unpaid subsistence production – various	1h 44min	1h 19min	24min	27min	1h 50min	1h 37min	unavailable	
TOTAL unpaid caring work	**5h 12min**	**2h 48min**	**4h 33min**	**1h 45min**	**5h 30min**	**2h 0min**	**4h 37min**	**1h 12min**

Figure 1. Hours spent per day, various activities, by gender and age group, Lesotho, 2002/3 [Data Source: Dawson 2008]

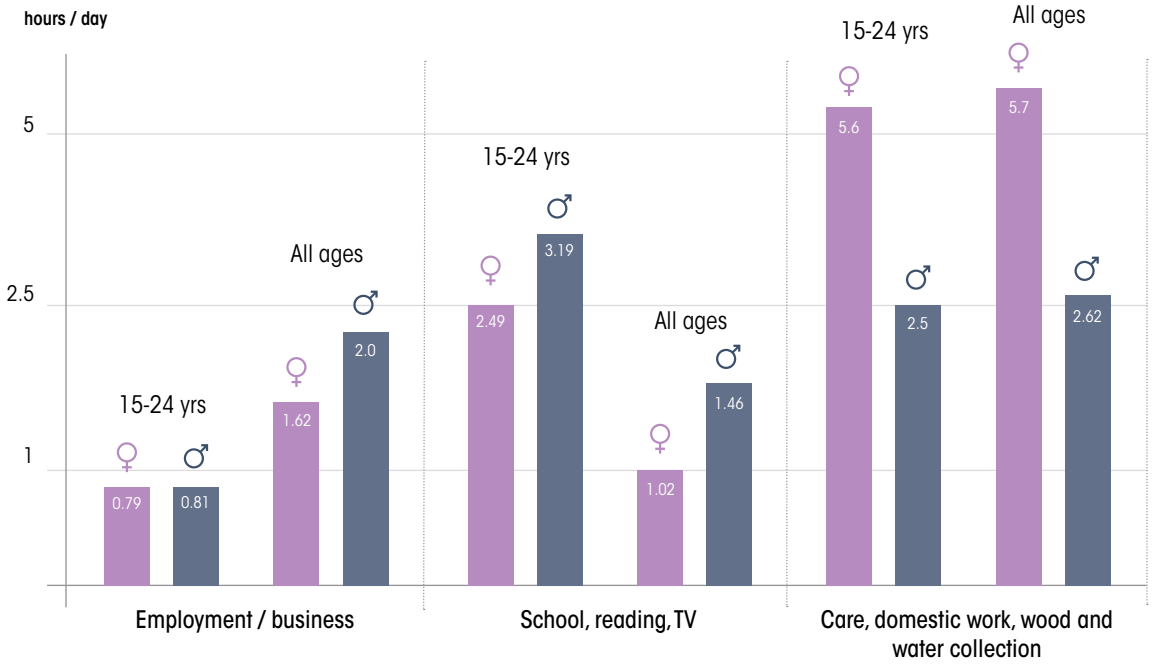


Figure 2. Hours spent per week, various activities, by gender and age, Ghana, 2009
[Data Source: National Transfer Accounts 2017]

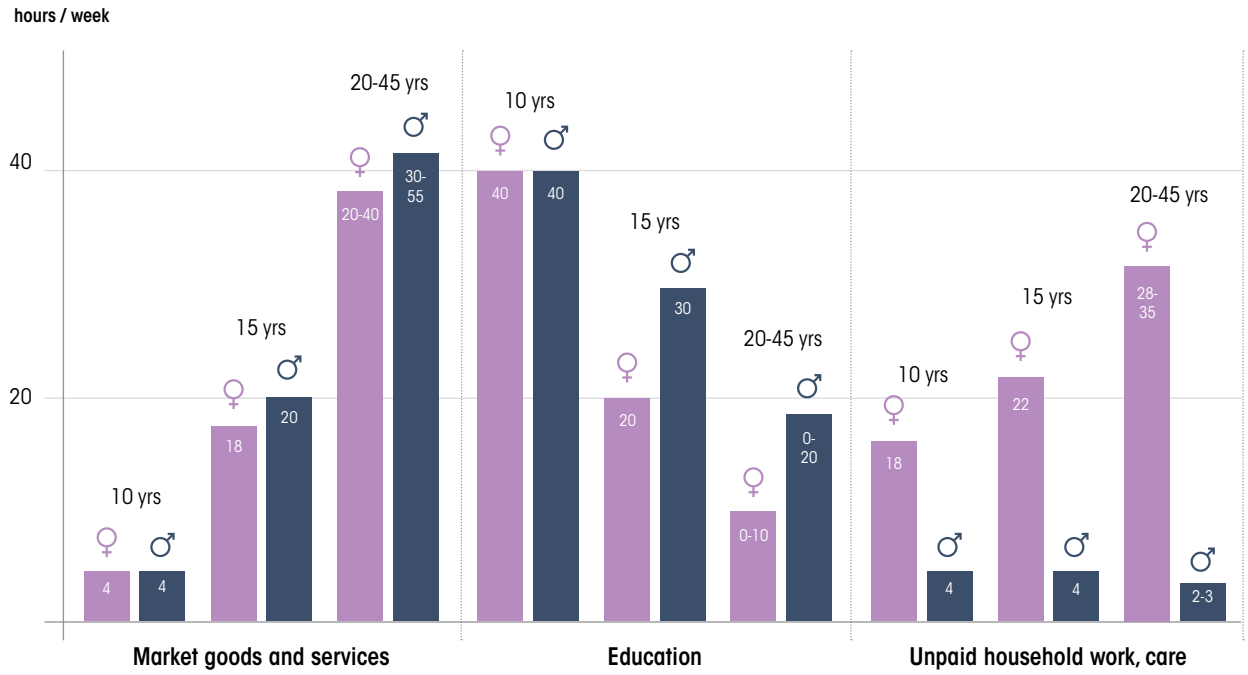


Figure 3. Hours spent per day, various activities, by gender and age group, Egypt, 2010
[Data Source: Population Council 2010]

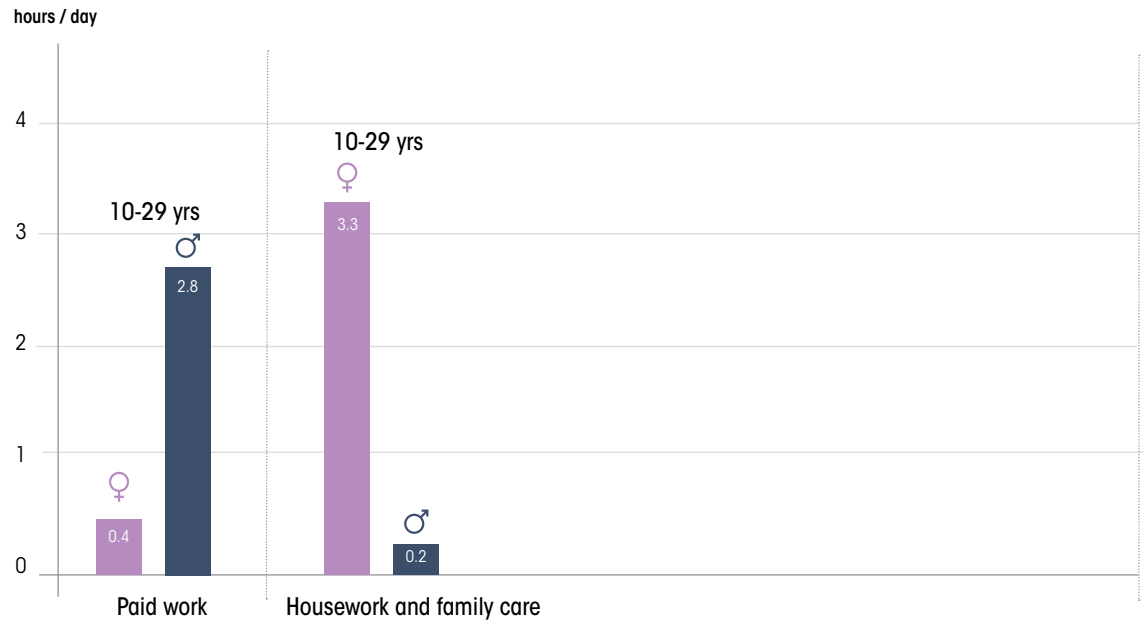


Figure 4. Minutes spent per day, unpaid household work and care, by gender and age group, South Africa, 2010 [Data Source: Statistics South Africa 2013]

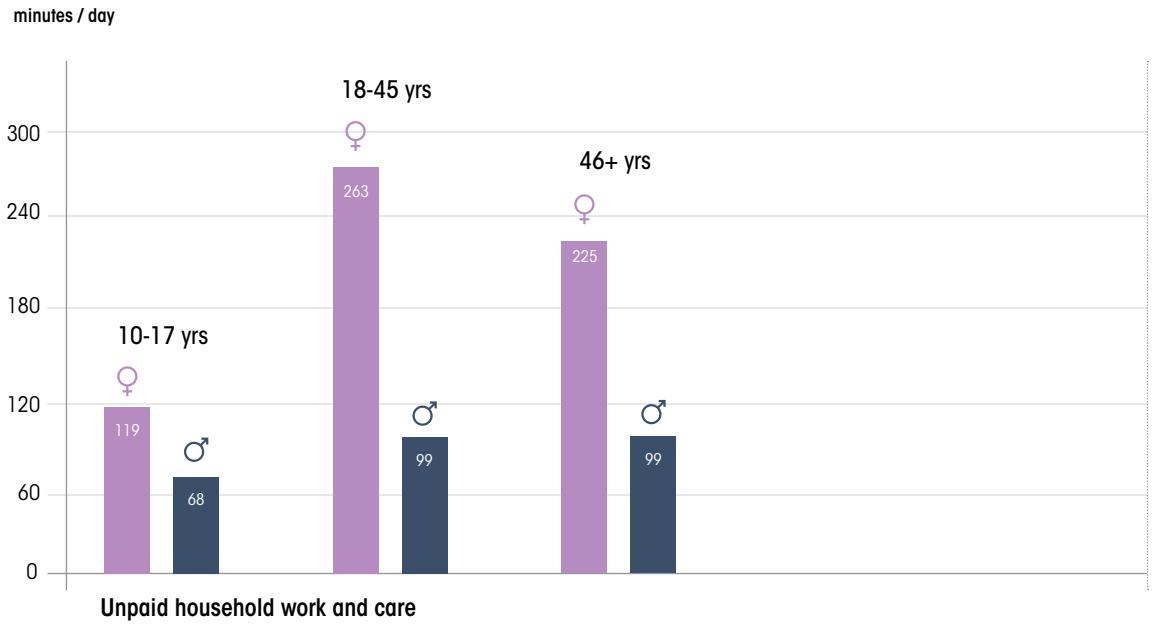


Figure 5. Minutes spent per day, paid and unpaid work in establishments, by gender, South Africa, 2010 [Data Source: Statistics South Africa 2013]

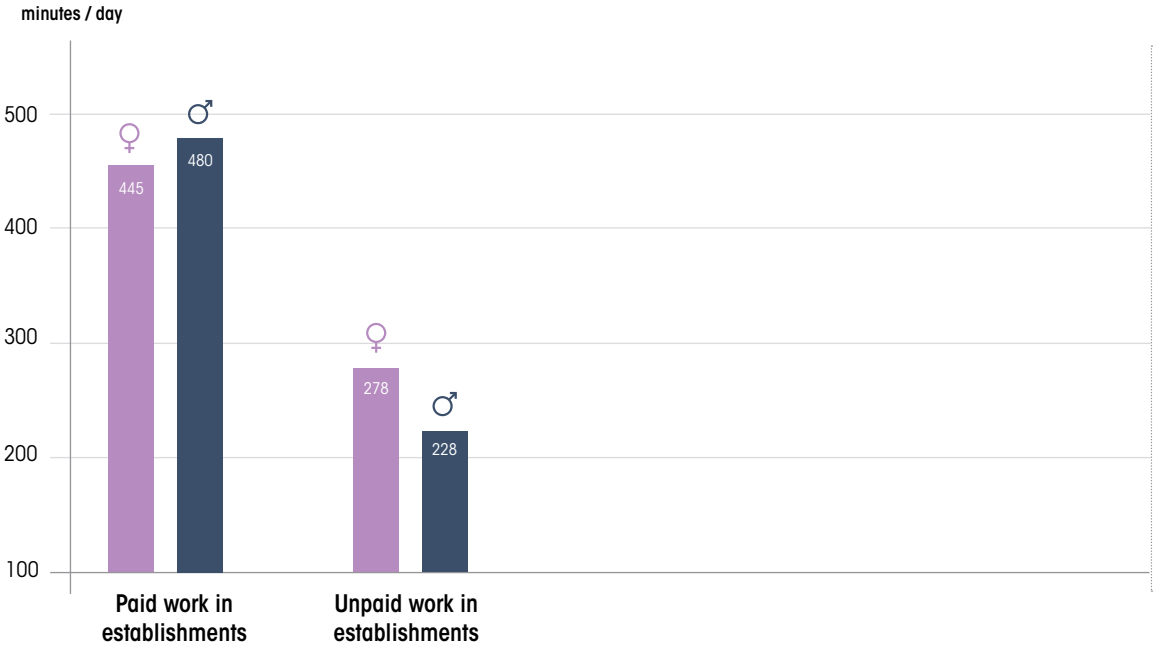
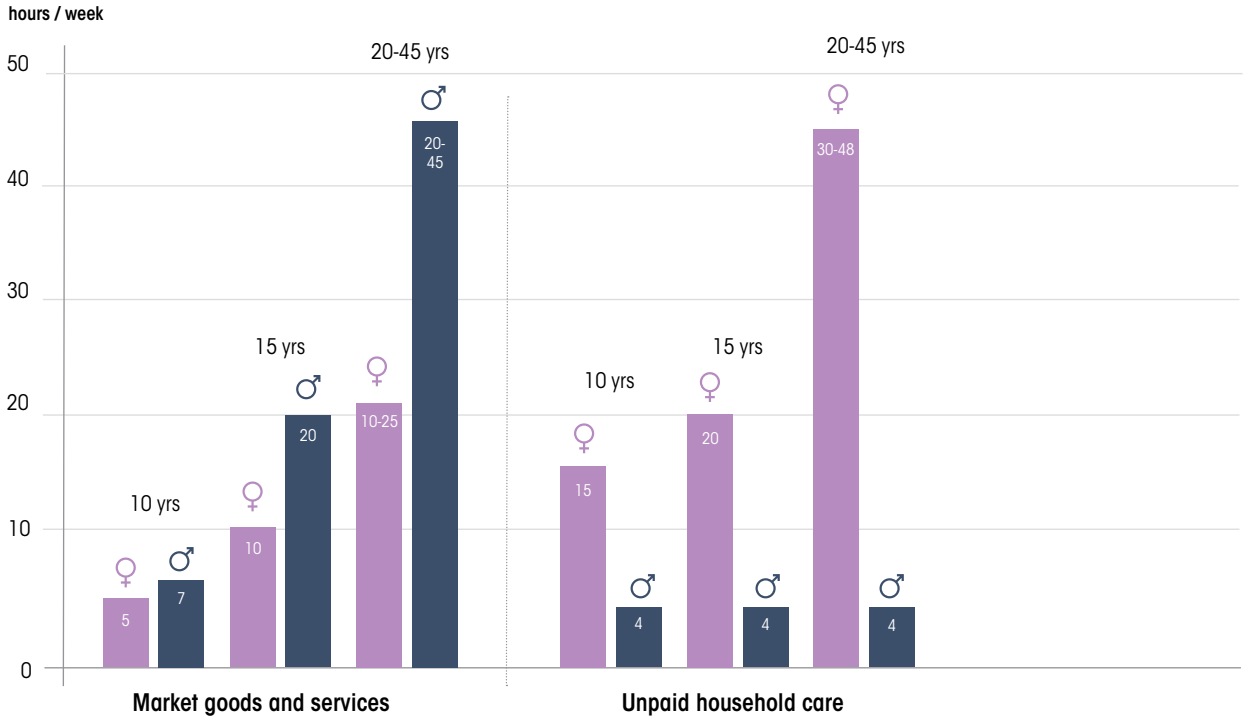


Figure 6. **Hours spent per week, various activities, by gender and age, Sénégal, 2011**
[Data Source: National Transfer Accounts 2017]



Alongside the highly gendered supply of unpaid care at a micro scale, the WHO Regional Office for Africa (2021) paints a picture of poor health of women in the continent:

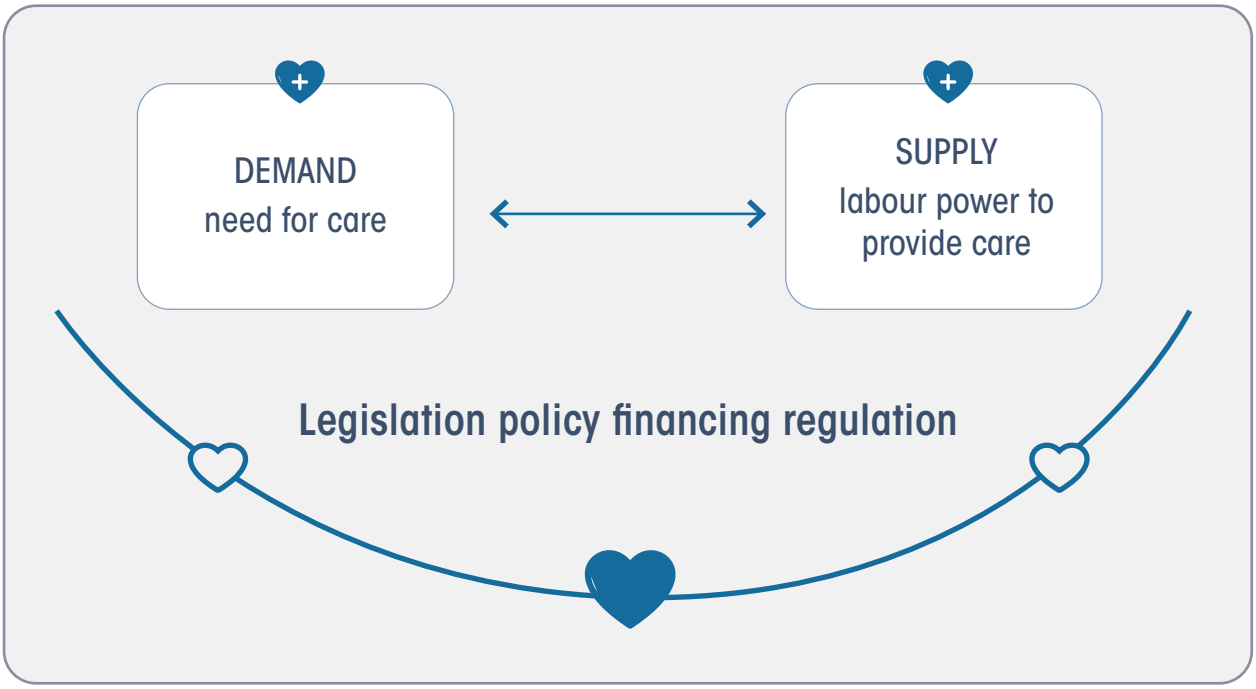
> gender inequity, poverty among women, weak economic capacity, sexual and gender-based violence including female genital mutilation (FGM) are major impediments to the amelioration of women's health in the African Region … Women in the African Region are more likely to die from communicable diseases (e.g. HIV, tuberculosis and malaria), maternal and perinatal conditions, and nutritional deficiencies, than women in other regions. Globally, about 468 million women aged 15–49 years (30% of all women) are thought to be anaemic, at least half because of iron deficiency and most of these anaemic women live in Africa (48–57%).

Taken together, these facts suggest that the current structure of the supply of care in Africa is not sustainable. Nevertheless, the care economy is far from a policy priority in the continent. To begin to address this, the Africa Care Economy (ACE) Index seeks to measure social recognition (in the form of legislation), and state support (in the form of government spending), for care in the 54 countries of Africa.

Drawing on the conceptual discussion above, the care economy is defined as:

- the labour power required to provide unpaid and paid care, or the supply of care;
- the various parts of the population in need of unpaid and paid care, or demand for care;
- national and subnational legislation, policy, financing and regulation that support care.

Figure 7. The Care Economy



The persistent undervaluing of carework elaborated by Abel and Nelson (1990), Valiani (2012), Duffy et al. (2013), and others, necessitates a socialised, or public sector response. Without adequately financed public care programs, services, regulation, and training — carework will continue to be undervalued in Africa and elsewhere.

The meaning of socialised, or public care programs merits elaboration. Fully socialised refers here to public financing and public delivery of non-profit care services and programs. Partially socialised refers to varying mixes of public and private financing, and public and private delivery. In addition to adequate levels of financing measured by need, another fundamental element of socialising care in Africa is collective definition of culturally and socially appropriate care programs and services. Collective definition of care programs and services must be a participatory and ongoing process, from the bottom-up and led by women, with financing and coordination provided by the state.

The ACE Index is presented through:

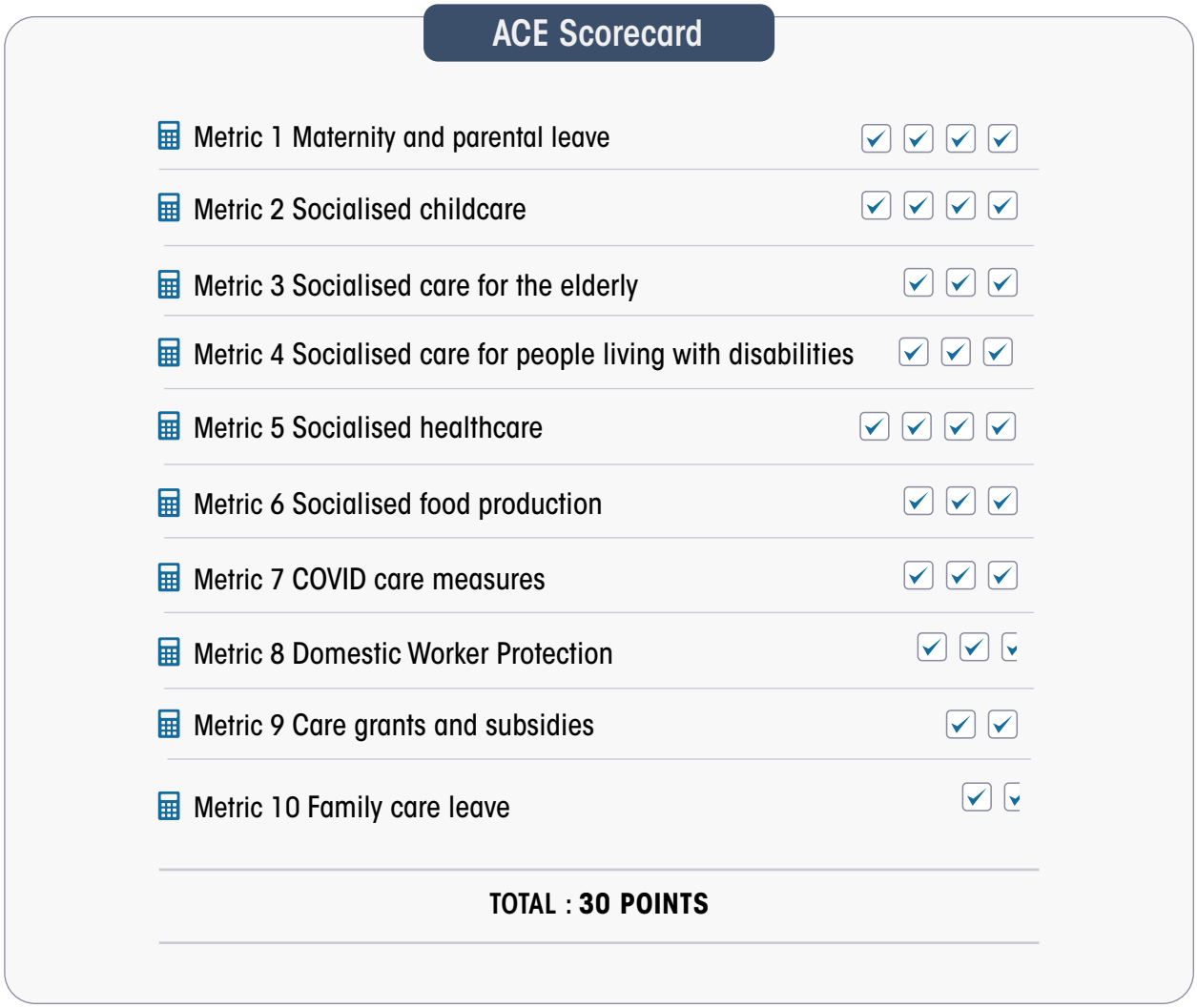
a) ten metrics measuring social recognition and state support for carework in relation to regionally-defined need (remainder of this section);

b) tallies by country and analysis of the ACE index results (Section C);

c) criteria and scores, by metric, for each country (Appendix).

For each metric, highlights from country-specific data are featured along with research questions to enable national policy development and implementation. Weighting for each metric ranges from 1.5 to 4 points, for a total score of 30 points per country (see figure below). Weightings reflect the importance of each metric in terms of the proportion of population affected and relevance in African contexts.

Figure 8. ACE Index Scorecard



Metric 1. Maternity and parental leave (4 points)

Defining need

Paid maternity leave is one of the most elementary forms of social recognition and respect for carework. This is especially true for Africa, with the world's highest average fertility rate of 4.4 live births per woman (United Nations Department of Economic and Social Affairs 2019). Calculating from this data, the average fertility rate in Africa is almost double the world average of 2.39.

Measuring social recognition and support

A legal database search for maternity leave legislation in Africa shows that all African countries, with the exception of Sierra Leone, have maternity leave legislation.[5] In the 53 countries with maternity leave legislation, the length of leave varies from 8 to 17 weeks.

[5] For details of legislation consulted for this study contact the author: valianisalimah@gmail.com

Maternity leave legislation in Burkina Faso and South Sudan stand out in that these are the only countries that extend the full leave and benefits to women who give birth to stillborn infants. Maternity leave and benefits for women that experience stillbirth are critical given profound psychological and related trauma. This is particularly salient in Africa as stillbirths in Sub-Saharan Africa have increased from 27 percent of the global total in the year 2000, to 42 percent in 2019 (UNICEF 2020).

Cash benefits are included in all national maternity leave legislation, with the exception of Lesotho. In 36 of the 52 countries with paid maternity leave, cash benefits are 100 percent of salaries earned prior to the leave, with varying qualifying conditions. Maternity leave cash benefits in 16 countries range from 50 to 90 percent of salaries earned prior to the leave. While legislation in most countries include wives of male public and private sector workers as beneficiaries of maternity leave and benefits, not a single country in Africa includes same sex female partners.

Another major shortcoming of this raft of legislation, across the continent, is the range of female workers excluded from the right to maternity leave or/and cash benefits. In 39 countries, large segments of female workers are excluded, by law, from accessing maternity leave and benefits. This includes various mixes of the following groups: self-employed workers, domestic workers and other employees of households, agricultural workers, casual workers, migrant workers, artisans, apprentices, and workers employed without contracts or by family members.

In addition, maternity leave and cash benefits are limited in some countries by time period or number of children. The number of permitted children is usually below 4, the average live birth rate per woman in Africa. Legislation in Malawi, Tanzania and Egypt, for example, permits maternity leave and cash benefits only once every 3 years. Lesotho limits maternity leave to two children per female.

Other types of exclusions reinforce gender segmentation in the labour market. For instance, the following female workers are explicitly barred from maternity leave and benefits: the few female workers employed in the military and police in South Africa and Tanzania; taxi drivers in Madagascar; aircraft, vessel, public sector professional and technical workers in Nigeria.

Maternity leave in the remaining 14 countries is more inclusive. These are Botswana, Cameroun, Tchad, Comoros, Congo, Côte d'Ivoire, Djibouti, Equatorial Guinea, Eswatini, Gabon, Ghana, Guinea, Guinea-Bissau, and Zimbabwe. Notable inclusions in the right to maternity leave and cash benefits in these countries are: migrant workers in Comoros and Djibouti; migrants, emigrants, household, and casual workers in Equatorial Guinea; and domestic workers in Eswatini and Mauritius.

The International Labour Organization (2014, 36) reports that due to legislative exclusions, restrictive qualifying conditions, and weaknesses in implementation, only 28.4 percent of the global female labour force is "effectively protected" with maternity cash benefits. Effective protection is as low as 15 percent in Asia and Africa. In other words, only some 15 percent of women in Africa actually receive maternity benefits.

To begin unravelling the reasons, this is primarily due to the largely agrarian nature of societies in Africa and Asia. In Africa, depending on the country, 25 to 90 percent of females work in agriculture (Palacios-Lopez, Christiaensen, Kilic 2015; FAO undated) without being full time employees or having employers in the legal sense. The ILO (2014, 39) highlights a survey conducted in two rural areas of Sénégal showing that 26 percent of women work in farms until the day of childbirth, largely due to need. The lack of maternity leave and cash benefits for agricultural and other excluded workers has detrimental effects for mothers, infants, and society as a whole.

African states can commit to strengthening the care economy by ensuring paid maternity leave for all female workers, regardless of sector of employment, legal status as workers, or legal status as full or part time workers. States could thus support the health of some of the continent's most productive workers, while also taking the first step in realising the socio-economic potential of the demographic bulge.

In some detail, research shows the long term, biosocial benefits of nutrition, lactation and other care for children in the first 1000 days of life (Martorell 2017; Karakochuk et. al 2018; Kinsey 2019). Kinshella, Moore and Elango (2020) make the link between lactation and infant nutrition with women's nutrition and health. The Food and Agricultural Organisation of the United Nations and African Union (2018, 3) acknowledge the centrality of female labour in food production, food preparation, and other care for children in Africa. Country-specific research could investigate strategies to replace female workers during maternity leave. In many countries, youth can be key in such strategies given that according to a recent ILO (undated) estimate, some 20.7 percent of youth in Africa are not in employment, education or training.

UN Women underscores the importance of parental leave in the redistribution of carework (Razavi, 2020). Rather than being limited to mothers, parental leave allows both parents, regardless of sex, to share leave related to early infant care. In Africa, rather than parental leave, legislated paid paternity leave exists in 15 countries: Tunisia (1 day private sector, 2 days public sector), Algeria, Burkina Faso, Burundi, Djibouti, Ethiopia, Mali, Tanzania, Morocco (3 days)[6], Uganda (4 days), Mauritius (5 days), Kenya, Seychelles, Sudan (10 days). Angola and South Africa have legislated unpaid paternity leave for 1 day, and 10 days, respectively. The considerably short periods of paternity leave, and explicit mention in all legislation that leave must be taken immediately after birth, suggest that paternity leave in the continent has little to do with the goal of redistributing carework.

[6] Limited to every 3 years in Tanzania.

Metric 2. Socialised childcare (4 points)

Defining need

If paid maternity and parental leave are the most basic collective expressions of valuing and redistributing carework, universal, quality childcare follows closely. The importance of the first 1000 days in the physical, mental and social development of infants has already been noted. From a care economy perspective, socialised childcare is fundamental from the end of maternity/parental leave through the first 1000 days, to early childhood education. After school care is also crucial to enable both parents to work in paid employment. This is especially true in Africa, where even after accounting for regional differences, the child dependency ratio is and will continue to be high until at least 2050 (see tables below).

Given low income levels of females in Africa, adequately funded, socialised childcare is the means to make quality childcare universal, or accessible to all families. With regard to quality, a range of international research demonstrates the superior quality of non-profit childcare versus for-profit childcare. Non-profit childcare is superior in terms of caregiver wages and turnover, child to staff ratio, caregiver education, positive caregiving, and staff development for childcare centre employees (Rigby et al. 2007; Sosinsky et al. 2007; Cleveland and Krashinsky 2009).

Table 2. **Ratio of children (0-14 years) per 100 working age persons (15-65), World Regions [Source: United Nations Conference on Trade and Development (undated), based on UNDESA 2019 data]**

	2021	2030	2040	2050
Developing				
Africa	71.3	64.0	57.1	51.5
America	35.2	31.8	28.6	26.7
Asia	34.5	31.5	29.2	27.7
Oceania	54.9	50.0	45.9	42.3
Developed				
America	27.7	27.6	27.5	26.7
Asia	22.5	21.0	22.7	24.8
Europe	24.1	23.5	23.8	25.0
Oceania	30.1	29.2	27.5	27.6

Table 3. Ratio of children (0-14 years) per 100 working age persons (15-65), Sub-regions, Africa [Source: United Nations Conference on Trade and Development (undated), based on UNDESA 2019 data]

	2021	2030	2040	2050
North Africa	52.9	47.3	41.6	40.2
East Africa	74.6	65.2	56.9	49.9
Middle Africa	85.5	76.2	67.3	59.0
Southern Africa	44.9	39.4	35.2	33.1
West Africa	79.1	71.7	64.3	57.4

With regard to access, some evidence suggests strongly that where the state both finances childcare, and provides it through the public sector, cost per child is reduced, making care more accessible (Mathieu 2021). In the Canadian province of Quebec, for example, the per child annual cost of public early childhood centres is less than 5 percent of the average worker's annual salary. This compares with a per child cost of 43 percent of the average worker's annual salary in Ontario, the neighbouring province, where childcare centres are mostly private, and public subsidies are minimal.[7]

In addition to provision through the public sector, adequate public financing is central to universal access. Despite public financing and public provision in Quebec, early childhood centres are still not accessible to all due to underfunding by the state. According to Mathieu (2021), over 50,000 families cannot access a space in public early childhood centres, and low income families are under-represented in public centres.

Measuring social recognition and support

A legal database and policy search for childcare-related laws and policies in African countries shows a lack of socialised childcare in all countries, with the sole exception of Algeria, where childcare is partially socialised. Under the Ministry of Labour and Social Works in Algeria, 83 percent of the cost of nurseries, kindergartens and community- based centres is subsidised by the state. In depth research around provision and quality of care, the roles of the public and private sectors, regulation, and levels of funding over time, would allow for an assessment of the extent of access to state subsidised childcare in Algeria.

Regulation of privately provided childcare in the continent is also sparse, existing in various written forms in only ten countries. The Institute of Early Childhood Development Act 2014, of Seychelles, specifies measures for the establishment, registration, inspection, appointment of inspectors, and monitoring and compliance of childcare establishments. Legislation and regulation in Ghana are similar, additionally specifying a minimum education requirement (middle school completion) for childcare staff.

[7] Computation of childcare costs in relation to average salaries by author.

The National Department of Social Development of South Africa requires early childhood development facilities caring for six or more children to register with provincial governments. The Department has also issued guidelines and minimum requirements for public sector employers operating childcare facilities. Regulation of childcare facilities is laid out explicitly in by-laws of only two municipalities in South Africa: Ethekwini and the City of Tshwane. [8]

In Kenya, The Nairobi County Acts 2017 covers the licensing of childcare facilities, staff requirements, inspection, and the appointment of quality assurance and standards officers. Ethiopia issued guidelines, in 1998, addressing the upgrading of existing childcare facilities and institutions, performance standards, and measures to regulate, monitor and evaluate. Policies in Rwanda, Uganda and Sierra Leone are similar but cover only early childhood education. Zimbabwe has a draft early childhood education policy.

In Namibia, the City of Windhoek has issued a comprehensive Early Childhood Development Draft Policy for childcare facilities including educational requirements, employment conditions, staff to child ratios, health and sanitation standards, monitoring and compliance, and others. The undated draft policy covers facilities established by the municipality or in partnership with "stakeholders." It is unclear whether private childcare facilities are included in the policy.

To begin imagining and creating socialised childcare in African countries, the emphasis of "active citizenship" in Scandinavian countries is relevant. This involves the participation of parents, childcare workers, administrators, and municipal officials in shaping and selecting different forms of care (Sivesind and Saglie 2017). New forms of publicly supported, collective childcare should be shaped in African countries according to cultural and social preferences, through publicly funded, participatory processes.

Metric 3. Socialised care for the elderly (3 points)

Defining need

Focusing on care for dependent persons at a macro, global scale, Jesus Rogero-Garcia (2012) identifies Africa as the world region most associated with an "unshared system of care." In his typology of systems of care, Rogero-Garcia estimates that over 70 percent of care in Africa is provided within the family, with the remainder provided by the non-profit, private and public sectors. Latin America, Asia and parts of Europe fall into Rogero-Garcia's "semi-shared system of care." Australia, Japan, Canada, the USA and most of Europe figure into the "shared system of care" category (Rogero-Garcia 2012, 4-6).

[8] The Children's Bill 2020 of the National Department of Social Development includes measures for regulation and the provision of subsidies to early childhood facilities but it is unclear when it will be enacted. Contestation around the Bill includes arguments for a separate piece of legislation on early childhood education.

With regard to the elderly, though old-age dependency ratios are, and will continue to be low in Africa compared to the rest of the world, they are on the rise and will almost double in North and Southern Africa by 2050 (see tables below). Given significantly higher and rising old-age dependency ratios in every other major world region, Africa risks losing yet more care workers, of various types, to other regions. Combined with high child dependency ratios, and the heavily skewed gender division of unpaid labour discussed above, African countries would do well to begin investing in socialised care for the elderly in the near term.

Table 4. **Ratio of elderly (65+ years) per 100 working age persons (15-65), World Regions [Source: United Nations Conference on Trade and Development (undated), based on UNDESA 2019 data]**

	2021	2030	2040	2050
Developing				
Africa	6.3	6.8	7.7	9.2
America	13.6	17.8	23.1	29.6
Asia	12.7	16.9	23.0	27.6
Oceania	7.0	8.5	10.2	11.9
Developed				
America	26.6	33.0	35.9	37.2
Asia	46.8	50.8	61.4	68.5
Europe	32.5	39.5	47.5	53.0
Oceania	25.8	31.3	35.2	38.0

Table 5. **Ratio of elderly (65+ years) per 100 working age persons (15-65), Sub-regions, Africa [Source: United Nations Conference on Trade and Development (undated), based on UNDESA 2019 data]**

	2021	2030	2040	2050
North Africa	9.6	11.7	14.0	17.7
East Africa	5.3	5.6	6.4	8.1
Middle Africa	5.3	5.4	5.7	6.6
Southern Africa	8.4	9.6	11.3	15.0
West Africa	5.2	5.4	5.8	6.9

Socialised care — whether for children, the elderly, people living with disabilities, or others — includes supported training of various types of care workers, as well as living wages. This would help to retain care workers within the continent, and potentially draw back, to Africa, at least a portion of care workers that have emigrated.

Measuring social recognition and support

A scan of legislation and policy around public homes and care programs for the elderly shows that socialised care for the elderly is non-existent in the continent. Legislation on the regulation of privately provided care for the elderly was found for three countries: Algeria, South Africa and Mauritius.

A 2016 Executive Order in Algeria recognises the right of the elderly to governmental assistance with homebased care, and specifies forms of homebased care. The Order also defines public regulation of private firms and social groups providing homebased care. In South Africa, under the Older Persons Act (2006), old age residential facilities and organisations providing homebased care must be registered with provincial governments. Regulations under the Act, issued in 2010, specify norms and standards of care, a code of conduct for community-based caregivers, and conditions and terms for state funding of private and nongovernmental organisation (NGO) care operations. The Province of the Western Cape has a policy around funding NGOs that provide social services and community development. Similarly, Mauritius has broad legislation around residential care homes covering the areas of licensing, protocol, governance and inspection. The latter specifies two yearly inspections, one announced and one unannounced.

Metric 4. Socialised care for people living with disabilities (3 points)

Defining need

Estimates of disability rates in Africa range from 10 to 40 percent of the population, of which 10 to 15 percent are school-age children (African Studies Centre Leiden 2020; Nyangweso 2018; Disabled World 2018). Globally, it is estimated that 10 percent of world population, or 600 million people, live with disabilities, a figure that translates to 1 in 5 people in low income countries (Disability World 2018). In 2003, the UNDP estimated that including family members that care for people living with disabilities, disability affects 25 percent of the world's population (as cited by Cameron et al. 2005, 1).

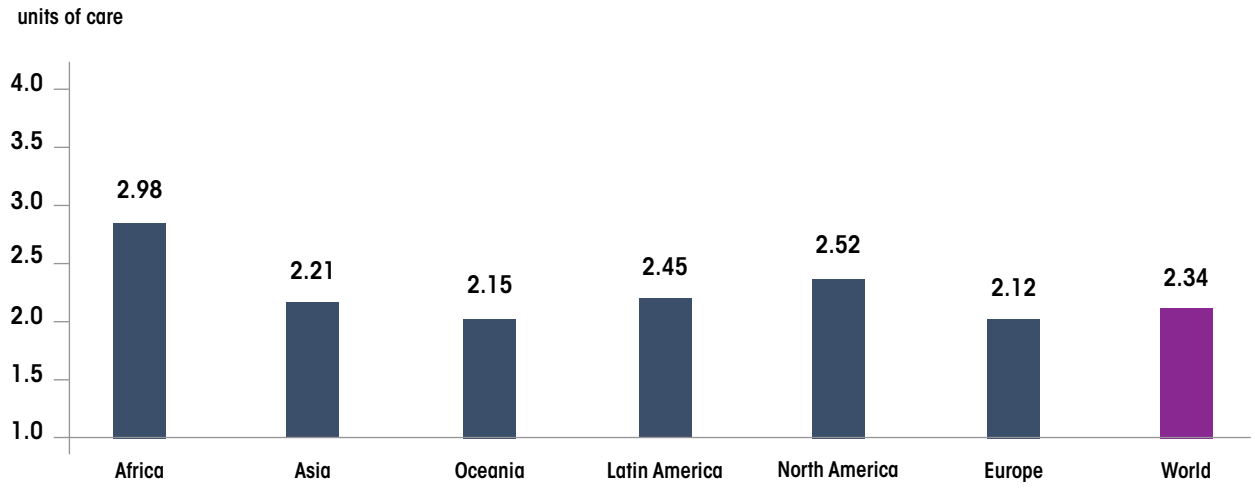
Honing in on unpaid caring work related to disability by world region, Rogero-Garcia (2012) offers the Freetown Scale (see figure).[9] The Scale combines disability rates and health status with demographic structure to estimate the average amount of unpaid caring work carried per caregiving adult (15 to 64 years). Due to high levels of illness and disability through all age groups in Africa, each unpaid caregiver in the continent is estimated to carry 3 units of care, compared to a world average of 2.34 units.[10] In terms of the caregiving population, the Freetown Scale takes into account gender, estimating that

[9] The scale is named after the capital of Sierra Leone, which has the world's highest proportion of population affected by disability and poor health.

[10] Following the Madrid scale, the Freetown scale assigns 1 unit as the care requirement for 15 to 64 year olds, 2 units for 65 to 79 year olds, and 3 units for those over 80. In the Freetown scale these figures are multiplied by the percentage of the population in poor health, and divided by the population of those providing unpaid care.

70 percent of providers around the world are non-elderly adult females, 25 percent are non-elderly males, and 20 percent are elderly people.

Figure 9. Freetown Scale: Estimated units of unpaid care carried by caregiving population, World Regions, 2010 [Source: Rogero-Garcia 2012, 20]



Measuring social recognition and support

A scan of legislation and policy related to care for people living with disabilities in the continent shows that not a single African country has legislation on public programs for the care of people living with disabilities. Four countries have other legislation or policy relating to people living with disabilities.

Botswana has a 1996 national policy outlining the role of government ministries, the private sector, NGOs, local organisations, community leaders, and persons with living with disabilities. As a result of ratification of the UN Convention on the Rights of Persons with Disabilities, Burkina Faso has a national strategy on the promotion of rights of persons living with disabilities. In Ghana, The Persons With Disabilities Act 2006, affirms the right of people living with disabilities in "specialised establishments" to environments and living conditions "as close as possible to those of a person without disability of the same age as the person with disability." Neither policy nor legislation were found for any of these countries on the regulation of care provided by private firms, NGOs or local organisations.

Only The Persons with Disabilities Act 2018, of Eswatini, specifies that an NGO providing care for people living with disabilities is subject to inspection by an authorised officer of government for the purpose of ensuring compliance with standards and regulations. Without specifying details with regard to financing or delivery, the Swaziland National Disability Plan of Action 2015-2020 ensures people living with disabilities access to services and programs.

Given the high rate of disability in the continent and its impact on demand for unpaid care, country-specific research and policy development around socialising care for people living with disabilities is crucial. This would include research around the most prevalent types of disability, causes and prevention, culturally and socially appropriate forms of care, and training of care workers. Given the high rates

of children affected by disability in the continent, research, policy development and public programs around education for children living with disabilities would be key to assuring that these children are included in the socio-economic realisation of Africa's demographic dividend.

Metric 5. Socialised healthcare (4 points)

Defining need

Socialised healthcare is a key indicator of social recognition and state support for medical care. Along with traditional medicine, public healthcare is the principal site to which the majority of caregivers in Africa turn, once unpaid care is not sufficient to tend to the ill.

Writing on South Africa, Valiani (2019, 67-68) underscores the public health system is composed of a massive female labour force providing the bulk of professional healthcare: 81 percent of filled professional public healthcare positions are those of nurses, 89 percent of which are female. This is true for Africa as a whole, which registers the world's highest nurse to doctor ratio, at 5.2 to 1 (Crisp and Chen 2014), with 65 percent of nurses being female (Boniol et al. 2019, 3).

Given reliance on public healthcare by the vast majority, and heavy reliance of African health systems on predominantly female nurses and other female health workers, adequately financed, public healthcare is an important vehicle for both valuing, and redistributing carework. More specifically, living wages and adequate training for all healthcare workers is an expression of collective value and respect for carework. Comprehensive public healthcare services and programs would redistribute care for the ill from unpaid labour in households and communities, to paid workers.

This contrasts with the approach taken in the continent in recent decades. Looking at the HIV/AIDS pandemic in Africa, Akintola (2008) notes that a host of national and international policies have been formulated, and maintained, based on the assumption that unpaid, homebased care for people living with HIV/AIDS is less costly than institutional care. Arguing that comprehensive cost accounting would put this assumption into question, Akintola underlines the need to include financial, physical, emotional, and opportunity costs of unpaid caregivers within the home, as well as volunteer community caregivers.

The amount of water required in HIV/AIDS care is one example of many that illustrates Akintola's point. According to a 2004 UNDP commissioned study, an estimated 24 buckets of clean water are required daily for the care of one HIV/AIDS patient (Azari et al. 2004). Time spent fetching and sanitising water for such care in households lacking running water would need to be included in a comprehensive cost accounting of homebased care.

In a range of rich countries, healthcare services that are fully socialised (publicly funded services provided through the public sector), have been shown to be more cost efficient, more socially efficient, and of higher overall quality than services provided by private firms. This includes Sweden, Finland,

the United Kingdom, and New Zealand (Saltman and Bergman 2005; Isaksson et al. 2016; Figueras et al. 2005; Maynard and Dixon 2016). Since the 1980s, these countries have been experimenting with publicly funded healthcare services provided by private firms, with poor results.[11]

Adequately funded public healthcare plays a major role in prevention. Linking to disability, for instance, it is estimated that 65 percent of disability in children is preventable (Cameron et al. 2005). In Africa, disability in children could be be prevented through treatment of infectious diseases, the foremost cause (World Health Organization, Disability and Rehabilitation Team as cited by Cameron et al. 2005). Adequately funded, fully socialised healthcare is thus also key to assuring the greatest possible collective benefit of the demographic bulge in Africa. Though of great collective value, prevention programs would not be deemed profitable by private health firms, which would therefore be unlikely to invest in them. As with socialised care programs for children and others, culturally and socially appropriate forms of healthcare should be context-specific and collectively defined.

Measuring social recognition and support

For this metric, rather than legislation and policy, national healthcare spending data is used. Due to the magnitude of healthcare cost, as well as low income levels of the majority in Africa, government health expenditure as a percentage of general government expenditure is selected. This is measured against the minimum 15 percent target agreed upon by African Union Heads of State in the 2001 ***Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases***. Taking average government health expenditure as a proportion of general government expenditure for all years available, per country, from 2002 (after the 2001 Abuja commitment), not a single African government attains the target. Average health spending ranges from the extreme low of 1.9 percent in Equatorial Guinea, to 13.8 percent in South Africa (see table including all country averages in Appendix).

Given high levels of illness and disability throughout the continent, and the central role of healthcare and health literacy in prevention, in depth research to assess specific healthcare and health literacy needs, by locale, is required to determine meaningful levels and types of public healthcare investment in each country.

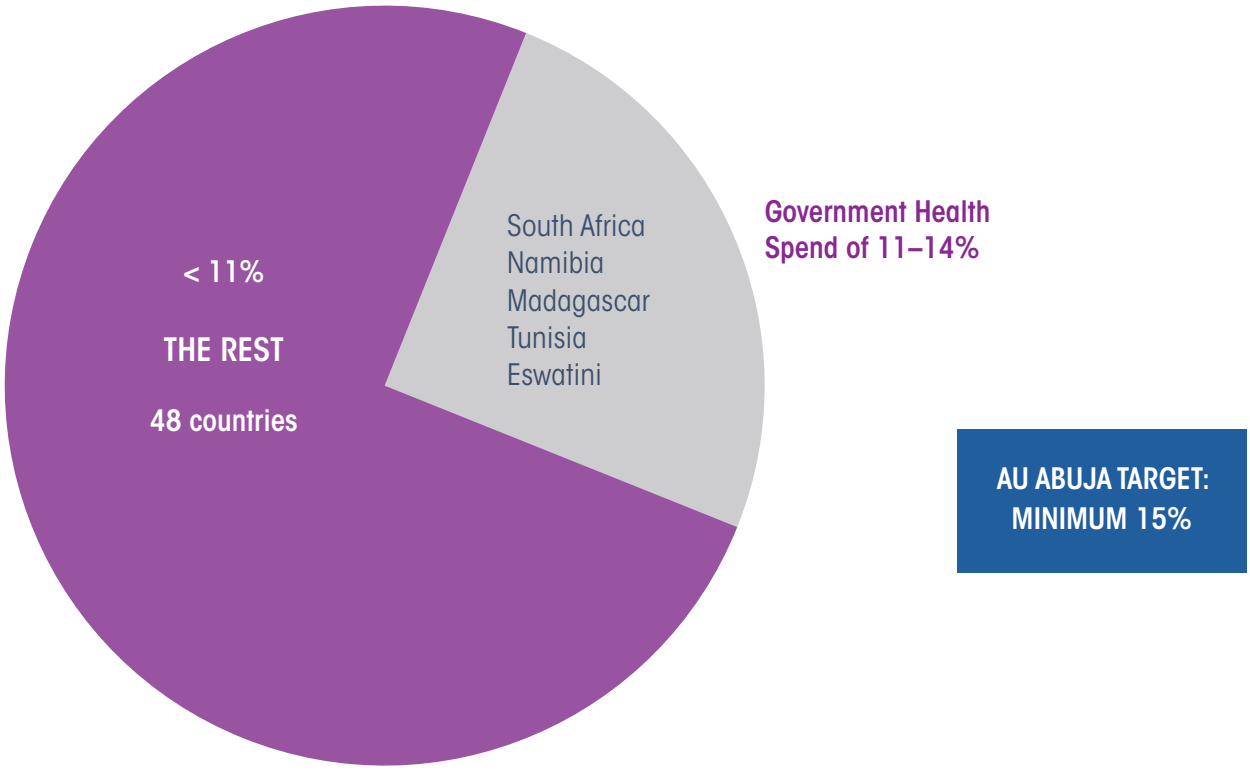
Metric 6. Socialised food production (3 points)

Defining need

As discussed above, depending on the country, large numbers, if not the majority of women, work in agriculture in most African countries. According to the Food and Agriculture Organisation and African Union (2018, 3), female labour dominates provision of local food supply in the form of subsistence agriculture, small ruminant livestock raising, livestock feeding, fish processing, and others.

[11] Known as the *purchaser provider split* in health systems analysis, see Valiani, S. (2020) "Structuring Sustainable Universal Health Care in South Africa" , *International Journal of Health Services*, v.50, i.2 for an extensive discussion of this policy choice and country experiences.

Figure 10. Government health spending as a percentage of total government spending, average percentage, 2002-2019 [Data Source: World Bank 2022, averages computed by author]



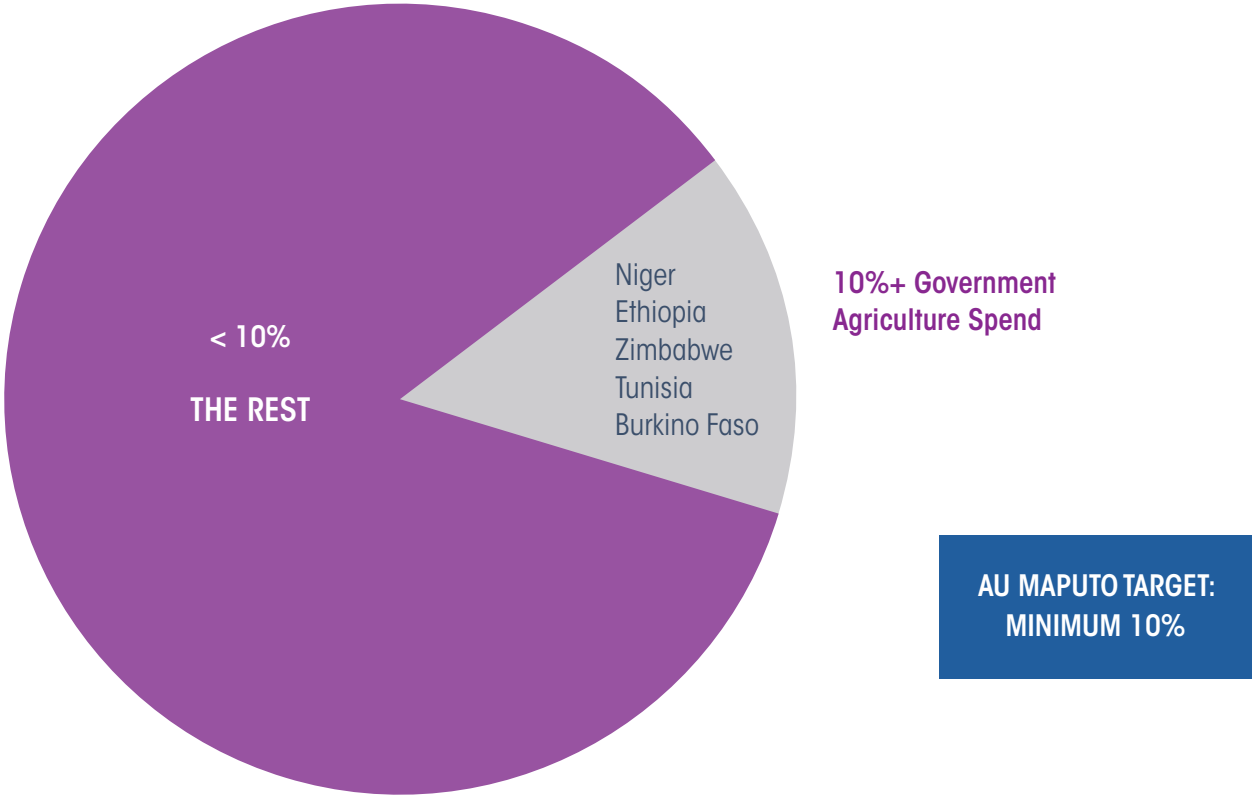
Women throughout the continent are also the main processors of crops into food. This involves labour intensive methods that can consume even more time than cultivation. Kes and Swaminathan (2006, 23) cite examples from research in Congo and Nigeria. In Congo, processing tapioca and maize takes four times more time than cultivation of cassava and maize crops. Similarly in Nigeria, threshing and milling grains can take 3 to 4 hours per day. Given that food production for the family is a substantial component of unpaid care in Africa, socialising the production of food is pivotal to strengthening the care economy. A first step to this is public investment in agriculture.

Measuring social recognition and support

For this metric, government expenditure on agriculture as a proportion of general government expenditure is used. Measuring against the minimum 10 percent target set by African governments, between 2000 and 2014, government expenditure on agriculture amounted to, or exceeded 10 percent only in Burkina Faso, Ethiopia, Malawi, Niger and Zimbabwe (see Figure 11). Upon agreeing that investment in agriculture was inadequate, African governments first committed to the target in the 2003 Maputo Declaration on Agriculture and Food Security. African governments recommitted to the 10 percent target in 2014, at the 23rd African Union Assembly in Malabo, Equatorial New Guinea.

As with government expenditure on healthcare, this metric demonstrates low prioritisation of care in contexts where subsistence agriculture is central to the supply of food consumed by the majority. Among other elements, socialising the production of food would entail significantly greater investment

Figure 11. Government expenditure on agriculture as a percentage of total government expenditure, average percentage, 2000-2014 [Data Source: Goyal and Nash 2017 for Sub-Saharan Africa and Algeria; FAO 2015 for Egypt, Libya, Morocco, Tunisia]



in research on nutrition-rich crops, climate resilient cultivation methods, and environmentally sound crops. Though the examples above of food processing time and labour are dated, country/region-specific research could determine how this aspect of carework can be collectivised, redistributed, and valued while maintaining and broadening access to food.

Metric 7. COVID care measures (3 points)

Defining need

Globally, during the COVID-19 pandemic, a variety of supports have been offered by governments to businesses, workers and women. Among these, despite the added unpaid care needs arising from the persistent novel coronavirus and its after effects, support related to unpaid care has amounted to 4.5 percent of total measures adopted (see table). COVID care-related measures include legislation and public services that: support parents with care responsibilities, improve services for populations with special care needs, and protect jobs of working parents who take leave to tend to unpaid care responsibilities.

Table 6. Various COVID-19 measures by World Region [Source: United Nations Development Programme 2021a]

	All Measures	Gender Sensitive	Unpaid Care	Violence Against Women	Women's Economic Security
Africa	842	270	14	112	144
Americas	1265	455	50	227	178
Asia	1220	360	35	197	128
Europe	1360	419	113	247	59
Oceania	281	101	14	70	17
	4968	**1605**	**226**	**853**	**526**

Measuring social respect and support

Of the 226 unpaid care related measures adopted by governments around the world, 14 were adopted in Africa, by 6 of 54 states: Algeria, Angola, Burundi, Cabo Verde, Egypt, and Seychelles.

In some detail, Algeria, during the first wave of the pandemic, granted public sector workers (at least 50 percent in each institution) 14 days paid leave, by executive decree (March 20, 2020). Priority was given to working mothers, pregnant workers and workers raising children. The same measure was instituted for private sector workers through another executive decree two days later (UNDP 2021c).

Egypt and Seychelles adopted similar labour market measures for working mothers and parents, though essential workers in Seychelles were excluded, without being accorded alternatives such as financial assistance for new, pandemic-related care needs (UNDP 2020a; UNDP 2020b). In Egypt, special leave was accorded to workers living with chronic illnesses and disabilities and workers with medical certificates. In Cabo Verde, for the period of March to June 2020, government encouraged employers to grant teleworking regimes to parents with children under three years, but this was not accompanied by legislation (UNDP 2021b).

In terms of non-labour market measures, in Angola, the state arranged for children living in the street to be housed. In Burundi, government distributed food and hygiene kits to flood victims and other vulnerable people living in care centres (UNDP 2020a). In Cabo Verde, social workers, caregivers and volunteers were recruited, by the public sector (national and municipal governments), to provide homebased care to the elderly and dependent persons living in isolation. This allowed 712 elderly people living in care facilities to be moved out of facilities and receive care at home for the month of April 2020 (UNDP 2021b). These measures shed light on the scope and potential of the state to strengthen the care economy in Africa.

Metric 8. Domestic worker protection (2.5 points)

Defining need

In 2013, 13.6 percent of paid female employees in Africa were domestic workers (ILO 2016). From a care economy perspective, after healthcare workers, this is the major paid care workforce on which families rely to supplement unpaid care. The proportion of families that can afford to employ domestic workers is small in most countries. Nevertheless, legal protection of domestic worker rights is an important indicator of the social respect accorded to the labour of these paid care workers, the majority of which, as elsewhere, are not represented by unions in Africa.

Measuring social respect and support

A review of legislation shows that 11 countries accord domestic workers the same rights as other workers under general labour law: Botswana, Cabo Verde, Equatorial Guinea, Ghana, Kenya, Libya, Madagascar, Mali, Mauritius, South Africa and Tanzania. Legislation in Libya specifies that households are permitted to employ domestic workers only in exceptional circumstances. Legislation in Mauritius provides advanced protections for all household workers, including additional pay when domestic workers are required to work outside the home, uniform entitlements, and allowances for travel and meals.

In 17 countries domestic workers have partial rights protection. These are: Benin, Burkina Faso, Burundi, Democratic Republic of Congo, Côte d'Ivoire, Eswatini, Lesotho, Morocco, Mozambique, Namibia, Sénégal, Seychelles, Sudan, Zambia, and Zimbabwe. The remaining 26 countries do not protect domestic workers rights. The labour code in Egypt explicitly excludes domestic workers. In both Egypt and Algeria, large numbers of domestic workers are minors, likely mostly female, though research is sparse (Ahmed and Jureidini 2010; Bureau of International Labour Affairs undated).

Metric 9. Care grants and subsidies (2 points)

In the absence of fully or partially socialised care, grants for caregivers and subsidies for paid care are a form of recognising carework. A review of legislation and policy on care grants and subsidies reveals three grants, in two countries. The Kenyan government offers a grant for poor households of people living with severe disabilities and requiring care. The value of the grant is KES2000 per month. The South African government offers a grant of R1860, per month, to caregivers of children (0-18 years) living with disabilities. Also, a grant of R440 per month is offered, in South Africa, to those requiring care and already receiving old age, war veterans, or disability grants.

The extent of social recognition for care represented by these grants could be determined through country-specific research evaluating the cost and quality of paid care, and comprehensive costs incurred by unpaid and paid caregivers.

Metric 10. Family care leave (1.5 points)

Around the world, family care leave is typically accorded through labour legislation. In most of Africa, the vast majority of workers (90 percent or more), are employed in the so-called informal economy where labour laws do not apply. The exception to this is Southern Africa, where 40 percent of workers are employed in the informal economy (see table). Nevertheless, legislated family care leave is an important marker of the social recognition of unpaid care responsibilities of workers.

Table 7. Percentage of workers employed in the informal economy, by sex and World Bank Region [Source: Bonnet, Vanek and Chen 2019]

	Total	♀	♂
Asia and Pacific	71	67	74
Sub-Saharan Africa	89	92	86
Southern Africa	40	42	38
Rest of Africa	92	95	89
Latin America, Caribbean	54	55	53
Middle East, N. Africa	68	62	69
E. Europe, Central Asia	37	36	38

Only 12 countries in the continent include family care leave in labour legislation. Most define family narrowly and provide minimal leave time. These are: Algeria (3 days paid per year), Benin (1 day paid per year), Botswana (5 days paid only for police, frequency unspecified), Burkina Faso (6 months unpaid, renewable twice), Egypt (2 years unpaid, only for female workers to care for a child), and Mali (1 day paid per year per child, only for female workers). Ethiopia provides 3 days paid leave for death of family members (defined broadly), 3 days of paid leave at the end of a marriage, and 5 days unpaid for other family issues (twice yearly). Family leave in South Africa, the country with the highest level of formal sector employment in the continent, is particularly narrow, consisting of only 3 paid days per year, only for illness of a child or death of an immediate family member.

Labour legislation in Cameroun and Gabon allows for considerably more family care leave: 10 paid days per year without a limiting definition of family. Legislation in Sao Tome and Principe, covering the 5 percent of total working population in the formal economy, includes the most generous, non-gendered family care leave in the continent: 6 months of paid leave (at 60-79 percent of salary) for parents who have made a minimum of 180 days contribution to the national social security fund. This leave, however, is limited to care for an ill child under the age of 4 years, or, a child of any age living with a disability.

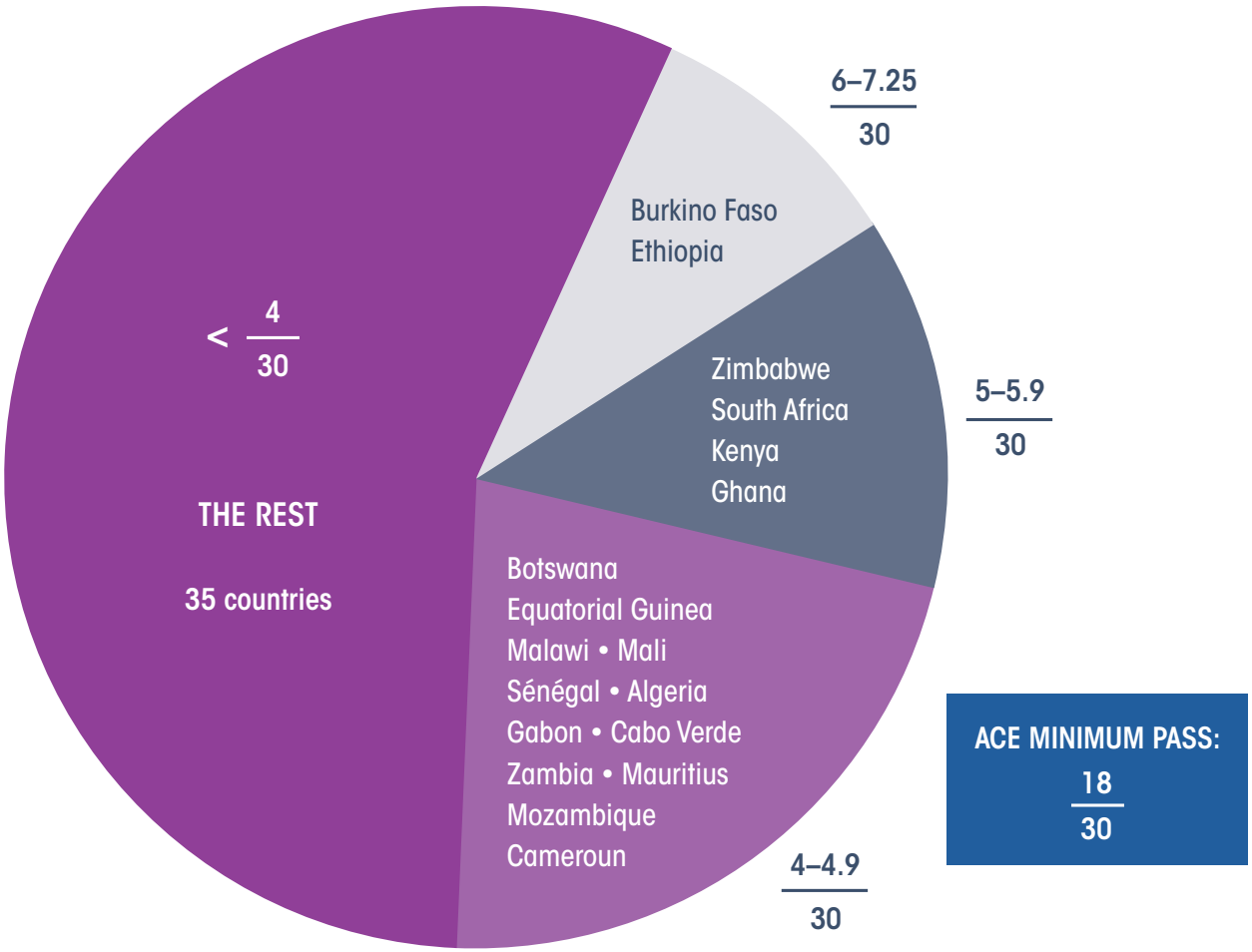
SECTION C

Tallying-up: The Africa Care Economy Index Scores

Africa faces a range of health and demographic challenges. As discussed in the previous section, these include the world's highest fertility rate, high levels of disability, inequality and illness, highly gendered division of carework, poor health of unpaid caregivers, and high levels of care worker emigration. In turn, 18 out of 30, or high performance in Metrics 1 to 6, is the minimum passing grade in the ACE Index.

All countries in the continent figure extremely low, scoring less than half of the passing grade (see figure). Only six countries attain a total of more than 5 points: Burkina Faso (7.25), Ethiopia (6.3), Zimbabwe (5.95), South Africa (5.7), Kenya (5.65), and Ghana (5.5).

Figure 12. **ACE Index scores**



Of the ten metrics used to evaluate each country, most African countries fare moderately well only in Metric 1: Maternity and parental leave legislation. However, parental leave does not exist anywhere in the continent. This reflects extremely gendered notions of responsibility for early infant care. Access to maternity leave is limited by the small proportion of working women considered 'employed', by law, and hence eligible for maternity leave and benefits.

In Metrics 2 to 5 — socialised childcare, socialised care for the elderly, socialised care for people living with disabilities, and socialised healthcare — despite the massive volume of care needed, all countries in the continent fare poorly. Extensive work is required to redistribute care from unpaid spheres to the paid sphere. This includes assessing need for various types of care through in depth research, collectively conceiving of and designing culturally and socially appropriate care programs, and public investment in training and living wages for care workers.

Unlike most countries and world regions, a considerable portion of unpaid caring work in Africa involves the cultivation and processing of food for family consumption. This is captured in Metric 6. Public investment in environmentally sound agriculture that responds to local need is a crucial first step in recognising and redistributing caring work in Africa. Though African states have long committed to increased pubic spending on agriculture, few have done so in the past two decades. Food shortages during the COVID-19 pandemic have re-emphasised the importance of domestic food production.

Had African countries performed well in the first six metrics, they would have been equipped to manage the COVID-19 pandemic. The extent of environmental destruction in Africa and globally, and inter-related likelihood of increased emergence of zoonotic disease (Berger 2020), suggest that work on the care economy is urgent in Africa — not only to harness the productive potential of the demographic dividend, but to be prepared for future pandemics.

Conclusion

This study is based on the argument that a socialised, public sector response is crucial to reverse the normalised, unequal distribution of carework in Africa. Operationalising feminist theories of social reproduction, care, and human infrastructure, the ACE Index measures the extent of social recognition and state support for the care economy in the continent. Legislation, policy, and public spending on care are examined, relative to regionally defined need, through ten metrics argued to have specific meaning for the care economy in Africa.

With all countries of the continent scoring extremely low in the ACE Index, political commitment to the care economy is long overdue. In depth, country-specific research to assess and understand diverse care needs, policy development and implementation, and public investment would enable the continent to begin undoing deep gender and other inequalities while realising Africa's demographic dividend.

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Appendix

Scoring criteria and points per country per metric

1. Maternity and parental leave (4 points maximum)

Measure: Maternity and parental leave legislation

Scoring Criteria:

- Maternity leave: 1 point
- inclusive: 0.5 point (0.5 for all workers included)
- length: 0.5 point (0.5 for 14-16 weeks; 0.4 for 9-12 weeks; 0.3 for 4-8 weeks)
- percentage pay: 0.5 point (0.5 for 100%)
- qualifying conditions: 0.5 point (0.5 for no qualifying conditions)

- Parental leave: 2 points
- inclusive: 0.5 point (0.5 for all workers included)
- length: 0.5 point (0.5 for 14-16 weeks; 0.4 for 9-12 weeks; 0.3 for 4-8 weeks)
- percentage pay: 0.5 point (0.5 for 100%)
- qualifying conditions: 0.5 point (0.5 for no qualifying conditions)

- bonus: 0.5 point (for including migrant workers, or mothers of stillborn infants, or emigrants)

Country		ACE Index Score /4
Algeria		0.9
Angola		0.8
Benin		1.0
Botswana		1.9
Burkina Faso	(bonus: mothers of stillborn)	2.5
Burundi		0.9
Cabo Verde		1.3
Cameroun		2.5
Central African Republic		1.0
Tchad		1.0
Comoros	(bonus: migrants workers)	3.0
Congo		1.0
Democratic Republic of Congo		1.0
Côte d'Ivoire		2.0
Djibouti	(bonus: migrant workers)	3.5
Egypt		0.9
Equatorial Guinea	(bonus: migrant workers and emigrants)	2.4
Eritrea		0
Eswatini		1.9
Ethiopia		2.5

Country	ACE Index Score /4
Gabon	3.0
Gambia	0.9
Ghana	1.0
Guinea	1.0
Guinea-Bissau	2.8
Kenya	1.9
Lesotho	0.9
Liberia	2.0
Libya	1.0
Madagascar	1.0
Malawi	1.8
Mali	2.0
Mauritania	2.0
Mauritius	0.8
Morocco	0
Mozambique	2.8
Namibia	0.9
Niger	0
Nigeria	0.9
Rwanda	0.9
Sao Tome and Principe	0.8
Sénégal	(bonus: migrant workers and adoptive parents) 3.5
Seychelles	1.0
Sierra Leone	0
Somalia	1.0
South Africa	1.0
South Sudan	(bonus: mothers of stillborn) 2.9
Sudan	0.8
Tanzania	0.9
Togo	3.0
Tunisia	0.8
Uganda	1.8
Zambia	2.9
Zimbabwe	1.5

2. Socialised childcare (4 points maximum)

Measure: Legislation on public childcare and regulation of public and private childcare

Scoring Criteria:

- Fully socialised: 4 points
- Partially socialised: 2 points
- Regulation of private centres (inspection, standards, norms): 1 point
- Policy/Guidelines: 0.3 point
- Draft Policy: 0.2 point

Country	ACE Index Score /4
Algeria	2.0
Angola	0
Benin	0
Botswana	0
Burkina Faso	0
Burundi	0
Cabo Verde	0
Cameroun	0
Central African Republic	0
Tchad	0
Comoros	0
Congo	0
Democratic Republic of Congo	0
Côte d'Ivoire	0
Djibouti	0
Egypt	0
Equatorial Guinea	0
Eritrea	0
Eswatini	0
Ethiopia	0.3
Gabon	0
Gambia	0
Ghana	1.0
Guinea	0
Guinea-Bissau	0
Kenya	1.0
Lesotho	0
Liberia	0
Libya	0
Madagascar	0
Malawi	0
Mali	0
Mauritania	0
Mauritius	0
Morocco	0

Country	ACE Index Score /4
Mozambique	0
Namibia	0.2
Niger	0
Nigeria	0
Rwanda	0.3
Sao Tome and Principe	0
Sénégal	0
Seychelles	0
Sierra Leone	0.3
Somalia	0
South Africa	0.4
South Sudan	0
Sudan	0
Tanzania	0
Togo	0
Tunisia	0
Uganda	0
Zambia	0
Zimbabwe	0.2

3. Socialised care for the elderly (3 points maximum)

Measure: Legislation on public care for the elderly and regulation of public and private care for the elderly

Scoring Criteria:

- Fully socialised: 3 points
- Partially socialised: 1.5 points
- Regulation of private centres (inspection, standards, norms): 0.75 point

Country	ACE Index Score /3
Algeria	0.75
Angola	0
Benin	0
Botswana	0
Burkina Faso	0
Burundi	0
Cabo Verde	0
Cameroun	0
Central African Republic	0
Tchad	0
Comoros	0
Congo	0
Democratic Republic of Congo	0
Côte d'Ivoire	0

Country	ACE Index Score /3
Djibouti	0
Egypt	0
Equatorial Guinea	0
Eritrea	0
Eswatini	0
Ethiopia	0
Gabon	0
Gambia	0
Ghana	0
Guinea	0
Guinea-Bissau	0
Kenya	0
Lesotho	0
Liberia	0
Libya	0
Madagascar	0
Malawi	0
Mali	0
Mauritania	0
Mauritius	0.75
Morocco	0
Mozambique	0
Namibia	0
Niger	0
Nigeria	0
Rwanda	0
Sao Tome and Principe	0
Sénégal	0
Seychelles	0
Sierra Leone	0
Somalia	0
South Africa	0.75
South Sudan	0
Sudan	0
Tanzania	0
Togo	0
Tunisia	0
Uganda	0
Zambia	0
Zimbabwe	0

4. Socialised care for people living with disabilities (3 points maximum)

Measure: Legislation on public programs for care of people living with disabilities and regulation of private care of people living with disabilities

Scoring Criteria:

- Fully socialised: 3 points
- Partially socialised: 1.5 points
- Regulation of private or NGO-operated centres (inspection, standards, norms): 0.75 point
- Policy/Strategy: 0.2 point

Country	ACE Index Score /3
Algeria	0
Angola	0
Benin	0
Botswana	0.2
Burkina Faso	0.2
Burundi	0
Cabo Verde	0
Cameroun	0
Central African Republic	0
Tchad	0
Comoros	0
Congo	0
Democratic Republic of Congo	0
Côte d'Ivoire	0
Djibouti	0
Egypt	0
Equatorial Guinea	0
Eritrea	0
Eswatini	0.75
Ethiopia	0
Gabon	0
Gambia	0
Ghana	0
Guinea	0
Guinea-Bissau	0
Kenya	0
Lesotho	0
Liberia	0
Libya	0
Madagascar	0
Malawi	0
Mali	0
Mauritania	0
Mauritius	0
Morocco	0

Country	ACE Index Score /3
Mozambique	0
Namibia	0
Niger	0
Nigeria	0
Rwanda	0
Sao Tome and Principe	0
Sénégal	0
Seychelles	0
Sierra Leone	0
Somalia	0
South Africa	0
South Sudan	0
Sudan	0
Tanzania	0
Togo	0
Tunisia	0
Uganda	0
Zambia	0
Zimbabwe	0

5. Socialised healthcare (4 points maximum)

Measure: 2001 Abuja Declaration commitment to minimum 15 percent government health expenditure of general government expenditure

Scoring Criteria:

- Average 15 percent or more, 2002-2019: 4 points
- Less than 15 percent, 2002-2019: 0

Government Health Expenditure (GHE) as percentage of general government expenditure (GGE), 2002-2019, [Data Source: World Bank 2022; averages computed by author]

Country	% 2002-2019	ACE Index Score /4
Algeria	9.2	0
Angola	5.4	0
Benin	4.5	0
Botswana	10.2	0
Burkina Faso	7.3	0
Burundi	6.8	0
Cabo Verde	9.5	0
Cameroun	3.4	0
Central African Republic	6.2	0
Tchad	6.5	0
Comoros	4.5	0

Country	% 2002-2019	ACE Index Score /4
Congo	2.6	0
Côte d'Ivoire	4.5	0
Democratic Republic of Congo	3.1	0
Djibouti	5.8	0
Egypt	4.9	0
Equatorial Guinea	1.9	0
Eritrea	2.3	0
Eswatini	11.2	0
Ethiopia	5.5	0
Gabon	6.9	0
Gambia	5.8	0
Ghana	8.4	0
Guinea	3.0	0
Guinea-Bissau	7.3	0
Kenya	7.3	0
Lesotho	8.6	0
Liberia	4.2	0
Libya (2002-2011)	5.4	0
Madagascar	12.3	0
Malawi	6.9	0
Mali	4.9	0
Mauritania	4.7	0
Mauritius	8.3	0
Morocco	6.7	0
Mozambique	5.5	0
Namibia	12.9	0
Niger	8.3	0
Nigeria	4.4	0
Rwanda	8.5	0
Sao Tome and Principe	7.1	0
Sénégal	6.2	0
Seychelles	9.1	0
Sierra Leone	7.1	0
Somalia	not available	0
South Africa	13.8	0
South Sudan (2017-2019)	2.1	0
Sudan	9.8	0
Tanzania	9.3	0
Togo	5.0	0
Tunisia	12.2	0
Uganda	6.5	0
Zambia	6.8	0
Zimbabwe (2010-2019)	9.6	0

6. Socialised food production (3 points maximum)

Measure: 2003 Maputo Declaration on Agriculture and Food Security commitment of minimum 10 percent government expenditure on agriculture as percentage of general government expenditure

Scoring Criteria:

- Average 10 percent or more over time: 3 points
- Less than 10 percent over time: 0

Public agricultural spending as share of total public spending, average percentages (Sources: Goyal and Nash 2017, 70-72 for Sub-Saharan Africa and Algeria; FAO 2015, 13 for Egypt, Libya, Morocco, Tunisia)

Country	%1990-1999	% 2000-2014	ACE Index Score /3
Algeria	6.4	5.18	0
Angola	1.14	1.4	0
Benin	8.26	6.17	0
Botswana	5.85	3.28	0
Burkina Faso	27.14	9.99	3
Burundi	4.9	3.42	0
Cabo Verde	—	2.91	0
Cameroun	4.16	4.43	0
Central African Republic	5.56	2.89	0
Tchad	—	5.81	0
Comoros	—	—	—
Congo	0.19	1.38	0
Democratic Republic of Congo	5.11	2.46	0
Côte d'Ivoire	3.4	3.27	0
Djibouti	—	—	0
Equatorial Guinea	—	1.11	0
Eritrea	7.58	5.28	0
Eswatini	7.13	3.27	0
Ethiopia	9.22	12.28	3.0
Gabon	—	—	0
Gambia	7.57	6.23	0
Ghana	2.55	2.48	0
Guinea	—	8.09	0
Guinea-Bissau	0.8	1.15	0
Kenya	6.45	4.0	0
Lesotho	9.58	2.93	0
Liberia	2.9	4.56	0
Madagascar	10.24	8.12	0
Malawi	8.14	12.73	3.0
Mali	12.41	9.84	0

Country	%1990-1999	% 2000-2014	ACE Index Score /3
Mauritania	—	5.65	0
Mauritius	5.46	2.95	0
Mozambique	—	5.98	0
Namibia	6.49	5.02	0
Niger	23.25	13.57	3.0
Nigeria	2.03	3.21	0
Rwanda	—	4.39	0
Sao Tome and Principe	—	6.93	0
Sénégal	5.66	7.28	0
Seychelles	1.6	1.46	0
Sierra Leone	1.8	3.63	0
Somalia	—	—	0
South Africa	.63	1.89	0
South Sudan	—	1.28	0
Sudan	12.63	5.15	0
Tanzania	6.16	5.72	0
Togo	3.99	5.58	0
Uganda	1.74	4.14	0
Zambia	2.99	7.99	0
Zimbabwe	5.85	11.92	3.0
NORTH AFRICA (other than Algeria)	2008-2012		
Egypt	2.4-4.1		0
Libya	—		—
Morocco	0-0.74		0
Tunisia	4.1-11.8		3.0

7. COVID care-related measures (3 points maximum)

Measure: Legislation and public services that support parents with care responsibilities, improve services for populations with special care needs, and protect jobs of working parents who take leave to tend to unpaid care responsibilities

Scoring Criteria:

- Non-gendered labour market measures for all workers with unpaid care responsibilities: 1 point
- Partial or/and gendered labour market measures for unpaid care: 0.5 point
- Assistance to all populations with special needs: 1 point
- Partial assistance to populations with special needs: 0.5 point
- Financial assistance with pandemic-related care costs for all workers: 1 point
- Partial financial assistance with pandemic-related care costs: 0.5 point

Country	ACE Index Score /3
Algeria	0.5
Angola	0.5
Benin	0
Botswana	0
Burkina Faso	0
Burundi	0.5
Cabo Verde	0.5
Cameroun	0
Central African Republic	0
Tchad	0
Comoros	0
Congo	0
Democratic Republic of Congo	0
Côte d'Ivoire	0
Djibouti	0
Egypt	0.5
Equatorial Guinea	0
Eritrea	0
Eswatini	0
Ethiopia	0
Gabon	0
Gambia	0
Ghana	0
Guinea	0
Guinea-Bissau	0
Kenya	0
Lesotho	0
Liberia	0
Libya	0
Madagascar	0
Malawi	0
Mali	0

Country	ACE Index Score /3
Mauritania	0
Mauritius	0
Morocco	0
Mozambique	0
Namibia	0
Niger	0
Nigeria	0
Rwanda	0
Sao Tome and Principe	0
Sénégal	0
Seychelles	0.5
Sierra Leone	0
Somalia	0
South Africa	0
South Sudan	0
Sudan	0
Tanzania	0
Togo	0
Tunisia	0
Uganda	0
Zambia	0
Zimbabwe	0

8. Domestic worker protection (2.5 points maximum)

Measure: Domestic workers' rights legislation

Scoring Criteria:

- Protection equal to all other employees: 2.5 points
- Partial protection: 1.25 points

Country	ACE Index Score /2.5
Algeria	0
Angola	0
Benin	1.25
Botswana	2.5
Burkina Faso	1.25
Burundi	1.25
Cabo Verde	2.5
Cameroun	0
Central African Republic	0
Tchad	0
Comoros	0
Congo	0
Democratic Republic of Congo	1.25

Country	ACE Index Score /2.5
Côte d'Ivoire	1.25
Djibouti	0
Egypt	0
Equatorial Guinea	2.5
Eritrea	0
Eswatini	1.25
Ethiopia	0
Gabon	0
Gambia	0
Ghana	2.5
Guinea	0
Guinea-Bissau	0
Kenya	2.5
Lesotho	1.25
Liberia	0
Libya	2.5
Madagascar	2.5
Malawi	0
Mali	2.5
Mauritania	0
Mauritius	2.5
Morocco	1.25
Mozambique	1.25
Namibia	1.25
Niger	0
Nigeria	0
Rwanda	0
Sao Tome and Principe	0
Sénégal	1.25
Seychelles	1.25
Sierra Leone	0
Somalia	0
South Africa	2.5
South Sudan	0
Sudan	1.25
Tanzania	2.5
Togo	0
Tunisia	0
Uganda	0
Zambia	1.25
Zimbabwe	1.25

9. Care grants and subsidies (2 points maximum)

Measure: Legislation on grants for caregivers and subsidies for paid care

Scoring Criteria:

- For childcare, all parents: 1 point
- For childcare, some parents: 0.5 point
- For elder care, all: 0.5 point
- For elder care, partial: 0.25 point
- For care for people with disabilities, all: 0.5 point
- For care for people with disabilities, partial: 0.25 point

Country	ACE Index Score /2
Algeria	0
Angola	0
Benin	0
Botswana	0
Burkina Faso	0
Burundi	0
Cabo Verde	0
Cameroun	0
Central African Republic	0
Comoros	0
Congo	0
Côte d'Ivoire	0
Democratic Republic of Congo	0
Djibouti	0
Egypt	0
Equatorial Guinea	0
Eritrea	0
Eswatini	0
Ethiopia	0
Gabon	0
Gambia	0
Ghana	0
Guinea	0
Guinea-Bissau	0
Kenya	0.25
Lesotho	0
Liberia	0
Libya	0
Madagascar	0
Malawi	0
Mali	0
Mauritania	0
Mauritius	0
Morocco	0
Mozambique	0

Country	ACE Index Score /2
Namibia	0
Niger	0
Nigeria	0
Rwanda	0
Sao Tome and Principe	0
Sénégal	0
Seychelles	0
Sierra Leone	0
Somalia	0
South Africa	0.75
South Sudan	0
Sudan	0
Tanzania	0
Tchad	0
Togo	0
Tunisia	0
Uganda	0
Zambia	0
Zimbabwe	0

10.Family care leave (1.5 points maximum)

Measure: Family care leave legislation

Scoring Criteria:

- Broad, paid, non-gendered: 1.5 points
- Broad, paid, gendered: 1 point
- Narrow, paid, non-gendered: 0.5 point
- Narrow, gendered/unpaid: 0.3 point

Country	ACE Index Score /1.5
Algeria	0.5
Angola	0
Benin	0.5
Botswana	0.3
Burkina Faso	0.3
Burundi	0
Cabo Verde	0
Cameroun	1.5
Central African Republic	0
Tchad	0
Comoros	0
Congo	0
Democratic Republic of Congo	0
Côte d'Ivoire	0

Country	ACE Index Score /1.5
Djibouti	0
Egypt	0.3
Equatorial Guinea	0
Eritrea	0.3
Eswatini	0
Ethiopia	0.5
Gabon	1.5
Gambia	0
Ghana	1.0
Guinea	0
Guinea-Bissau	0
Kenya	1.0
Lesotho	0
Liberia	0
Libya	0
Madagascar	0
Malawi	0
Mali	0.3
Mauritania	0
Mauritius	0
Morocco	0
Mozambique	0
Namibia	0
Niger	0
Nigeria	0
Rwanda	0.3
Sao Tome and Principe	1.5
Sénégal	0
Seychelles	0
Sierra Leone	0.3
Somalia	0
South Africa	0.3
South Sudan	0
Sudan	0
Tanzania	0
Togo	0
Tunisia	0
Uganda	0
Zambia	0
Zimbabwe	0

11. ACE Index total scores (30 points maximum; 18 points passing grade)

Country	ACE Total Score /30
Burkina Faso	7.25
Ethiopia	6.30
Zimbabwe	5.95
South Africa	5.70
Kenya	5.65
Ghana	5.50
Botswana	4.90
Equatorial Guinea	4.90
Malawi	4.80
Mali	4.80
Senegal	4.75
Algeria	4.65
Gabon	4.50
Cabo Verde	4.30
Zambia	4.15
Mauritius	4.05
Mozambique	4.05
Cameroun	4.00
Eswatini	3.90
Tunisia	3.80
Djibouti	3.50
Libya	3.50
Madagascar	3.50
Tanzania	3.40
Cote d'Ivoire	3.25
Comoros	3.00
Niger	3.00

Country	ACE Total Score /30
Togo	3.00
South Sudan	2.90
Guinea-Bissau	2.80
Benin	2.75
Seychelles	2.75
Burundi	2.65
Namibia	2.35
Sao Tome Principe	2.30
Democratic Republic of Congo	2.25
Lesotho	2.15
Sudan	2.05
Liberia	2.00
Mauritania	2.00
Uganda	1.80
Egypt	1.70
Rwanda	1.50
Angola	1.30
Morocco	1.25
Central African Republic	1.00
Tchad	1.00
Congo	1.00
Guinea	1.00
Somalia	1.00
Gambia	0.90
Nigeria	0.90
Sierra Leone	(insufficient data) —
Eritrea	0.30