Global pathways to men's caregiving: Mixed methods findings from the International Men and Gender Equality Survey and the Men Who Care study

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Abstract
Promoting men's participation in unpaid care work is part of the Programme of Action for the International Conference on Population and Development. However, men's involvement in care work does not mirror the advances women have made in paid work outside the home. This mixed method study explores which men are more involved in caregiving, and what childhood and adulthood factors influence their level of involvement. Quantitative research presents findings from 1169 men across six countries with children aged 0–4, and a qualitative study presents findings from in-depth interviews with 83 men engaged in atypical caregiving practices. Survey research finds that being taught to care for children, witnessing one's father take care of one's siblings, respondents' present attitudes about gender equality and having outside help (or none, in some cases) were all also associated with men's higher level of involvement. Qualitative research reveals that men's experiences of violence, the normalisation of domestic work as children and life circumstances rather than greater-than-average beliefs in gender equality all propelled them into care work. Findings suggest that engaging more men into care work implies changes to policies and structural realities in the workplace coupled with changing gender attitudes. These insights inform policy and practice aimed at promoting greater involvement in care work by men.

Keywords: caregiving; fatherhood; gender equality; masculinity; men

Introduction

The discourse around the International Conference on Population and Development (ICPD) commonly centres on the need to ensure women's access to sexual and reproductive health services and supporting women and girls' rights to self-determination

and gender equality. Growing attention has focused on how to engage men and boys as allies to achieve this global vision of a healthier and more equitable future. Promoting men's involvement in raising children and increasing men's participation in caregiving and domestic work are part of the Programme of Action for the ICPD (chapter 4, section C), and have been the subject of discussion as part of the annual UN Commission on the Status of Women, as well as other major policy arenas for a number of years.

However, despite the well-established relationship between men's participation in care work and positive outcomes for children (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008), women (Mullany, Becker, & Hindin, 2007) and men themselves (Bartlett, 2004), men's involvement in care and domestic work does not mirror the advances women have made in the past few decades in participation in paid work outside the home. Research on lower-, middle- and high-income countries found that the mean time spent on unpaid work by women was between two and ten times more on care work than men (Budlender, 2008) despite a remarkable increase in the numbers of women entering the paid workforce, even in this recent global economic crisis. According to the World Development Report 2012, women are now 40% of the paid global workforce and nearly 50% of the world's food producers (World Bank, 2012). However, the World Bank (2013) states that the caregiving divide is still one of the primary drivers in the gender pay and employment gap.

Though multiple and complex, the reasons for men's limited participation in care work include gendered expectations from early childhood onward that care work is a woman's responsibility and traditional social norms that frequently excuse men who play the role of the absent or uninvolved father (Boudet et al., 2013). Additionally, one of the

defining characteristics of men's gendered identities is the ability to earn income to support a family. Young men in particular face societal pressure to fulfil rigid expectations of manhood such as that of the 'breadwinner' and feel a sense of shame if they cannot do so (Leahy, Engelman, Vogel, Haddock, & Preston, 2007).

Gender norms also influence men's utilisation of paternity leave benefits in those global North countries that offer it. Research from industrialised countries including Canada and Sweden finds that structural factors such as paternity and paid family leave, and 'family friendly' workplaces policies that regulate working hours, all contribute to men's involvement in care work (Caragata & Miller, 2008). However, according to Caragata and Miller, few countries except Sweden explicitly target gender inequitable norms as obstacles to men's uptake of such policies (2008). In short, research from the global North shows that utilisation of such policies can be particularly difficult without society-wide social norms change. In developing countries, more research is needed to explore what factors contribute to men's engagement in caregiving in order to tap into potential forces for large-scale change. Emerging research on men and gender equality in the global South reveals that men who have gender equitable attitudes and men who witnessed their own father carry out domestic housework were more likely to carry out these tasks themselves later in life (Barker et al., 2011). Other research shows that involvement during pregnancy predicts, or is associated with, lifelong fatherhood involvement (Caragata & Miller, 2008). Additionally, men's participation in caring for children is also seen as gendered; research suggests that men are more likely to engage in physical play with children than bathe or cook for them (Craig, 2006). Adverse childhood experiences, notably witnessing violence against one's mother by an intimate partner,

have also been shown to negatively impact fatherhood involvement (Barker et al., 2011; Contreras et al., 2012; Fulu et al., 2013). Overall, however, more rigorous analysis is lacking in terms of our understanding of these complex 'pathways' in developing country contexts, particularly in qualitative research.

Using knowledge from existing research and the researchers' own expertise on this topic, this study sought to understand the enabling childhood and adulthood factors that promote and encourage men's involvement in caregiving. First, using quantitative data from the International Men and Gender Equality Survey (IMAGES) this paper will (1) present findings on men's care work in six low- and middle-income countries (Bosnia, Brazil, Chile, Croatia, India and Mexico) and (2) identify what factors are associated with men's greater involvement with their children, with caregiving chores and playing with children seen as two different types of engagement. Second, using qualitative data from the *Men Who Care* study this paper will highlight key experiences of men with a greater-than-the-norm involvement in caregiving to provide additional contextual understanding of men's caregiving practices. This paper intends to highlight key experiences in men's lives that can inform present and future policies and programmes to bridge the gender divide in caregiving.

Data and methods

The quantitative and qualitative data from IMAGES and the *Men Who Care*[1] study (Barker et al., 2012), respectively, are both part of the Men and Gender Equality Policy Project coordinated by Promundo and the International Center for Research on Women

[1] The full **Men Who Care** study can be downloaded at www.promundo.org.br/en.

(ICRW).

Quantitative data

The quantitative data for this study come from IMAGES surveys in six countries – Brazil, Chile, Mexico, India, Bosnia and Croatia – collected between 2009 and 2012 with a total of 7681 men aged 18–59 participating. For this analysis, a total of 1169 respondents across six countries report having children aged 0–4. It is based in part on the Norwegian study*, Gender Equality and Quality of Life Survey* (Holter, Svare, & Egeland, 2009), and on Promundo and ICRW's experience in researching men and masculinities. Since a primary goal of IMAGES was to produce data that would be used locally for programme development and policy advocacy, the research was intentionally undertaken as a partnership with local organisations with expertise in issues of gender and masculinities. As such, research and sampling procedures varied somewhat across settings. Generally, however, following the design of the World Health Organisation's multi-country study on violence against women regarding sample size and procedures, the survey was carried out as a representative household survey in one or more urban settings in each country, with the exception of Bosnia, where it is nationally representative. Within a survey location, neighbourhoods or blocks were chosen based on population distributions from the most recent census data. Stratified random sampling and probability proportion to size sampling methods were used within each neighbourhood or community to ensure the inclusion of adequate sample sizes. More detailed information about each country's research procedures can be found in individual country reports and in Barker et al. (2011, Annex IV).

IMAGES assessed the current practices and attitudes of men on a range of issues

including attitudes about women and masculinity, employment, education, childhood experiences, parenting, health and quality of life, partner/spousal relations, sexual behaviour and violence. The questionnaire had approximately 250 items[2] and took between 45 minutes and an hour to complete. The format – self-administered versus interviewer administered – varied by country. In all settings, male interviewers interviewed male respondents, except in Mexico where most interviews were carried out by female interviewers. The study protocol was approved by ICRW's institutional review board (IRB) and by in-country IRBs, when such existed, and all research sites followed standard practices for carrying out research on intimate partner violence (WHO & PATH, 2005).

In each country, the survey was adapted, double-back translated and pretested in collaboration with local partner organisations with experience in gender and masculinities. This meant that questions were adapted, added or removed as appropriate in each context, though most of the questionnaire was similar in all countries.

Qualitative data

The qualitative data come from the five-country *Men Who Care* study. A research protocol used to identify men engaging in atypical (meaning greater than the 'norm' or in different ways than the norm) caregiving practices was developed for all country partners that was then adapted to each country setting. The protocol and ethical procedures were approved by ICRW's IRB and by local IRBs. Ethical procedures included maintaining the men's anonymity and taking appropriate measures to safeguard data collected from

[2] There was some variation in the survey content by country: some country-specific questions were included while some countries excluded items due to local political and/or cultural considerations.

them. All interviews were carried out in the native language of the interviewee or in a language in which he was comfortable. All of the men were over age 18 and informed consent was obtained from all participants. Interviews generally lasted from one to four hours. All interviews were audio-recorded with the consent of participants, and transcribed and translated if necessary. A total of 83 men were interviewed from both rural and urban areas with varied educational and socio-economic backgrounds.

Additionally, it is important to note that the qualitative findings presented here do not include Croatia or Bosnia. Bosnia was carrying out its own *Men Who Care* study at the time of writing this article, while partners in Croatia chose not to participate in this portion of the study. The *Men Who Care* study also included South Africa, but South Africa was not included in this IMAGES study, thus those data are not included here either.

Measures used for quantitative analysis

Dependent variable

Two dependent variables were included in the multivariate analysis: the first is a composite mean variable that was constructed to represent men's involvement in caregiving of children aged 0–4 and the second is a single-dependent variable that asked respondents about playing with their children.

The composite variable was constructed from responses to the following questions: How often do you cook or fix food for your children at home? How often do you change diapers or clothes of your children? How often do you give a bath to your children? Responses on the individual items ranged from 1 to 4 with 1 = 'Rarely' or

'Never' and 4 = 'Every Day'. The composite variable ranged from 4 to 16, with higher values representing more involvement in care giving (Cronbach's alpha = 0.817). The composite represents the sum of the responses across the four items. If there was one missing value, it was replaced with the mean of the other responses and then the generated value was used in the calculation of the mean score.

To offer a richer understanding of men's caregiving practices, the researchers looked at men's participation in playing with children as a separate dependent variable. The question is 'how often do you play with your children?' Response categories are the same as noted earlier. Studies in other settings confirm that fathers are more likely to be involved in recreation and play activities rather than in direct care-related activities such as bathing or preparing food (Rendon, 2000). Therefore, the variables that predict men's involvement in playing may be different from those that predict men's involvement in caregiving chores.

It is also important to note that domestic work unrelated to direct caregiving of children (such as cleaning and repairing the house) was not included in the multivariate analysis. This is due to the insufficient variability in men's participation in these domestic work tasks – a finding in and of itself – though descriptives on men's domestic work participation will be presented.

Independent variables

This study looked at men's specific experiences of caregiving from both (1) childhood and (2) adulthood, and its impact on the level of men's fatherhood involvement. The

childhood factors analysed include the education level[3] of the respondent, and that of his mother and father, witnessing the father or another male figure caring for young children as a child, and if they were taught to care for children during childhood.

The adulthood factors analyses include men's gender attitudes assessed using the Gender Equitable Men (GEM) scale, men's employment status, presence at birth (in the delivery room or elsewhere in the hospital) and prenatal visits and work stress. 'Work stress' was defined as whether a man ever felt ashamed, stressed, depressed or drank alcohol as a result of not having enough work or income.

The GEM[4] scale was constructed from men's responses ('Disagree', 'Partially Agree' or 'Agree') to a set of statements about men's and women's roles across a range of domains including domestic work, childcare, sexual relationships and violence. Country specific scales were developed by including the items that were asked in that country and creating a standardised scale for that country. This standardised scale variable was used in the analyses, with higher scores representing more equitable attitudes (Cronbach's alpha= 0.893). Because each country's scale included different items, they are not strictly comparable with one another. However, they are all constructed with the same conceptual logic, show similar high rates of internal reliability and are standardised values.

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[3] The authors used the education as an ordinal variable, with levels of education grouped into three categories: people who had (1) primary education or less, (2) completed secondary education and (3) had education beyond secondary level.

[4] The GEM Scale was originally developed by the Population Council and Promundo with young men aged 15–24 years (Pulerwitz & Barker, 2008). For IMAGES, the GEM scale was slightly adapted with additional questions appropriate for adult men. However, care was taken that each country should have at least 15 common GEM items covering the same range of issues from the original scale: sexuality, violence, household tasks, homophobia and male/female roles.

Data analysis

Quantitative data

For the quantitative data, frequencies and other descriptives were generated by country for all variables and these were explored as an additional data quality check and to look for any anomalies or outliers. Next, we ran two multiple regression models (one for each dependent variable described earlier) that included, as independent variables, childhood and adult factors that we hypothesised would explain variance in our dependent variable, men's caregiving of children aged 0–4. These independent variables were entered into the regression models in two groups, so that we could examine the explained variance for the 'childhood' variables and the 'adult' variables. The regression was run for the full data-set, with all countries included. The regression was a stepwise model, with the independent variables associated with childhood entered first, and all results (including significance of the model, significance of the variables and variance explained) were reported. The independent variables associated with adulthood were entered next, and the changes in explained variance, significance and other results of interest were reported.

Qualitative data

Qualitative analysis was conducted using a grounded theory approach meaning that a theory was constructed from existing data rather than proven against it (Martin & Turner, 1986). The topics selected for cross-country analysis include: (1) men's description of their caregiving activities; (2) men's household and relationship dynamics; (3) men's childhood experiences and pathways to caregiving; and (4) men's attitudes towards

gender equality more broadly.

Results

Descriptive findings from quantitative data on men's caregiving

For this analysis, a total of 1169 respondents across six countries report having children aged 0–4, about 11% of the total sample. Table 1 presents a description of the sample by country. The mean age for men in this sample is 35. Approximately 42% of men completed up to a primary level of education, 33% completed up to secondary and 26% have beyond a secondary level of education. Three quarters of men in this sample (76%) are employed. Ninety-nine per cent of all men have a regular or stable partner.

Domestic work

Approximately 68% of men in this sample said that housecleaning is 'usually' or 'always' carried out by their female partner, with as many as 93% of men in India reporting this. A small minority of men across all six countries said that they took on a larger share of housecleaning than their partner, except in Mexico where 0 men out of 153 reported this.

There are, however, gender divisions within domestic work. The majority of men across all countries report that they 'always' or 'usually' repair the home, though the proportions are much larger in the Balkans – Bosnia (81%) and Croatia (87%) – and in Mexico (84%). Across all countries, except India, men were more likely to report that they shared housecleaning responsibilities equally with their partner rather than house repair responsibilities (Table 2).

Satisfaction with domestic work divide

Across all countries, the vast majority of men (93%) say that they are satisfied with the current – and highly unequal – division of household duties. Men's reports of positive satisfaction (either 'very' or 'fairly' satisfied) ranged from 87% in Brazil to 98% in India.

Prenatal care visits

The majority of men (84% across all countries) say that they were present during at least one prenatal visit ranging from 73% in India to 92% in Chile (Table 1). Despite these high rates, what we know from qualitative data is that participation in the actual prenatal consultation with the pregnant partner was not likely the norm of 'being present'. Follow up discussions with key informants in each of the research sites suggest that 'being present' sometimes meant that the man dropped off his partner, and in some cases meant that he was in the waiting area. Nonetheless, in spite of this variation of what presence means, research shows that participating in prenatal care visits – even if only peripherally – may be an important indicator of and possible gateway to early fatherhood involvement (Bronte-Tinkew, Ryan, Carrano, & Moore, 2007).

Men's presence at birth

Being present during birth means either present in the delivery room or elsewhere in the hospital. A significant proportion of men (33% across these countries) surveyed are not present during childbirth, with some notable exceptions. In Chile, 89% of men reported that they were present during the birth of their last child, with most men in the delivery

room. Seventy-one per cent of men in India are also present, but almost all were elsewhere in the health facility.

Types of caregiving for children

Men's most common engagement with children is playing (65% across all countries), doing this several times a week or more. The second most common was changing diapers or bathing children (35% across all countries). Because playing with one's children is conceptually different from participating in chores related to caregiving, in the multivariate analysis, the 'playing with children' item is separated out from the other caregiving tasks (Figure 1).

Multivariate results of caregiving of children

Table 3 provides a summary of the statistically significant multivariate results related to both childhood and adulthood factors and their association with men's caregiving.[5] Overall in the analysis, which pooled together data from the six countries, having a mother with higher levels of education ($p = 0.001$), having gender equitable attitudes ($p < 0.05$) and accompanying one's partner to at least one prenatal care visit ($p < 0.001$) are all positive predictors of a higher level of men's involvement in caregiving. The model, which looked at both childhood and adulthood factors, explained about 6% of the variation in caregiving practices.

Looking at the country-level regressions (Table 4), early childhood influences seem to matter in Bosnia and Brazil. Bosnian men who saw their fathers take care of

[5] Specific results can be obtained from the author.

younger siblings ($p < 0.05$) and Brazilian men who were taught to care for siblings ($p < 0.001$) had a significantly higher level of involvement in caregiving (though for Brazil, the model did not explain a significant amount of the variance in caregiving possibly due to the smaller sample size). Notably, Chilean men in this sample also participate more in caregiving if they were taught to care for siblings when looking only at childhood factors, but this association disappears in the full model.

As adults, having outside help in India and Bosnia may significantly influence fathers' involvement in caregiving of children, but in opposing and, most likely, culturally specific ways. In India, having outside help promoted a higher level of men's involvement in caregiving – the only statistically significant variable in this multivariate model ($p = 0.001$) – while in Bosnia those men who did *not* have outside help participated significantly more in caregiving ($p < 0.05$). This Bosnian association was also mirrored in Brazil ($p < 0.05$).

In Chile, the more gender equitable a man was in his attitudes ($p < 0.05$) and, in Mexico, the higher the level of education the respondent had ($p < 0.01$) the more involved the respondent was in caregiving of children – the only significant variables in their models.

Multivariate results of playing with children

The full model of both childhood and adulthood factors explained about 12% of the variability in men's playing activities with children ($p < 0.001$). In analysis of the pooled country data, having a lower level of education, having a mother with more formal education, having more gender equitable attitudes, lower work stress, having outside

help, being present at birth and accompaniment to prenatal care visits were all associated with higher levels of fatherhood involvement.

At the country level, again, we see that in India and Croatia that childhood experiences seem to promote an increased level of involvement in engagement with children later on in life for some men. Witnessing one's father take care of children in Croatia ($p < 0.05$) and being taught to care for younger siblings in India ($p < 0.05$) were both positively associated with their engagement in playing with their children.

As adults, having gender equitable attitudes and being younger both significantly predicted men playing more with their children in Balkans countries, Croatia and Bosnia (both $p < 0.05$). Being gender equitable was also significant in Brazil, though this model did not explain a significant amount of the variance. Other IMAGES studies have also found correlations between both younger men and those who have gender equitable attitudes with increased participation in care work (Barker et al., 2011).

Mirroring the findings for caregiving work, having outside help also plays an interesting and notable role in India and Bosnia in ways not reflected in other countries. Having outside help in India contributed to more time spent playing with children ($p < 0.05$), while in Bosnia having **no** outside contributed to men playing more with their children ($p < 0.05$).

Additionally for Indian men in this sample, being involved in parenting before a child is even born by being present at the birth of the last child ($p < 0.01$), and accompanying a partner to prenatal care visits ($p < 0.01$) are both significant predictors of spending more time playing with children (Table 5).

Qualitative findings from **Men Who Care**

For many men in Brazil, Chile, India and Mexico, the pathways that led them to being involved caregivers were far from linear. Their childhood experiences such as being put in positions of responsibility for younger siblings and witnessing or experiencing violence often influenced their attitudes towards being different from their male peers. As adults, care work was an activity often thrust upon them by life circumstances more so than a decision borne out of egalitarian attitudes towards men's and women's roles in the family.

Male primary caregivers in Chile, India and Brazil had complex relationships with their fathers. On the one hand, in Chile, one man reflected that his own involved father positively influenced his current caregiving practices:

> *My dad was the one who took us to the pediatrician, my dad was the legal guardian, my dad was the one who got scared when we were sick and took us to the emergency room. He was very, very present (…) much of what I do is a reflection of what I learned from my dad.*

However, it was difficult for this man to find a consistency in his father's gender equitable behaviours as a child. For example, whenever he had nightmares his father would not consent to him sharing his brother's bed due to fears that doing so would make his sons gay. Many other men in Brazil and India described fathers who were emotionally and physically abusive towards their mother and them. One Indian man, a *Brahmin* (upper caste), spoke of being severely beaten by his father for eating with a lower caste friend. And these experiences of violence were not limited to the immediate home environment. Another man (an immigrant from Central America) reflected that an atmosphere of political repression and civil war prior to his emigration to Brazil helped

shape his aversion to violence. For some men, these early traumatic experiences served as motivation to reject traditional definitions of masculinity, but did not seem to be chief motive for their later participation in caregiving.

The normalisation of domestic tasks in early childhood or adolescence seemed to play a role in men's caregiving practices for some of the men. In Brazil, many men grew up in households where house rules – usually put in place by their mother – dictated that they learn how to carry out domestic chores such as cooking and cleaning. For instance, one Brazilian man raised by a single mother who worked late at night reported that he had no choice but to wash the dishes on his own. Another Brazilian man living in a *favela*, or urban slum, had to learn to care for siblings from an early age because the adults in his family were absent, alcoholic or involved in drug trafficking. These childhood experiences of poverty and economic insecurity often increased men's social awareness and sensitivities towards the importance of taking on household and caregiving responsibilities.

As adults, while beliefs in gender equality made many men more open to sharing caregiving tasks, this relationship did not seem causal. In fact, oftentimes being involved in care work was something thrust upon men by external circumstances. In India, two men were primary caregivers for spouses who later became severely incapacitated, while in Mexico, divorce and unemployment forcefully shifted men's practices. These experiences were sometimes coloured by feelings of resentment and shame:

> *My problem now is that there is no money. And you know that money is basic. That is a problem for you as a dad, as head of the family (…) Emotionally it hits you because you feel powerless, you don't have the resources (…) A part of me says, 'Hey, you're losing time here being in the house cooking. You can do a lot of things'. So, that makes me feel a bit unstable, it makes me feel bad.*

This Mexican man's description of his unemployment shows that it may be acceptable for some men to take on caregiving as long as it does not imply a complete renunciation of traditional masculine identities such as the 'breadwinner' role. Interestingly, while all the men interviewed were involved in direct care-related activities of some kind, many men 'drew the line' at carrying out domestic chores and instead relied on women (family members or hired help) to do these tasks. This implies that breaking down the gendered hierarchical order of domestic chores may be more difficult than doing so with caregiving of children.

In sum, despite some contextual variation across countries, patterns emerge that reflect these men's ability to reconstruct their masculinity in order to support and justify their caregiving practices. However, changes in their behaviours and attitudes also reveal that gender practices are non-linear and inconsistent. Some men seemed to participate in caregiving because of early childhood experiences and holding more equitable norms, while others had caregiving thrust upon them; for others it was perhaps a combination of both.

Limitations

IMAGES was carried out as a city-based, random household survey. The findings presented here are representative of individual cities where the survey was carried out and not of their countries as a whole (except in the case of Bosnia, where the data are nationally representative). Throughout this report, city data are aggregated in order to present overall percentages for each country, but the initial results presented here are, strictly speaking, only representative of their city or neighbourhood settings.

Additionally, given the cross-sectional nature of these data, it is not possible to determine causality and any attempts to hypothesise directionality of relationships are informed by the authors' knowledge of the context and topic and other research.

It is also quite possible that the variable created for the purposes of this study – men's caregiving of children aged 0–4 – does not represent the entirety of fatherhood involvement in these countries. Men may still be present and involved fathers and not participate in these tasks.

Finally, as a qualitative study, the findings from *Men Who Care* cannot be generalized to a wider population because the data come from one specific group of men. Therefore, there are limitations in terms of the findings' wider implications, even as the data provide insight and triangulation of the survey findings.

Discussion

The analysis of both the quantitative and the qualitative data shows that while men's participation in caregiving continues to lag behind that of women, there are men who do participate to some degree, and that there are many possible and interacting 'pathways' that lead to this involvement.

In this study, we find that childhood experiences may play a large role in influencing men's later caregiving practices. In some places, seeing one's father engage in caring for children or being taught to care for siblings may contribute to men's caregiving later in life. Qualitatively, adverse childhood experiences such as witnessing violence in the home and economic insecurity also lead to some men's desire to be different from other men. In the field of family violence and violence against women, it is

well established that men who witness and/or experience violence as children, including neglect, are at increased risk of perpetrating violence against an intimate partner (Contreras et al., 2012; Fulu et al., 2013) and being uninvolved fathers (Barker et al., 2011) later in life. Using these insights, it may be possible to transform intergenerational cycles of violence into cycles that instead promote nurturing environments of men as caring fathers and supportive partners.

We also saw that having gender equitable attitudes as well as being younger were associated with men playing and interacting with their young children rather than care-related chores across many countries. This suggests that even men who are the most gender equitable limit their participation to less laborious tasks – a finding consistent with other literature (Huerta et al., 2013; Rendon, 2000) and the *Men Who Care* study.

Finally – and perhaps related to the previous point– the *Men Who Care* study shows how many men consistently took on their atypical caregiving practices at least as much due to life circumstances as because of some greater-than-average belief in gender equality. These life circumstances included the illness of a partner, unemployment on their part or having a single mother who made the men responsible for their younger siblings. In the IMAGES analysis, the lack of domestic support in Croatia and Bosnia may also push men to spend more time with children, while in India *having* such support provided opportunities to engage in such activities. In short, these findings suggest that propelling more men into care work implies making changes to larger structural norms around caregiving such as providing mandated paternity leave and providing childcare services in some settings *coupled with* changing attitudes towards these practices. As one example of how to promote this change, looking at the percentage of Chilean men from

IMAGES present at the birth of their last child, it is possible that attitude changes in Chile together with government efforts to encourage women to bring their partners to the maternity wards have resulted in generational shifts in men's presence in the delivery room.

Conclusion

The results presented here support the need to promote caregiving among boys and young men from early ages, and for identifying opportune moments in the cycle of parenthood for engaging men. Programme interventions, whether in the area of gender-based violence prevention or health promotion, have found that 'gender transformative' interventions can lead to measurable changes in men's and boys' attitudes related to gender equality, including caregiving and domestic work (van den Berg et al., 2013).

Perhaps equally important are policy-level and structural interventions that seek to encourage a more equitable division of care work. Engaging men in the public health sector may be a key approach. For example, in 2006, the government of Chile launched *Chile Grows up with You,* a policy to ensure access to health and early childhood education for children belonging to Chile's poorest families. Even before this policy, the Chilean health sector sought to 'humanise' the delivery process. Fatherhood involvement is seen as a critical piece to ensure the success of this policy initiative.

Twenty years after the ICPD Programme of Action, data suggest that men's participation in care work is increasing, but often at painfully slow rates. As women's participation in the labour force has increased in dramatic ways, it is clear that full equality for women can be sped up and achieved only if care work and domestic

activities are shared more equally between women and men. Additionally, care work may be an area of gender equality where men perceive benefits and self-interest in achieving change. This, in turn, means that caregiving may be an arena in which gender equality can finally be viewed and promoted beyond a 'zero-sum' approach that is beneficial to women, children, men and societies as a whole.

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Table 1: Demographic and Descriptive statistics

	Bosnia	**Brazil**	**Chile**	**Croatia**	**India**	**Mexico**
Total N with children ages 0-4	**252**	**128**	**192**	**160**	**281**	**156**
Mean Age (SD)	37 (7.9)	32 (9.0)	36 (8.6)	37 (7.5)	32 (6.6)	33 (8.2)
Employed (%)	81.7	84.4	90.6	86.9	97.2	94.9
In a stable relationship (%)	98	98	98	99	96	99
Respondent's Education (%)						
Up to primary education	60.7	55.5	11.5	4.4	18.1	12.8
Secondary Education	36.9	35.9	52.1	57.5	39.1	35.3
More than Secondary Education	2.4	8.6	36.5	38.1	42.7	51.9
Respondent's Mother's Education (%)						
Up to primary education	74.2	57.8	46.9	34.4	71.5	58.3
Secondary Education	9.5	15.6	40.6	46.9	24.2	21.8
More than Secondary Education	5.6	26.6	5.7	18.8	4.3	19.9
Respondent's Father's Education (%)						
Up to primary education	75.8	53.9	36.5	17.5	45.9	47.4
Secondary Education	13.5	10.2	39.6	51.9	34.9	23.1
More than Secondary Education	7.9	35.9	7.8	28.8	19.2	29.5
Respondent's father took care of respondent or siblings ("Frequently" and	68.3	58.6	63.0	80.6	77.2	58.3

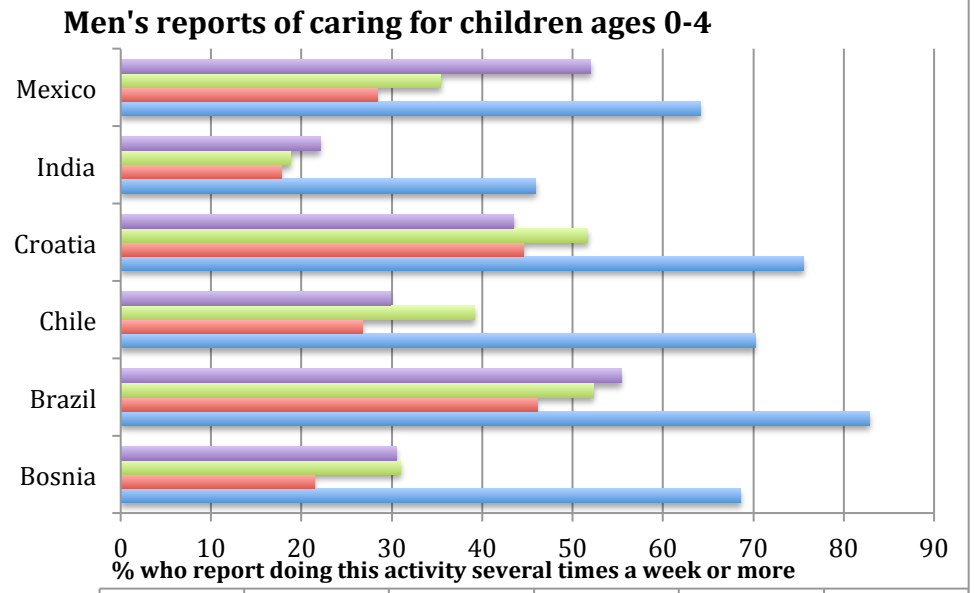
"Sometimes") (%)						
Respondent taught to take care of siblings (%)	71.0	67.2	65.1	55.0	63.3	57.7
Respondent has feelings of work stress (%)	41.7	32.0	54.7	47.5	54.4	82.1
Respondent has outside help (%)	36.1	16.4	29.2	41.9	19.6	13.5
Respondent accompanied partner to at least one prenatal care (%)	80.6	83.6	92.2	89.4	72.6	91.7
Respondent was present at the birth of last child (%)	66.3	44.5	89.1	61.3	70.8	30.1

Table 2: Men's reports of gendered division of household tasks

Who cleans the house?						
	Bosnia	**Brazil**	**Chile**	**Croatia**	**India**	**Mexico**
Man does everything or Usually man (%)	4.6	4.9	2.3	4.6	3.5	0
Shared equally or done together	29	42.3	39.3	37.9	3.1	39.9
Usually partner *or* Partner does everything	66.4	52.9	58.4	57.5	93.3	60.2
Who repairs the house?						
Man does everything or Usually man (%)	80.9	55.0	75.1	86.9	55.7	83.5
Shared equally or done together	14	31.7	13.0	7.9	16.9	8.6
Partner does everything or Usually partner	5.1	13.3	11.9	5.3	27.4	8

Table 3. Men's satisfaction with division of labor.

Satisfaction with division of labor	**Bosnia**	**Brazil**	**Chile**	**Croatia**	**India**	**Mexico**
Total N	**239**	**122**	**187**	**156**	**259**	**152**
Very Satisfied (%)	43.5	63.1	35.3	31.4	70.2	7.2
Fairly Satisfied (%)	50.6	24.6	56.7	60.3	27.4	84.9
Unsatisfied (%)	5.85	12.3	8.0	8.3	2.3	7.9



	Bosnia	Brazil	Chile	Croatia	India	Mexico
Give bath to children	30.5	55.4	29.8	43.5	22.1	52
Change diapers/clothes of children	31	52.3	39.2	51.7	18.8	35.4
Cook/fix food for children	21.4	46.1	26.7	44.6	17.8	28.4
Play with children	68.6	82.9	70.2	75.6	45.9	64.1

Table 4. Multivariate Regression – Playing with Children

	All	**Bosnia**	**Brazil**	**Chile**	**Croatia**	**India**	**Mexico**
Childhood Factors							
Age of the respondent (completed years)	-0.01(0.01)	-0.03(0.01)**	-0.01(0.01)	-0.01(0.01)	-0.03(0.02)*	-0.01(0.02)	-0.01(0.01)
Education level of respondent (recoded into three categories)	-0.18(0.06)**	0.26(0.16)	-0.41(0.16)*	-0.40(0.34)	0.25(0.18)	0.24(0.14)+	-0.07(0.14)
Education level of respondent's father	-0.12(0.07)	-0.11(0.14)	0.02(0.13)	0.80(0.34)	-0.16(0.21)	-0.07(0.16)	-0.04(0.15)
Education level of respondent's mother	0.27(0.08)***	0.10(0.14)	0.01(0.13)	-0.23(0.33)	0.23(0.18)	-0.09(0.18)	0.09(0.16)
Taught to care for younger siblings (1=yes; 2=no)	-0.01(0.09)	0.04(0.17)	-0.7(0.20)	0.05(0.28)	0.23(0.20)	-0.43(0.22)*	-0.08(0.23)
Father took care of respondent or siblings (1=frequently; 4=never)	-0.03(0.04)	-0.07(0.07)	0.03(0.08)	-0.05(0.10)	-0.23(0.11)*	-0.08(0.08)	0.06(0.10)
Adulthood Factors							
GEM Scale	0.13(0.04)**	0.17(0.07)*	0.41(0.11)***	0.21 (0.12)+	0.19(0.09)*	0.08(0.10)	.03(0.11)
Employment Status (0=unemployed/retired; 1=employed)	0.35(0.40)	--	--	0.24 (0.39)	0.68(0.86)	--	--
Frequent feelings of work stress (0=no; 1=yes)	-0.18(0.09)**	-0.05(0.17)	0.13(0.19)	0.10(0.21)	0.14(0.19)	-0.12(0.18)	0.11(0.26)
Received outside help (1=yes; 2=no)	-0.21(0.09)*	0.33(0.16)*	0.14(0.24)	0.15(0.23)	0.01(0.20)	-0.53(0.21)*	-0.70(0.38)+
Present at the birth of last child (0=no; 1=yes)	0.26(0.09)**	0.15(0.16)	-0.20(0.20)	0.19(0.34)	-0.16(0.22)	0.67(0.24)**	0.72(0.24)**
Accompanied partner to prenatal care visits (0=no; 1=yes)	0.62(0.14)***	0.27(0.22)	-0.22(0.26)	0.22(0.47)	0.87(0.90)	1.03(0.32)**	-0.13(0.40)
n	646	122	87	73	82	200	84
R^2	0.12	0.27	0.19	0.11	0.33	0.28	0.18

Table 5. Multivariate Regression - Care Chores

	All	**Bosnia**	**Brazil**	**Chile**	**Croatia**	**India**	**Mexico**
Childhood Factors							
Age of the respondent (completed years)	0.00(0.00)	-0.01(0.01)	0.01(0.01)	-0.01(0.01)	0.01(0.02)	0.01(0.01)	-0.01(0.01)
Education level of respondent (recoded into three categories)	-0.06(0.05)	0.19(0.15)	0.03(0.18)	-0.23(0.27)	-0.09(0.19)	-0.02(0.09)	0.34(0.12)**
Education level of respondent's father	-0.11(0.06)	-0.16(0.13)*	0.02(0.15)	0.00(0.27)	0.10(0.22)	0.01(0.10)	0.11(0.12)
Education level of respondent's mother	0.22(0.06)**	-0.07(0.13)	0.08(0.15)	0.10(0.26)	0.09(0.19)	-0.05(0.12)	-0.24(0.13)
Taught to care for younger siblings (1=yes; 2=no)	-0.09(0.08)	-0.17(0.16)	-0.64(0.22)**	-0.38(0.20)	-0.02(0.22)	0.20(0.14)	-0.30(0.18)
Father took care of respondent or siblings (1=frequently; 4=never)	0.01(0.03)	-0.15(0.07)	-0.04(0.09)	-0.02(0.08)	-0.15(0.12)	0.03(0.05)	0.01(0.08)
Adulthood Factors							
GEM Scale	0.09(0.04)*	0.45(.07)	0.17(0.13)	0.21(0.10)*	0.13(0.10)	-0.05(0.06)	0.12(0.09)
Employment Status (0=unemployed/retired; 1=employed)	-0.03(0.31)		--	--	0.43(0.91)	--	--
Frequent feelings of work stress (0=no; 1=yes)	-0.05(0.07)	-0.10(0.15)	-0.07(0.21)	0.14(0.29)	0.09(0.21)	0.08(0.12)	0.25(0.21)
Received outside help (1=yes; 2=no)	-0.10(0.08)	0.33(0.14)*	0.57(0.26)*	0.01(0.16)	0.13(0.21)	-0.48(0.14)**	-0.06(0.31)
Present at the birth of last child (0=no; 1=yes)	-0.06(0.07)	0.27(0.14)+	-0.56(0.23)*	-0.32(0.18)	0.02(0.23)	0.20(0.16)	0.04(0.19)
Accompanied partner to prenatal care visits (0=no; 1=yes)	0.46(0.12)***	0.07(0.20)	0.17(0.30)	0.01(0.27)	1.30(.95)	0.14(0.21)	0.47(0.32)
n	646	122	87	74	82	200	83
R^2	0.06	0.21	0.21	0.27	0.15	0.16	0.29