

A decorative graphic consisting of a grid of dots in various shades of gray and red, arranged in a pattern that suggests a world map or a network of connections.

Innovations in Care

New Concepts, New Actors, New Policies

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- The Sustainable Development Goal 5 on gender equality marks an unprecedented advance in the care agenda in terms of the visibility of care as a central dimension of sustainable development. The new international commitment for recognizing, redistributing and reducing unpaid care and domestic work through care policies needs to be matched to actual policy implementation at the national level.
- This report contributes to understanding how care policies are being implemented in the Global South – in Sub-Saharan Africa, Asia and the Pacific, and Latin America and the Caribbean –, as well as the elements that have the potential to make them *transformative*. It also reviews the linkages between different conceptualizations of care, reflected in the framing of care policies and their relation to gender equality policies more broadly, and the different actors that shape the actual existence and implementation of care policies.
- The report aims at providing policy-makers, development practitioners, women movements and other stakeholders with concrete policy examples that are useful for their specific national or regional context as well as contributing to the attainment of target 5.4 of the SDGs.



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Summary

Sustainable Development Goal 5 — »Achieve gender equality and empower all women and girls« — includes the mandate to »recognize and value unpaid care and domestic work«. Target 5.4 calls for »the provision of public services, infrastructure and social protection policies.« Together they offer a point of entry to advocate for care policies at the national level.

»Innovations in Care« contributes to understanding how care policies are being implemented in the Global South — Sub-Saharan Africa, Asia and the Pacific, and Latin America and the Caribbean — and the elements that have the potential to make them transformative — in the sense of changing the structural inequalities associated with current ways in which care is provided and received (or not received), as opposed to simply remedying its worst effects. Taking Target 5.4 as the point of entry, the report assesses care services, care-related infrastructure and social protection policies through a care lens. Following Sustainable Development Goal 8 — »Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all« — it also applies the care lens to labour market policies.

This report is based on the specialized literature and on Beijing+20 country and regional reports produced by nations at the request of UN regional economic and social commissions, an exceptional and up-to-date source of information. It also draws on research by the United Nations Research Institute for Social Development and others on the processes of claims making for care provision, including at the global level, and explores how care policies are framed and implemented in different contexts, the agendas that support their implementation and the tensions in implementing them. In doing so, it provides policymakers, development practitioners, women's movements and other stakeholders with concrete examples of care policies that can be replicated and scaled up to realize the transformative potential of the care agenda.

Introduction

After years of feminist movements, academics and policymakers perfecting concepts, developing normative frameworks and building political momentum, the Sustainable Development Goal 5 — »Achieve gender equality and empower all women and girls« — included unpaid care and domestic work, in Target 5.4 (see Box 1):

5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

Target 5.4 includes unpaid care and domestic work in terms of recognition and valuation in the now-common wording of the Beijing Platform for Action (UN Fourth World Conference on Women 1995), but it is bolder than the platform, as it also cites the ways in which this recognition should be realized: i. e., »through the provision of public services, infrastructure and social protection policies.« Without explicating so, Target 5.4 shows how unpaid care and domestic work can be redistributed, from households to the public sector, and also reduced, when providing care involves drudgery, through social infrastructure provision.

The explicit inclusion of unpaid care and domestic work in the 2030 Agenda for Sustainable Development (United Nations 2015) marks an unprecedented advance in the care agenda in terms of the visibility of care as a central dimension of sustainable development.¹ The target's explicit mention of care policies will possibly elevate them within national policy agendas and represents an opportunity for women's movements to support, shape and hold governments accountable with regard to policy implementation. In turn, the agreed monitoring indicator for this target — »5.4.1 Percentage of time spent on unpaid domestic and care work, by sex, age group and location« (ECOSOC 2016) — will require the expansion in coverage, complexity and regularity of time-use surveys, particularly in the Global South — Sub-Saharan Africa, Asia and the Pacific and Latin America and the Caribbean.

1. For an analysis of the sustainable development goals from a feminist perspective, see Esquivel and Sweetman 2016.

The international commitment for recognizing, redistributing and reducing unpaid care and domestic work through care policies needs to be matched to actual policy implementation at the national level. This report contributes to understanding how care policies are being implemented in the Global South as well as the elements that have the potential to make them transformative — in the sense of changing the structural inequalities associated with current ways in which care is provided and received (or not received), as opposed to simply remedying its worst effects (Esquivel 2014, 434). Taking Target 5.4 as the point of entry, the report examines care services, care-related infrastructure and social protection policies through a care lens. Following Sustainable Development Goal 8 — »Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all« — it also applies the care lens to labour market policies.

The report reviews the linkages between different conceptualizations of care, reflected in the framing of care policies and their relation to gender equality policies more broadly, and the different actors shaping care policies and their implementation. In paying particular attention to mobilization around care, it takes the view that care policies emerge from political processes. Indeed, care policies are contested terrain. The concerted efforts of women's movements, as well as other social and labour movements, have proved to be crucial to the implementation of transformative care policies (UNRISD 2016).

Defining Care Policies

Care policies are public policies that assign resources to care in the form of money (including income, transfers and subsidies), services and time. They range from payments and subsidies to caregivers or to people who need care and the direct provision of care services and regulations to complementary service provision, such as transportation, water and sanitation. They also include labour regulations, such as maternity protection and paternity leave and the regulation of paid working times, which assign time to care. Care policies therefore encompass

Box 1: Unpaid Care and Domestic Work

»Unpaid care and domestic work« refers to care of persons and housework performed within households without pay and unpaid community work. As a term, *unpaid care and domestic work* is used similarly to the older terms *reproductive work* and *unremunerated work*, as used in the Beijing Platform for Action (UN Fourth World Conference on Women 1995).

The »care of persons« is the component of unpaid care and domestic work devoted mostly, but not uniquely, to the direct care of persons with care needs, like children or frail adults. The time devoted to the care of persons overburdens women (and men) who engage in care relationships, posing limits for gainful employment and leisure time.

The »housework« component of unpaid care and domestic work refers to household maintenance activities — household chores like cleaning, cooking and clothing family members, which can also be understood as »indirect care.«

The »unpaid community work« component of unpaid care and domestic work refers to unpaid working activities provided to households beyond one's own. It includes work undertaken for friends, neighbours or next of kin and work undertaken out of a sense of responsibility for the community as a whole.

Source: Esquivel 2014.

policies developed by various sectors, including health and education, labour and social policy, and serve different objectives, including poverty reduction, enhanced labour force participation, employment creation and expansion of future generations' human capabilities.

For the purpose of this report, and based on Target 5.4's formulation, care policies include the following:

- **Care services**, which redistribute some of the caregivers' workload from the private to the public sphere: early childhood development and care (ECD) services plus care services for sick, disabled and older persons. In the case of Sub-Saharan Africa, focus is also on care services for persons living with HIV/AIDS;
- **Care-relevant infrastructure**, which reduces women's workloads, such as obtaining water, providing sanitation and procuring energy, particularly in the case of Sub-Saharan Africa and Asia;
- **Social protection policies**, which involves such policies as cash transfer programmes and public work programmes; and
- **Labour market policies**, which include maternity benefits and parental leave.

This report reveals that different care policies are favoured in different contexts, depending on demographic, economic, social and cultural dimensions (see Table 1). Whilst care-relevant infrastructure is emphasized in Sub-Saharan African countries, for example, care services are prior-

itized in Asia and in Latin America. Only in Latin America and the Caribbean do care policies appear »situated« within gender equality agendas, resulting from the recognition that the unequal distribution of the unpaid care and domestic work between women and men is a powerful driver of gender inequality in the economic and social realms (Figure 1). In other regions, care policies are part and parcel of poverty reduction policies, often taking on instrumentalist framings. In many country cases reviewed in this report, some care policies are in place, but others are not, and the care dimensions of social protection policies and labour policies are frequently not taken into consideration.

Transformative Care Policies

Care policies mould the ways in which care is provided and funded, for whom and by whom. In their design and implementation, care policies can contribute to gender equality and to mitigating other dimensions of inequality, such as class, cast and ethnicity, or to exacerbating them. They can contribute to fulfilling women's human rights, particularly those of the poorest, but if poorly designed or implemented, they can also reinforce inequalities and undermine women's rights (Sepúlveda and Donald 2014). Moreover, care policies have the potential to simultaneously guarantee the rights, agency, autonomy and well-being of caregivers and care receivers (UNRISD 2016). And they can have positive effects in governance, citizenship and social accountability (Molyneux, Jones and Samuels 2016). In other words, care policies can be transformative.

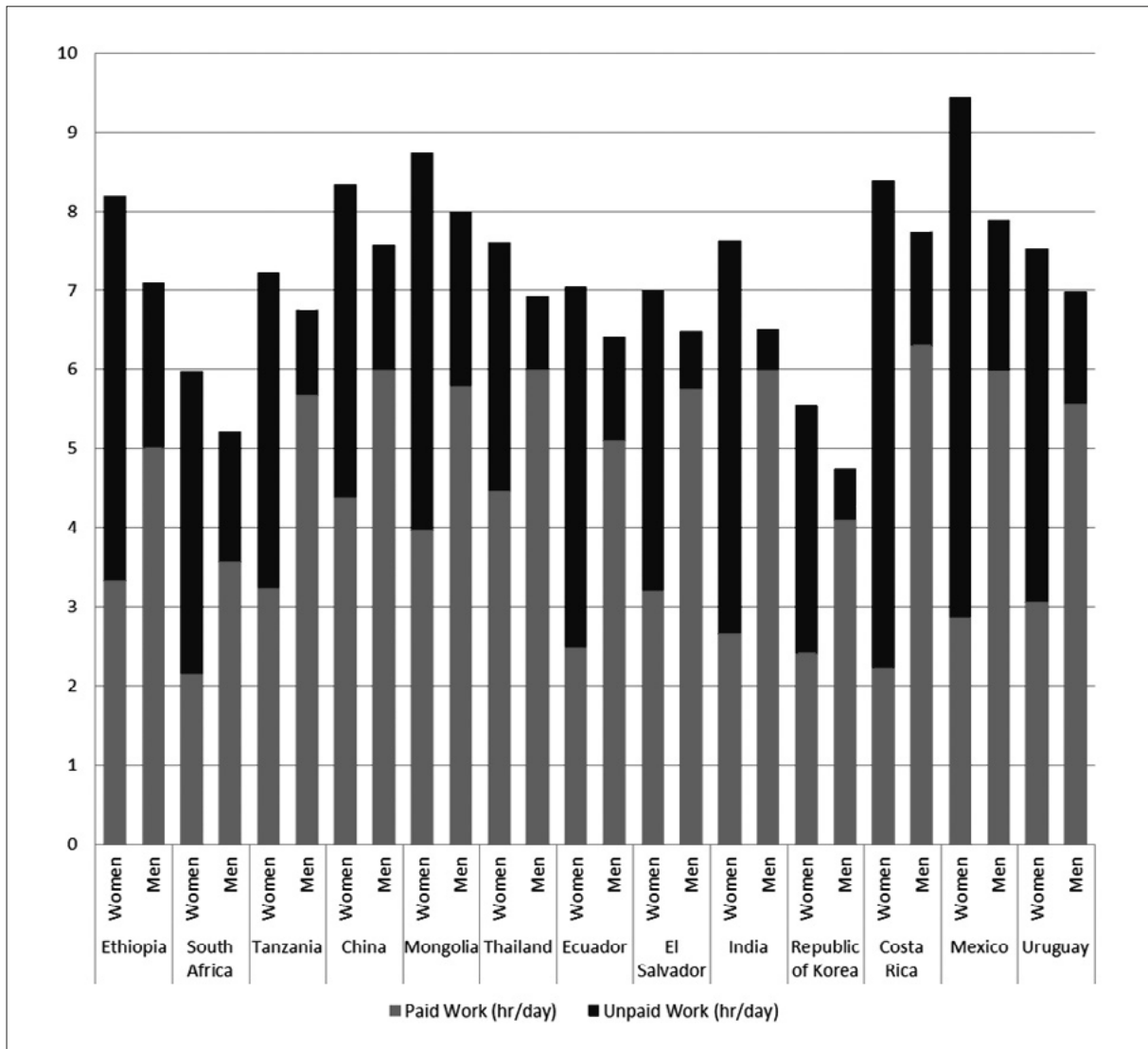


Table 1: Care Policies in the Global South

Region		Sub-Saharan Africa	Asia and the Pacific	Latin America and the Caribbean
Context	Main trends and issues	<ul style="list-style-type: none"> Widespread and multidimensional poverty Young and growing population High economic growth but low development Big informal sector Poverty-related problems Strong conservative forces Conflict and natural disasters Low social protection coverage, many pilots 	<ul style="list-style-type: none"> Heterogeneity in all regards Diverse levels of poverty and inequality Diverse stages in demographic transition Diverse stages in economic growth Social protection coverage varies across countries and regions 	<ul style="list-style-type: none"> High income inequality Some poverty Early demographic transition Economic slowdown High coverage of social protection
Gender equality	Policies: General background	<ul style="list-style-type: none"> Some improvements in establishing women's machineries A lack of policies Implementation weak where policies exist Lack of adequate funding Opposition from conservative forces 	<ul style="list-style-type: none"> High gender equality (Mongolia, Viet Nam) to very low (Afghanistan) Different political and economic regimes and policies 	<ul style="list-style-type: none"> Many advances at national and regional levels Progress in women's political participation and leadership Advances in policies and implementation Explicit care policies, many of them institutionalized
	Care	<ul style="list-style-type: none"> Care addressed, if at all, as part of poverty-reduction policies 	<ul style="list-style-type: none"> Care policies as a vehicle for women's economic empowerment (via higher labour force participation) and investment in children's human capital 	<ul style="list-style-type: none"> Triple R framework Co-responsibility
Care services	Child care, elder care, health care, etc.	<ul style="list-style-type: none"> ECDC policies adopted, often with instrumentalist framing, and uneven implementation Emphasis on maternal and child health care 	<ul style="list-style-type: none"> Care services linked to women's labour force participation and contribution to economic growth Uneven implementation of ECDC policies Impressive advances in health policies 	<ul style="list-style-type: none"> Institutionalized childcare services as systems (Costa Rica, Uruguay) Highest rates of ECDC policies among developing countries (comparable to European countries)
Infrastructure	Water, sanitation, roads, etc.	<ul style="list-style-type: none"> Low development Some improvement, but lagging behind, in particular in the water, sanitation and hygiene sector 	<ul style="list-style-type: none"> Low to high development, depending on country 	<ul style="list-style-type: none"> High development
Social protection and care	Cash transfers	<ul style="list-style-type: none"> Unconditional cash transfers (UCTs) with low coverage, but many pilots; impact women's lives positively, as they reduce poverty; do not incorporate unpaid care and domestic work as an explicit dimension though many beneficiaries are children 	<ul style="list-style-type: none"> Frequently used to relieve poverty (conditional cash transfers in India) 	<ul style="list-style-type: none"> Conditional cash transfers, widespread despite their disadvantages for women Conditionalities work in tandem with public policies
	Public works	<ul style="list-style-type: none"> Public works programmes as a way to relieve poverty and (re)build infrastructure (after disasters); some attempts (i.e., South Africa) to invest in social infrastructure and care service provision though not necessarily successfully 	<ul style="list-style-type: none"> Depending on the subregion, widespread efforts to relieve poverty and to rebuild infrastructure after natural disasters; in India, have been combined with childcare service provision 	<ul style="list-style-type: none"> Few public works programmes If implemented, have high women's participation and most often include childcare service provision
Labour policies	Maternity leave	<ul style="list-style-type: none"> High rate of informal employment with regional differences (33–82 percent) Maternity leave effectively covers only 15 percent of women workers High labour force participation and women »trapped« in informal work due to poverty 	<ul style="list-style-type: none"> Advances in labour policies in many countries (Viet Nam has advanced paternity leave policies whereas Papua New Guinea does not grant paid maternity leave) 	<ul style="list-style-type: none"> High rate of informal wage employment (40–75 percent) Advanced labour laws, including maternity (12 weeks rather than the international standard of 14 weeks) and in many cases, paternity leave
Mobilization around care	Focus and achievements	<ul style="list-style-type: none"> Care a low priority on feminist movements' agendas compared to other issues (violence against women, women's leadership and political participation) Care on agendas of large, internationally connected movements 	<ul style="list-style-type: none"> Care a priority for large, international movements Regional variations (high priority in India, low priority in Afghanistan and Papua New Guinea) 	<ul style="list-style-type: none"> Care considered central and pushed for in the past Several major achievements by women's movements in many countries Care once a top-down issue, but has been taken up where women's movements have made it part of their agendas



Figure 1: Paid Work and Unpaid Care and Domestic Work (by sex)



Source: Authors based on Charmes (2015) and Esquivel (2011).

In the last five years, the Triple R framework — recognizing, reducing and redistributing unpaid care and domestic work — has come to summarize the transformative approach to care policies, galvanizing progressive normative positions around care (see Box 2).² The framework has become a diagnostic and advocacy tool in development circles (ActionAid 2013a; Kidder and Pionetti 2013), and it has prompted a language change in UN reports, which up until very recently only used the Beijing

Platform for Action formulation focusing on recognition and valuation (Esquivel 2011b). The Triple R framework also featured in the proposed wording for Target 5.4 (UN Women 2013), even though the reduction or redistribution of unpaid care and domestic work did not make it into the final wording of the target. Despite this, the Triple R framework was «recovered» in the agreed conclusions of the Commission on the Status of Women in 2016 (UN Women 2016b, 7, «g»). Governments should, it stated, «Undertake all appropriate measures to recognize, reduce and redistribute unpaid care work by prioritizing social protection policies, including accessible

2. A reinterpretation of Fraser (1997, 2000), the Triple R framework has been proposed by Elson (2008). See Esquivel 2011a for elaboration and Esquivel 2013 for practical applications to policy.

Box 2: The Triple R Framework

The Triple R framework — recognizing, reducing and redistributing unpaid care and domestic work — expands the call in the Beijing Platform for Action (UN Fourth World Conference on Women 1995) for recognition and valuation, typically interpreted as measurement, by including a concrete economic justice dimension. Recognizing unpaid care and domestic work means avoiding taking it for granted, challenging social norms and gender stereotypes that undervalue it and make it invisible in policy design and implementation. It is therefore much more than facilitating women's unpaid care and domestic work with measures that recast women as the main care providers. Reducing unpaid care and domestic work means shortening the time devoted to it when it involves drudgery, primarily by improving infrastructure. Redistributing unpaid care and domestic work means changing its distribution between women and men, but also between households and the society as a whole.

Source: UNRISD 2016.

and affordable quality social services, and care services for children, persons with disabilities, older persons, persons living with HIV and AIDS and all others in need of care, and promote the equal sharing of responsibilities between women and men.« This effectively expands Target 5.4 and makes it even more concrete.

In Latin America, where there has been great progress in transformative care policies, the preferred normative framework has been social co-responsibility, which expands the more limited work-family reconciliation discourse. Similar in intent to redistribution, enacting social co-responsibility in care requires a strong public sector to guarantee that not all care responsibilities fall onto families, in particular, the women in them. Somewhat differently from the Triple R framework, it places stronger emphasis on the private sector, making it co-responsible for care provision. While the Triple R framework centres on the idea of care as a dimension of well-being, and takes analytical inspiration from the care diamond of households, state, markets and communities as sites of care provision (Razavi 2007), the co-responsibility framework positions interaction in the labour market at the centre of the debate (Martínez Franzoni 2015).

Care Agendas

Care agendas are normative stands defining who should provide care for whom, and bearing which costs, and the institutions, economic structures, gender norms and public policies that make them concrete in different contexts (Esquivel 2014, 433). Care agendas frame care policies.

Politically charged by nature, care agendas vary substantially. Actors adopting a social justice perspective take a

rights-based approach to care provision. They emphasize gender, class and race inequalities in care provision and who benefits from care, pointing out that these inequalities hinder women's enjoyment of their human rights and deepen already existing inequalities among care receivers (Sepúlveda Carmona 2013). Such analyses call for the redistribution of care responsibilities and the universalization of access to good quality care, in particular through active state interventions (UNRISD 2010a; Esquivel 2013). In turn, actors adopting a social investment perspective view care both as an input to care receivers' human capital formation and as an impediment to caregivers engaging in employment, making it a driver of poverty (Williams 2012). These approaches focus on children (but not on other dependents or on non-dependent adults) and on the efficiency gains of women partaking in the labour market when care services are publicly provided or subsidized. From this perspective, preferred interventions are those that focus on »vulnerable« or »dependent« population groups, an approach that can sideline women's equality claims (Razavi and Staab 2012).

Framing Care Policies

Moving forward from the path-breaking contributions of the United Nations Research Institute for Social Development (UNRISD) (UNRISD 2010a; UNRISD 2010b; Budlender 2010, Razavi and Staab 2012), in the last five years several UN agencies, multilateral funding institutions and donors have made care a part of ordinary development parlance. The *World Development Report, 2013: Jobs*, for example, identifies the shortage of care services as hindering female labour force participation and proposes the public provision or subsidization of childcare as a way to reduce the costs women incur at

home when they engage in market work (World Bank 2012b, 30). The *Human Development Report, 2015: Work for Human Development*, considers all forms of work, including unpaid care and domestic work, and calls for addressing imbalances in paid and unpaid work opportunities between women and men through an array of policy interventions that comprise among others enhancing women's employment, expanding care services and valuing (and even »rewarding«) care work (UNDP 2015, 20–21). The ILO report *Women at Work Trends, 2016* devotes an entire chapter to work-family conciliation policies, identifying the gender gap in the distribution of unpaid care and domestic work as a key determinant of slow progress in achieving gender equality at work (ILO 2016b). UN Women's *Progress of the World Women, 2015–2016* emphasizes the need for substantive equality in paid and unpaid work as the two sides of the same coin, promoting investment in social services as a key to gender equality (UN Women 2015c, 156). Target 5.4 is, in this respect, the result of a larger mainstreaming effort to make unpaid care and domestic work a public policy issue in the discourse of international development agencies.

This report shows that the abovementioned international debate contrasts greatly with the situation at the national and local levels. Very few social protection and childcare policies in low- and middle-income countries explicitly acknowledge unpaid care and domestic work in policy objectives, and even fewer incorporate it as a dimension of outcome evaluations (Chopra 2013). Country, regional and shadow reports, prepared to evaluate the progress and challenges 20 years after the Beijing Platform for Action, offer the same bleak view, although with some regional differences. African country reports show that governments and their gender machineries recognize women's unpaid care and domestic work, but policies aimed at reducing and redistributing care are either not implemented or implementation on the ground lacks adequate financial resources (with perhaps the exception of some progress in infrastructure). Asian country reports identify unpaid care and domestic work as hindering women's economic empowerment, cite the provision of childcare services as means to increase women's labour force participation and list among remaining challenges the balance between productive and reproductive responsibilities, but in no case is this a top priority (UNESCAP 2015). In contrast, unpaid care and domestic work figures prominently in Latin Amer-

ican Beijing+20 country reports as a central dimension of gender inequality. Designing and implementing care policies that redistribute paid and unpaid work between women and men, families, states, the not-for-profit sector and markets is among the main stated future challenges for gender equality in the region (CEPAL 2015a).

The apparent consensus around unpaid care and domestic work in international development circles – consensus, that is, on the importance of care for development, not necessarily on care agendas – coupled with the low priority of care agendas at the national level underscore developing countries possibly reading the care agenda as being »Northern« or »Western.« The risk is that a developed country–developing country divide »cracks« the progressivity of the consensus, giving an escape route to governments unwillingness to implement Target 5.4.³ Indeed, a final proviso of the target — »the promotion of shared responsibility within the household and the family as nationally appropriate« — designates care a cultural issue and therefore makes it »appropriate« to restrict women's position in society to their role as mothers and carers.

Women's Movements Mobilizing Around Care

The approaches of women's movements to unpaid care and domestic work mirror development discourses in policy arenas at the international, regional and national levels. Feminist organizations and women's movements that took part in the negotiations over the Sustainable Development Goals (SDG) as part of the Women's Major Group (WGM) used the Triple R framework to articulate policy claims around care, arguing forcefully for it from a rights-based perspective (Gabizon 2016). When language on reduction and redistribution was removed from SDG drafts, the WGM strenuously challenged the move, but to no avail.

Yet, the very concept of unpaid care and domestic work as used in the international development discourse, including in Target 5.4, is not necessarily on the agendas of women's movements at the national level. This report shows that in most Sub-Saharan African countries, women's movements mobilize around issues other than

3. This is playing on Eyben's (2012) »hegemony cracked.«

unpaid care and domestic work. This is sometimes a strategic decision, to frame advocacy in other political agendas that might gain more traction, like children's rights or the right to social security. In Nigeria, for example, a coalition including community members, trade union representatives and women's rights organizations decided to focus their advocacy work on early education, given the existence of an integrated ECDC policy, as a way to reduce women's childcare burdens, even if there was no explicit recognition of this work in the policy (ActionAid 2013b).

The same is true for Asia, where the unpaid care and domestic work concept is rarely found in feminist advocacy and mobilization (Rao 2016). Pervasive norms that naturalize women's caring responsibilities can explain the absence of claims around unpaid care work. For example in India, feminist activists felt that mobilizing around care was difficult, given how deeply internalized and private the distribution of care responsibilities are (Chigateri et al. 2016). The same was true in Nepal, where practitioners were sceptical that unpaid care work was an issue, because it is »what women do« (Chopra and Sweetman 2014).

In other situations, the unpaid care and domestic work agenda can be seen as a top-down agenda that does not fit well with local contexts, particularly in rural areas. This is partly because unpaid care and domestic work is viewed as in opposition to wage/market work (Mapedzahama 2014). In a recent debate in India, some practitioners opposed the artificial separation of unpaid care and domestic work from other forms of women's work in the informal sector, because agricultural workers, home-based workers and even domestic workers are not always compensated through a wage and this effectively excludes women from access to social security (ActionAid 2015). These views help explain why in the case of India, claims for recognition of unpaid care and domestic work were initially framed as an entitlement to social security, on a par with other forms of work, a framing akin to the »household wage« that also has some influence in Latin America (Esquivel 2015). This framing, however, did not make it into the 2008 Unorganized Workers' Social Security Act in India (Rao 2016).

The exception is Latin America, where claims for care policies have been articulated by urban academic feminists, officials in labour ministries, women members of


parliament and trade unionists (Rodríguez Gustá and Madera 2015). The alliances forged by these different actors have made it possible for care policies to rank high in the public agenda.

A Methodological Note

This report presents the results of a desk review of specialized literature and an exhaustive analysis of public policy documents made available by national governments. An original and innovative source for this policy review are the national review reports prepared for the Beijing+20 review process. The national reviews conducted by each state were made available on the websites of the United Nations Economic Commission for Africa (UNECA), the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) and the Economic Commission for Latin America and the Caribbean (ECLAC) (UNECA 2015b; UNESCAP 2015b; CEPAL 2015b). Reviews are available for 34 countries in Asia and the Pacific and all Sub-Saharan states except Equatorial Guinea and the Central African Republic.⁴ Twenty-eight Latin American and Caribbean countries submitted reports. Each regional commission generated an overview for its area (UNECA 2014; UNESCAP 2015b; ECLAC 2015b).

Information presented by the national Beijing+20 reviews was selected to represent subregions in Asia and the Pacific and Sub-Saharan Africa and the various national contexts in Latin America and the Caribbean based on their social, economic or political differences (e.g., middle- and low-income countries, war-affected nations, type of political regime, and regional, cultural and ecological differences). The national reports are not only up-to-date, but also encompass a broad range of dimensions concerning gender inequality, that is, the 12 areas of action set out in the Beijing Platform for Action.

4. The overview report of UNESCAP (2015a, 5) lists 36 Beijing+20 national review reports, whereas 34 reports are available on UNESCAP's website. For Africa, the reports for Equatorial Guinea, Libya and the Central African Republic are missing. For Asia and the Pacific, the list of missing reports is longer and includes American Samoa, Bhutan, the Cook Islands, the Democratic People's Republic of Korea, French Polynesia, Guam, Hong Kong, Indonesia, Japan, the Lao People's Democratic Republic, Macao China, Malaysia, Maldives, the Federal States of Micronesia, Myanmar, Niue, the Northern Mariana Islands, Pakistan, the Republic of Korea, Sri Lanka, Thailand, and Turkmenistan. In the case of Latin America, 28 out of 33 Latin American and Caribbean member states and 13 associate Caribbean members have delivered their reports. It must be noted that due to language constraints, in particular Russian and Portuguese, a number of reports could not be taken into account.



The Beijing+20 national and regional reports were prepared for the 59th Commission on the Status of Women (CSW), held in March 2015 in New York.⁵

The Beijing+20 national reports posed a few methodological challenges. For example, the quality and level of detail varies greatly, and not all reports cover some of the broader factors that reduce gender inequality, such as pre-school education/care arrangements that redistribute care from the private sphere to the state. To balance the perspective of the Beijing+20 reports, the report here also includes responses from civil society, in particular the Shadow Report by FEMNET for Sub-Saharan Africa, documents by Isis International for Asia and the Pacific, and literature from academia or activists.

5. Like in the three previous Beijing reviews, the Commission adopted a political Declaration reaffirming the commitments from Beijing. However, the Declaration was negotiated behind closed doors prior to the arrival of the national delegations to the CSW and issued on the first day of the CSW, in deep contrast with the open processes that the writing of national and regional reports entailed (Goetz 2015).

Sub-Saharan Africa

Context

One of the main characteristics of Sub-Saharan Africa is the widespread, high rate of poverty. Multidimensional demographic challenges interrelated and coupled with failures in the economy have perpetuated poverty. Gender inequality is persistently high, and in global comparisons, the region has the highest rates of violence against women (WHO 2013, 20).⁶ Absent or weak public services and infrastructure contribute to women's high burden of unpaid care and domestic work.

Sub-Saharan Africa's demographic challenges are characterized by a young and growing population (UNFPA 2014). In most countries of the region, birth rates are high, and about 42 percent of the population is under the age of 15 (Sippel et al. 2011, 8). The share of the overall elderly population is rather small, and compared to other regions of the world, the demographic transition of ageing is at an early stage (UNDESA 2015b, 12). In addition, life expectancy is reduced due to high HIV/AIDS rates (Folbre 2014, i146). Where parents are absent due to death in places with high HIV/AIDS rates, often the older generation takes care of the orphans (UNFPA 2012, 42). Children also often engage in paid care work, as many children are informal domestic workers (ILO 2013a).⁷ Infrastructure and services are generally inadequate for the particular needs of the high numbers of children and youth, in particular sanitation facilities for adolescent girls, school materials and sufficiently and adequately trained teachers (UNFPA 2014, 3).

Sub-Saharan Africa's economic performance as a whole has been remarkable in recent years. Foreign direct investment has increased seven times since the early 2000s, and economic growth is at 5–7 percent across the continent (UNECA 2014, 2). The extent of this is, however, varied. Some countries, for example Ghana, Mozambique, Namibia and South Africa, are profiting

from the economic upswing, whereas fragile states, such as Somalia, Liberia and Eritrea, do not show signs of economic progress.⁸ In particular, in the latter group of countries, decent job opportunities have not been created, and the lack of decent employment poses problems, including societal tensions (UNFPA 2014, 3; Sippel et al. 2011, 8). In many countries, the informal sector prevails, and nine out of ten rural and urban workers have informal jobs, most of them women and youth (African Development Bank 2013). Women have historically been confined to low-productivity sectors of the economy, which tend to be those that least benefit from economic growth (UNECA 2014, 14).

Africa's demographic and economic challenges have led to entrenched poverty. According to the 2015 *Human Development Report* (UNDP 2015), most of the poorest countries in the world are in Sub-Saharan Africa. The rate of extreme poverty is decreasing, but progress in poverty eradication has been slow (UNECA 2015a, 6). Poverty on the continent is severe and hard to solve due to its multidimensionality, even in South Africa, which is a middle-income country.⁹ Poverty-related issues remain key challenges despite significant economic growth (UNECA 2014, 2).

There are varying levels of economic, infrastructural and social development across and within countries, but these are generally low across the continent. Governments place poverty-related priorities high on their political agendas, and although these priorities encompass infrastructural development — including water, sanitation or transportation — implementation and provision remain precarious, with women bearing the brunt of the negative consequences (African Development Bank 2015). The absence of employment prospects in rural areas continues to lead to rural-urban migration, which increases the burden on already scarce infrastructure in urban areas and exacerbates the scarcity of services in many cities and the spread of informal settlements (Sippel et al. 2011, 12).

6. Africa's rates for the lifetime prevalence for having experienced intimate partner violence or non-partner sexual violence or both stands at 45.6 percent (WHO 2013, 20).

7. Little is known about child domestic labour in Africa. ILO estimates that about 65 million children, or one in four, are labourers. Because of the hidden nature of child labour in domestic work, it is difficult to obtain representative data (ILO 2013a).

8. The Ebola epidemic had a severe impact on economic performance in the West African subregion (World Bank 2015a).

9. South Africa has a high rate of income inequality, according to World Bank (2015c) estimates for 2011–2015.

Policies and programmes to reduce poverty are to a large extent funded by development partners in the Global North. These programmes have been constrained by the global economic downturn that began in 2008 (UNECA 2014, 14). Sub-Saharan Africa is low in spending on social protection when measured by international standards. However, expenditures at 1–2 percent of national gross domestic product (GDP), however, would be manageable for low-income countries (World Bank 2012a, 2).

Health challenges are many in Sub-Saharan Africa, and one of the biggest is the provision of quality health care. In particular, care for those with special needs — children, the elderly, disabled and ill — is primarily provided privately by the families and the women in them, as adequate public services are largely absent, in particular in rural areas (UNFPA 2012, 110).¹⁰ Among the many health challenges, HIV/AIDS is a significant problem in many regions of the subcontinent. Sub-Saharan Africa accounts for 70 percent of the global population, or one in twenty adults, living with HIV/AIDS (WHO 2016). About 51 percent of all persons living with HIV/AIDS on the continent live in Eastern and Southern Africa, and the majority are women (UN AIDS 2016). Apart from HIV/AIDS, Sub-Saharan Africa suffers a range of other severe public health challenges that affects its population, especially women and children (UNECA 2015a, 8). Because health care services are inadequate and women assume the role of primary caregiver at home and in communities and hospitals, they are exposed to significant health risks, as the Ebola outbreak and its death toll on women showed (Mutima, Gitomer and Hobson 2015; UN Women 2014). There has, however, been some progress in lowering maternal and child mortality (UNECA 2015a, 8). Policies that improve maternal and child health care are saving time and money dedicated to care and improving caregiver's and recipient's well-being.

A range of persistent social and cultural norms and stereotypes hinder women's empowerment in many Sub-Saharan African countries. UNECA (2014, 31) has

10. HIV/AIDS prevalence varies across Sub-Saharan Africa. Whereas Africa accounts for 71 percent of the global population living with HIV/AIDS, there are differences across the Sub-Saharan region. It varies as widely as 0.5 percent in Senegal to 6 percent in Kenya and 24.4 percent in Swaziland (ADVERT 2015b). Southern and Eastern Africa face the severe challenge of large numbers of orphans, with grandparents often carrying the care burden when parents die from consequences of AIDS. In Western Africa, HIV/AIDS is but one of many health issues, along with malaria, typhoid and precarious health care services that have severe consequences for women, in particular while pregnant and when older, and for children.

highlighted a number of factors related to societal norms that limit the power of rights and laws when it comes to women. On a general note, the implementation and enforcement of human rights laws are slow on the continent, and discrimination against women is persistent in many formal, statutory legal systems and institutions, including marriage, inheritance and control of productive resources. In addition, customary and religious laws enshrined in formal legislation and constitutions cover family law and make women's rights a contested issue. On top of this, social norms negatively impact the effective exercise of women's rights (UNECA 2014; see also Mohamed 2015).

Governments in a number of countries face strong conservative forces from within the political landscape and society, as the Beijing+20 national reviews show. For example, conservative religious forces slow reform of family and marriage laws. In particular, the concept of husband and wife as equals in marriage is contested (République de Côte d'Ivoire 2014; IRIN 2012). Where legal frameworks have been changed and gender machineries newly created, they face challenges in implementation by the abovementioned opposing conservative religious forces (FEMNET 2015a, 33).

Social norms have the potential to change in conflict-affected contexts, where gender roles are shifting due to new tasks women fulfil in the absence of men (Meintjes, Turshen and Pillay 2010). Some postwar countries have experienced a breakdown of barriers to women's empowerment in this regard (UNEP et al. 2013, 7).

In addition to the contextual issues cited in this section, a range of other challenges is confronting Sub-Saharan states, such as climate change. Its consequences are affecting smallholder farmers, of which many are women (Kanengoni 2015). These problems are interrelated, and along with infrastructural development challenges, such as a lack of access to water, health care and other services, they add to the burden of women's unpaid care work.

Policies, Frameworks and Challenges in Gender Equality

Policies of poverty reduction and economic growth often comprise multidimensional strategies and aims and touch on issues of gender inequality. Almost half of Af-

frican countries have poverty reduction strategies, and most of these have special provisions for women (UNECA 2014, 14). Legal frameworks and policies on gender equality have been implemented or advanced in almost all the states.

Improvements were made in many of the fields cited in the Beijing Platform for Action. At the continental level, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa is considered an instrument with great potential, as it is binding for state parties in their commitments to advance and protect the human rights of women and girls. It has been ratified by 36 of the 54 member states of the African Union, obligating them to address violence and discrimination against women and girls in public and private spaces (Mohamed 2015).

The UNECA (2015a) report on sustainable development priorities in Africa highlights gender equality as an explicit key policy priority in three of five African subregions (i.e., West, Central and Southern Africa). The policy focus in regard to gender equality is on women and education, participation in political and remunerated economic activities and women's voices in decision-making. Women's unpaid care and domestic work as a dimension of inequality that requires pertinent policies is not listed explicitly. Implicitly, it argues that empowering women through education will allow them to compete for high-skilled and well-paid jobs, and as mothers, they will be in a better position to feed, care for and educate their children (UNECA 2015a, 9). This take clearly emphasizes women's role as caregivers in the family and will not lead to a reduction or redistribution of unpaid care work to men or the state.

At the country level, almost all Sub-Saharan African states have improved on certain areas of the Beijing Platform for Action, in particular legal frameworks and gender machineries (UNECA 2014, 7; see also Mohamed 2015). The Beijing+20 national reviews highlight institutional mechanisms for the advancement of women that are accompanied by the formulation of either legal, policy or strategic frameworks for promoting gender equality and women's empowerment. This was accomplished through the establishment and strengthening of national gender machineries, i.e., stand-alone ministries of gender and women's affairs, gender directorates under various ministries, gender desks or dedi-

cated offices in key ministries and gender secretariats or gender and equality commissions. The national reviews also report on substantive progress in the implementation of policy and programmatic actions aimed at achieving gender equality and women's empowerment (UNECA 2014, 7).

One of the often-raised challenges in advancing women's rights in Sub-Saharan Africa is the lack of political will (Mohamed 2015). A closer look at the case of Rwanda highlights the relevance of political will in achieving gender equality and developing enabling policies. Although poor and still affected by the 1994 genocide, Rwanda has made impressive improvements towards gender equality,¹¹ ranking today among the most equal countries on the continent and leading the global charts on women's political participation. From the president to the national policy-making body, efforts at gender equality are made explicit and feature centrally in the national Beijing +20 review section on women and the economy with a subchapter on promoting the harmonization of work and family responsibilities of women and men (Republic of Rwanda 2014).

Scholars, activists and practitioners have all noted governments' insufficient social spending across Sub-Saharan Africa (e.g., Bibler and Zuckerman 2013, 2; see also the country reviews, like République du Cameroun 2015, 9). The subregion spends comparatively little on family and child policies, which is striking given the backdrop of the large number of children (ILO 2014c, 14). Underspensing on services and infrastructure has cumulating negative effects on women's unpaid care and domestic work, given the persistent high burden of diseases, including HIV/AIDS and Ebola, nature of the demographic challenges and climate-related depletions of water, fuel and food resources. These multiple factors combine and increase care-related demands on women's time. Inadequate provision of infrastructure, in particular water and sanitation, have interrelated consequences for women and children (ILO 2014c). Funding is particularly needed in the health sector, and programs that address quality of water, air and environmental issues — which affect maternal and child health — would relieve public health costs in the long run (UNECA 2015, 8).

11. Rwanda ranks 80th in UNDP's Gender Inequality Index, but 163th in the Human Development Index (UNDP 2015). For a critical review of Rwandan gender policies see Debusscher and Ansoms 2013.

Situating Care Policies

Against a challenging backdrop of improvements and on-going obstacles in working towards gender equality in Sub-Saharan Africa, care policies that recognize, reduce or redistribute the unpaid care and domestic workload of women are often part of several different policy frameworks. Care is often explicitly and implicitly rolled into anti-poverty, educational, infrastructural, health and other policies. It is presented through normative frameworks, for example, progressive or integrated framings or instrumentalist or familialist framings.

Anti-poverty policies are among the most frequently implemented policies in Sub-Saharan Africa due to the pertinent issues generated by poverty (UNECA 2014, 2), and policies that contribute to the recognition, redistribution or reduction of women's unpaid care burden are often situated within anti-poverty measures. Poverty has multidimensional facets and touches on a range of issues, and the format of many poverty-reduction policies reflect this. They address such persistent issues as infrastructure related to water and sanitation, health care, education and food security. Though not addressing women's unpaid care and domestic work explicitly, they reduce it and can generate time savings for women. Policies informed by concerns related to water, for example, are often situated within the discourse of public health and framed accordingly, but also have an impact on women's care work and gender inequality (Fontana and Elson 2014, 461).

Early child development and care (ECDC) policies are among the most frequently developed policies and have great potential to positively affect women's lives. Framed as early childhood development (ECD) or early childhood care and education (ECCE) policies, they have the potential to redistribute care from the family, or the private, to the state, if implemented adequately. These policies are typically services designed to cater to pre-school children, reflecting the needs of the young population of Sub-Saharan Africa. ECDC policies are found in almost all countries of the region. Though early childcare policies have a transformative potential as they redistribute care from the private to the public, many policies are framed in an instrumentalist fashion (Budlender 2015), that is, concern about how to foster economic growth and hence ensure that children achieve their full potential to become productive citizens. Though child rights

arguments are also employed, advocates use the economic argument, as supported by the World Bank, to bolster their case (Budlender 2015, 4).

Infrastructural policies have a positive impact on reducing the unpaid care burden of women, as improved infrastructure, in particular better access to drinking water, reduces time spent on fetching water and improves child health. Policies on infrastructural development do not formulate the unpaid care burden explicitly as a key factor of gender inequality that can in part be addressed by them. The »African Civil Society: Beijing+20, Shadow Report« highlights the structural factors that allow gender inequality to prevail (FEMNET 2015a). Poor service delivery for poor sustains and sometimes increases the burden of unpaid care work for women, especially the most vulnerable among them. It limits women's opportunities for engaging in paid work and in obtaining literacy and education. Evidence shows that the consequences for women are far reaching, including in reducing early and forced marriages (FEMNET 2015a, 16).

Health policies in Sub-Saharan Africa are often designed to deal with the HIV/AIDS epidemic. HIV/AIDS and the substantial additional care burden imposed by the epidemic facilitated recognition that families, and especially the women in them, cannot bear the burden alone (Budlender 2015). The care literature points to HIV/AIDS and its consequences as a particular feature of the African care economy (Folbre 2014, i128). Care-relevant health policies are often dedicated to relief and protection of orphans or other dependent groups and involve money-for-care measures. In regard to other diseases, women's means to protect themselves are limited, as the 2015 Ebola outbreak in West Africa revealed (UN Women 2014). Pregnant women are at risk due to inadequate provision of health care services (Taylor 2014). Hence, health care challenges demand a range of specific, tailored policies and actions from government. Policies that improve health care and care for orphans have a significant impact on women as they tend to be their primary caregivers.

Framing Care Policies

Though a range of policies can have a transformative impact on the unpaid care work of women, in practice, this burden is usually not sufficiently reduced or redistributed. In particular, ECD and infrastructural policies too of-

ten lack adequate funding, implementation and monitoring. Two country cases show that even if the unpaid care burden is recognized or even addressed in policies, the resulting policies are often inadequately funded and implemented. Experiences in Liberia and Rwanda, examples of poor, postwar countries in Sub-Saharan Africa, highlight what the difference between policy priorities and implementation mean.

The National Gender Policy of Liberia (2010–2015) (Republic of Liberia 2009) recognizes unpaid care work of women in several passages, in particular in relation to agriculture (p. 21), employment (p. 22), health (women as caregivers, p. 25), environment (as producers and consumers, p. 27), infrastructure and basic services (p. 28), and care of elderly persons (p. 39). The aim to reduce women's care burden is indirectly alluded to in the section on infrastructure policies on water, transport, electricity and energy development, as they would reduce women's workload and enhance their economic empowerment (Republic of Liberia 2009, 41). The Liberian Beijing+20 review, however, criticizes inadequate funding for gender machinery, ineffective implementation of the national gender policy and the inadequate capacities of the machineries (Government of Liberia 2014, 6).

The Beijing+20 national report for Rwanda, on the other hand, takes a strong gender-egalitarian approach throughout and appropriate language, and it promotes the harmonization of work and family responsibilities for women and men in a range of projects and programs. One explicit aim is to reduce women's burden of unpaid care work. Examples of projects geared towards this goal include the production and utilization of biogas and fuel-efficient cooking stoves, which would free women time from searching for firewood and reduce health risks. Another concrete project is the training of women on solar energy equipment production. In addition, the »one cow per poor family« programme helps reduce women's time spent on domestic work, increases their income from selling milk and improves family nutrition (Republic of Rwanda 2014).

A further reason for the persistence of the unpaid care burden of women and failure to address it with effective policies is that issues related to care are situated in a familialistic framework. The extended family is emphasized in many African policy documents, including those of the African Union, which aims to »strengthen families«.

The 2016 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa instructs states, »Adopt policies and legislation that provide incentives to all stakeholders including adult children, to support Older Persons in their communities, ensuring that they remain at home for as long as possible« (African Union 2014). The familialist perspective is often backed up by arguments citing »tradition« and culture, in particular in the context of elder care. As an example, the Liberian Beijing+20 review recognizes that elder care services are inadequate for accommodating large numbers of older people, but goes on to explain that the elderly are provided home care by immediate relatives, »consistent with tradition,« and that it is considered »demeaning to abandon« parents and elderly relatives to institutional care (Government of Liberia 2014, 19). This approach based on tradition and social norms places full responsibility on families and does not take the caregivers' (and receivers') needs into consideration.

Conservative actors, including religious groups, are increasingly influential at the international, national and local levels (Kabeer 2015a). Beijing+20 reviews show that in Côte d'Ivoire and Mali, for example, there was strong resistance towards reforming laws and making both partners equal in marriage. During a reform of the law on marriage and family relations in Malawi, conservative forces succeeded in resisting abolishing polygamy (Republic of Malawi 2014, 71).

Care Services

Sub-Saharan Africa does not fare well in care services, in particular in regards to public service provision. Childcare policies are quite common and widespread in Sub-Saharan Africa as part of ECD policies. These are designed for preschool children and encompass the inter-sectoral issues of health, education, nutrition and care. Generally, their focus is primarily on children's development, despite their potential to also redistribute care from the household to public or private sectors (Fontana and Elson 2014, 466). Some of these policies include parenting components,¹² but not much data is available on these.

12. ECD policies often include »parenting education,« to build parents' capacities to improved care for their children. Parenting initiatives are common, but the details are rarely provided in the literature reviewed by Budlender (2015).

Sub-Saharan Africa has made great strides in adopting integrated ECDC policies: 30 countries have adopted such policies, and 7 are developing them, many of these states being fragile or conflict affected (UNESCO 2015, 57). The reasoning behind these policies is often unrelated to the redistribution of women's unpaid care work. The ECD policy of Liberia, for example, formulates goals based on an instrumentalist approach »to ensure that all children achieve their full potential by providing quality, integrated ECD services and programs that will enable them to become useful, productive citizens and potential future leaders« (Republic of Liberia 2013). Limiting early childhood education to the instrumental emphasis on future productivity runs the risk of neglecting the present needs of caregivers.

In Nigeria, a policy to localize the Convention on the Rights of the Child was implemented by designing the National Policy for Integrated Early Childhood Development in 2007, to provide care for children up to the age of five while their parents work (Oluwafemi et al. 2014, 119). The goal was to expand, universalize and integrate interventions from various sectors in early childhood development and link to the National Policy on Education, Food and Nutrition, Health and the Child Rights Act. Implementation was hampered by inadequate funding (UNESCO 2015, 58). Most public schools cannot provide the required services because of a lack of classrooms and qualified caregivers. Even where services became available, they were generally limited to children aged 3–5 years (ActionAid 2013a, 31).

Kenya has a long tradition of early childhood development policies. Its pan-Africanist president Jomo Kenyatta launched the national philosophy of Harambee, to mobilize communal labour groups as well as to structure education and socioeconomic goals. Early care and education of children was considered a community concern necessitating collaboration. Communities acquired land and constructed schools, which led to increasing numbers of preschools and nursery schools. Women formed groups to champion and sustain early childhood education and care. They identified suitable persons to be engaged as preschool teachers. Whereas some schools held classes in regular educational facilities, others were organized to meet in individual homes, makeshift sheds and even outdoors (Mbugua 2004).

The Kenyan Ministry of Education launched the National Early Childhood Development Policy Framework in

2006, guaranteeing access to ECD for every child aged 4–5 years by 2010 (Yoshikawa and Kabay 2014, 21). The Beijing+20 national review shows a steady increase in pre-primary gross enrolment from 57.7 percent in 2005 to 66.3 percent in 2012 (Republic of Kenya 2015, xxvi). For 2006, 2007, and 2008, the number of girls enrolled in ECD programmes exceeded the number of boys.¹³ The argument was made that as a result of government efforts to improve ECD programmes, more girls were attaining early childhood educations. Similar increases in enrolment have also been recorded at primary school levels (Republic of Kenya 2014). Public pre-primary schools, however, do not have well-developed early childhood services for children under the age of 3. Teaching focuses on literacy and numeracy skills, because providers and parents view ECD as early schooling. Child-centred pedagogical methods exist only in a few private centres in urban areas (Republic of Kenya 2014). Also, very poor areas are even less adequately equipped, and safety concerns for younger children and the lack of availability of ECD centres close to home attract parents to private schools (Ngware 2015).

Ghana's ECDC experience is noteworthy as well. Ghana reached coverage in pre-primary gross enrolment due to a universal basic education provision that includes two years of kindergarten.¹⁴ The Ghanaian policy is considered commendable due to its integrated and coordinated services for children from birth to 8 years of age. Quality, however, is the biggest challenge: Many programmes are overcrowded, have poor infrastructure and lack well-qualified teachers (Yoshikawa and Kabay 2014, 21).

Although early child development policies are found in almost all African countries, Fontana and Elson (2010, 468) note that childcare policies remain scarce in developing countries. Policies exist, but their implementation is lagging. The cases of Kenya, Nigeria and Ghana reveal that where programs were put in place for early child development, they often lacked crucial capacities. In

13. Among older school-age children in a number of countries (Swaziland, Lesotho, or Mongolia), there is a higher risk of dropping out among boys, particularly in poor and rural areas, due to boys' obligation and often desire to work (UNESCO 2015, 173).

14. Pre-primary gross enrolment stood at 3 percent in 1971 and 113 percent in 2012 (Yoshikawa and Kabay 2014, 21–22). Pre-primary gross enrolment is expressed as a percentage of the population of official primary education age. Gross enrolment can exceed 100 percent due to the inclusion of over-aged and under-aged students because of early or late school entrance and repeating of grades (World Bank 2016).

rural areas, the availability and accessibility of adequate childcare services proved to be even more challenging.

Often, women tackle the issue of absent or inadequate childcare services by themselves, through community-based initiatives. In poor urban areas in Kenya, for example, women have organized day care in the absence of public care services. Such community-based solutions are affordable for poor women, and allow older children to go to school instead of caring for younger siblings. These informal day care centres, however, often provide inadequate care due to limited space, poor sanitation, nutrition, untrained personnel, insecure environments and a range of other issues (Premji 2014).

A further challenge is that gender and child development policies are often not coordinated. Rwanda, for example, has political will and strong policies to enhance gender equality (Republic of Rwanda 2014), but is weak in its provision of preschool child development and childcare services (Abbott, Mutesi and Norris 2015). Often, faith-based organizations step in, for example, in the provision of residential care (Better Care Network 2015).

A range of other public services also have transformative potential by reducing the burden of unpaid care work for women. Accessible and good-quality health care services have significant impacts on the health and well-being of children and mothers and women's time for care. For example, in the Gambia, public health care services have progressed due to an increase in government hospitals and accessible and affordable reproductive health services (Republic of the Gambia 2014, 25). So-called trekking stations, monthly visits to communities to provide such services as reproductive and child health care services, include antenatal care, child immunization, growth monitoring, registration of births and deaths and limited treatment of sick children. These trekking stations are an important strategy in making health services available to populations in rural areas (African Health Observatory 2014), and they are thereby reducing women's time spent to walk to clinics.

In Rwanda, the introduction of the Universal Community Health Insurance Scheme (Mutuelles de santé) led to a reduction in the financial barriers for women to access health care services. It provides health care to poor women for an annual minimum contribution of five US

dollars (Republic of Rwanda 2014, 19). Prior to this provision, women cited lack of money as preventing their access to health care. Investments included improving access and providing health facilities within a one-hour walk for each citizen (Republic of Rwanda 2014). This scheme expanded access to services. Between 2005 and 2011, skilled birth attendants increased from 39 percent to 69 percent, and women's use of contraception rose from 10 percent to 25 percent (UN Women 2015b). Due to Rwanda achieving health care coverage as high as 90 percent, governments from other African and Asian countries have looked into Rwanda's approach to universal health care (Makaka, Breen and Binagwaho 2012). Criticisms of the scheme include high dependency on donor money as well as high insurance fees given that many Rwandans live in extreme poverty (Nyandekwe, Nzayirambaho and Kakoma 2014).

Care and HIV/AIDS

The HIV/AIDS epidemic led to a range of policies to stop the spread of the disease and address its health-related consequences (UN Women 2015a). Though it is widely recognized that women's unpaid care and domestic work increase with the presence of persons living with HIV/AIDS in the household, there are few policies designed to reduce and redistribute women's increased care burden. Caregivers of persons living with HIV/AIDS need significant resources, infrastructure and services. Evidence from Tanzania, for example, shows that the amount of water needed for adequate care doubled (Brown 2010, 63). Also, time to care for persons living with HIV/AIDS requires women to take time off work and girls to stay home from school, as studies from South Africa have shown (Makina 2009, 313).

Southern Africa and Eastern Africa are the regions most severely affected by HIV/AIDS, and they are also where significant improvements in the provision of treatment have been achieved, in particular with regards to pregnant women. Almost 16 million people received treatment in 2015 (WHO 2015). Even without a universal response, HIV/AIDS-related deaths have decreased, and there has been a reduction in new infections (UNECA 2014, 4). Botswana, Namibia, South Africa and Swaziland have experienced such progress, as have Côte d'Ivoire, Malawi, Mozambique, Uganda, Zambia and Zimbabwe.

Since the early 2000s, massive funding from international donors, including the World Bank, the Global Fund, the United States President's Plan for Emergency AIDS Relief (PEPFAR), and others, has led to the mobilization of a variety of HIV programmes. Innovations in funding methods were introduced, such as a dedicated tax on airline tickets and fees for mobile phone use (WHO 2015, 32).

States have of course responded differently to HIV/AIDS. In the past, Zimbabwe emphasized families' and communities' »traditional« roles of taking care of the chronically ill and the home-based care model requiring women's unpaid care and domestic work (Makina 2009, 314). The strategy has changed over time, however, and Zimbabwe has been able to bring the epidemic under control with a combination of prevention strategies, decentralized health services, community services delivery and elimination of user fees (Republic of Zimbabwe 2015, 8).

South African is in a better position to provide health care services compared to other African countries, but remains challenged by the high number of persons liv-

ing with HIV/AIDS. Indeed, South Africa has one of the world's largest HIV/AIDS treatment programmes, which was launched in 2003. The National Strategic Plan, 2007–2011 and a national HIV counselling and testing campaign (HTC) aimed at testing of broad proportion of the population. Particularly good outcomes were achieved by testing women as a regular part of antenatal appointments. Another promising step was lifting a ban preventing pharmacies from selling take-home HIV testing kits in 2015, which has the potential to encourage more people to test for HIV (AVERT 2015a). South Africa has also scaled up state-supported, home-based care services, but these do not cover the all-day care needs of the ill, and therefore cannot replace unpaid care and domestic work (Makina 2009, 315).

Care-relevant Infrastructure

Sub-Saharan Africa is characterized by vast infrastructure deficits (Andrés, Biller and Herrera Dappe 2013, 3), which represent a major brake on development processes (African Development Bank 2015). Table 2 shows that Sub-Saharan Africa lags far behind all other regions of

Table 2: Infrastructure, Comparison Across Regions

	Avg GDP Growth (2000–2012) ^a	Urbanization Rate (2012)	Telecom Access (per 100 people) (2011) ^b	Electricity Access (% of pop.) (2010) ^c	Access to Improved Sanitation (% of pop.) (2011) ^d	Access to Improved Water (% of pop.) (2011) ^e
East Asia and Pacific (EAP)	8.9 %	50	98	92	67	91
Europe and Central Asia (ECA)	4.4 %	60	157	100	94	95
Latin America and the Caribbean (LAC)	3.1 %	79	125	94	81	94
Middle East and North Africa (MNA)	4.2 %	60	105	94	89	89
South Asia Region (SAR)	6.7 %	31	72	71	39	90
Sub-Sahara Africa (SSA)	4.7 %	37	54	35	30	63
World	2.5 %	53	103	78	64	89

Source: World Development Indicators, except when noted otherwise; taken from Andrés, Biller and Herrera Dappe (2013, 3).

Notes: ^a The average GDP growth for MNA is for the period 2000–2009; ^b Telecom access is defined as the number of fixed and mobile lines; ^c World Energy Outlook 2010 by International Energy Association; ^d Improved sanitation is defined as connection to a public sewer, a septic system, pourflush latrine, simple pit latrine, and ventilated improved pit latrine; ^e Improved water is defined as household connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection.

the world in access to telecom, electricity and improved water and sanitation.¹⁵ Furthermore, about 30 percent of the existing infrastructure is rundown and in urgent need of refurbishment (Africa Infrastructure Knowledge Program 2011, 2). Reductions in public spending, including on infrastructure since the mid-1980s, have had negative effects on women in redistributing social costs back to households, consequently increasing women's burden of unpaid care and domestic work (Seguino and Were 2014, i37; Tanzarn and Gutiérrez 2015, 14). Lack or inadequate infrastructure increases time and money needed for water collection, treatment and access to care and health services (Seguino and Were 2014, i37). Health risks due to a lack of water, sanitation and hygiene increase the care needs of children, the elderly and other vulnerable persons.

Time-use surveys in Tanzania serve to assess benefits of infrastructure availability for women. Women's yearly time spent on water collection in Tanzania was calculated to be as high as the equivalent of 640,000 full-time jobs for women and 120,000 full-time jobs for men (Fontana and Natali 2008). In the case of natural resource depletion, fetching water increased the burden on women even more, as they had to walk longer distances, which required more time (UNEP et al. 2013).

There have been some minor successes in the availability of improved sanitation facilities in Sub-Saharan Africa in the area of differences between urban and rural areas. Rural areas saw slight progress in coverage, from 25 percent in 1990 to 31 percent in 2010. Urban areas recorded a decline in coverage from 57 to 54 percent between 1990 and 2010. This decline is in part due to the high proportion of rapidly expanding urban populations relative to the available infrastructure (UNDESA 2014).

Some progress was made in coverage in improved water sources. The number of countries with at least 80 percent access to improved water sources in rural areas doubled from 5 percent in 1990 to 10 percent in 2010. Also, the number of countries with less than 50 percent coverage

fell from 27 percent to 16 percent in the same time period (UNDESA 2014). In Liberia, access to improved water sources increased from 52 percent in 2007 to 57 percent in 2010, according to a Liberian poverty reduction strategy report. Improvement, however, was mainly in urban areas. Access to sanitary facilities increased from 39 percent to 50 percent nationwide between 2007 and 2010. Water and sanitation was the public sector with the least deliverables achieved between 2008 and 2011. Improvements were rather meagre, as the Ministry of Public Works mainly focused on road construction (Republic of Liberia 2012, 36).

Water provision was part of pro-poor measures implemented in Uganda. There, the government reformed its urban water sector as part of its Poverty Eradication Action Plan. In 2006, the Ministry of Water and Environment updated policy to expand water supply services to the poor in urban as well as rural areas. Three pro-poor measures were implemented: an affordable connections policy lowering costs and increasing coverage (also in poor settlements); a pro-poor tariff policy tailored to customer categories; and a pro-poor targeting project subsidizing water supply in poor settlements of Kampala. These measures increased services delivered to the poor, serving approximately 81,000 more people and was successful overall. It decreased women's and girl's time fetching water and queuing (World Bank 2014, 57). A range of challenges, however, remain. Despite lowered costs, prices are still too high for the poorest of the population, thus blocking their access (World Bank 2014, v).

A large number of women, especially in rural areas, bear the brunt of the lack of water policies or their implementation. A range of countries do not have specific water policies, or where such policies exist, implementation is often poor. Policy implementation, and more so political will, is a precondition for positive change (Vidal 2012). Rwanda has successfully implemented policies for improved water, sanitation and hygiene. More than 54 percent of the population has decent sanitation, and rates of coverage increased from fewer than 1.5 million people in 1990 to more than 5.5 million in 2012. The country also has the ambitious goal of 100 percent coverage for water and sanitation supply by 2020. This is largely due to high-level political support for institutional frameworks and clear policy strategies (Sano n. d.; Vidal 2012).

15. An improved source of drinking water is defined as »one that, by nature of its construction or through active intervention, is protected from outside contamination, in particular from contamination with faecal matter« (WHO, JPM, UNICEF 2015b). In terms of gender equality and the unpaid care and domestic work, much of women and girls' time is spent collecting and treating water (UN Women 2016a, 60). Improved sanitation »hygienically separates human excreta from human contact« (WHO, JPM, UNICEF 2015b).

Social Protection and Care

Social protection systems aim at ensuring a basic level of economic and social well-being for all. These include social transfers, public works, social security and health for all. In Africa, unconditional in-kind transfers and public works are the most common programmes (World Bank 2015d, 8). The form of programmes varies by countries' income level. Conditional and unconditional in-kind transfers are prevalent among low-, middle- and upper-middle income countries. In-kind assistance and public works are prevalent among lower-income countries (World Bank 2015d, 9–10). Policies are increasing in number and complexity in all parts of the world. In Sub-Saharan Africa, the expansion of cash transfer schemes is particularly strong. In 2010, 21 countries had some form of unconditional cash transfer scheme in place, and by 2014, the number of countries had almost doubled, to 40 (World Bank 2015d, 7). Even if there is often no explicit mention of reducing the burden of unpaid care work for women in these policies, the examples below show how they affect women, in particular poor women and caregivers.

In poor countries, because of their limited budgets, the option of unconditional or conditional transfers requires consideration: Conditional transfers often do not lead to results better than unconditional ones, so women's efforts to meet the conditions procure them no additional social benefits. Like means testing, conditions are costly and complex to implement, consuming funds that could otherwise be used to boost the level of transfers (Fultz and Francis 2013, 34).

Cash Transfer Programmes

Zambia was one of the first countries in Sub-Saharan Africa to implement social cash transfers, in 2004. It was also a novelty for the country itself, as other forms of public services were provided only irregularly (Schuering 2008). Zambia has at least four different social cash transfer models in operation, including an ultra-poor and labour-constrained model, an elderly program, a child grant program, and the multiple categorical programme.¹⁶ The Child Grant Program (CGP) is an uncon-

16. The Multi Categorical Program targets households that meet any of the following conditions: a female — headed household keeping orphans; a household with a disabled member; an elderly — headed household

ditional cash transfer program that targets households with a child under five years of age in three districts with the aim of reducing extreme poverty and the intergenerational transfer of poverty. Payments are made directly to women (Natali et al. 2016). The CGP has met some of its goals of poverty reduction, improving food security, contributing to consumption smoothing, increasing productivity and increasing livestock ownership for better livelihoods. Programme households became significantly more secure financially. UNICEF has found significant impacts overall on consumption, food security and well-being as well as child health and development. The programme also has had positive impacts on assets and business development and agricultural production (Handa et al. 2014).

In 2008, Ghana's Livelihood Empowerment Against Poverty Programme (LEAP) became a pioneer in West Africa as a social cash transfer programme. It provided cash and health insurance to extremely poor households across the country. This unconditional cash programme targeted households with an orphan or vulnerable child, an elderly poor person or a person with a disability and unable to work (de Groot et al. 2015). Among participating households, 60 percent were headed by women. The aim of the programme was to alleviate poverty and encourage long-term human capital development. While in operation, 2008–2013, LEAP achieved a positive impact on children's schooling rate and absenteeism (Handa et al. 2013). The programme was, however, criticized for not providing cash transfers sufficiently adequate to make a significant difference. Another challenge was the irregular and inconsistent payment (Gbedemah, Jones and Perezniето 2010).

Liberia's Social Cash Transfer was piloted in 2009 to support extreme poor rural families. Poverty reduction was the primary aim of the programme. Households were selected on the basis of being extremely poor and labour constrained, meaning that among other criteria, they cared for three or more dependents. Sixty percent of recipients — about 1,900 families, including approximately 4,500 children — were female-headed households. The families were allowed to set their own priorities for use of the money (Borgarello, Figazzolo and Weedon 2011). These transfers improved homes, health

(over 60 years old) keeping orphans; and special cases that are critical but do not qualify under the other categories; for example, a household of two elderly people who are unable to look after themselves.

and children's education. They also had a positive impact on food security and income-generating opportunities (UNICEF 2012).

South Africa's social protection system is comprehensive and well developed compared to other Sub-Saharan African countries'. It aims at poverty reduction, like many other social policies on the continent, and has an impact on gender inequality although it is not framed as such. UNICEF-ESARO (2015) reviewed social cash transfers in Africa and examined evidence on child-related outcomes. Among the cases studied, the South African policy of unconditional cash transfers was considered successful. The Foster Child Grant (FCG) is a grant for foster parents of children determined by the courts »in need of care and protection« as a result of abuse, neglect, abandonment, trafficking or the like, as defined by the Children's Act, section 150 (Budlender and Woolard 2012). The Child Support Grant (CSG) is the main poverty-oriented child grant and it is means tested (Budlender and Woolard 2012).

Though praised for its unconditionality and for facilitating women's access to paid employment, the child grant system has weaknesses, most important confusion surrounding the purpose of the FCG, and the resultant inequities. The FCG is framed as providing adequate »care and protection,« rather than addressing poverty, and in reality, the distinction is blurred. In the late 1990s, approximately 50,000 children were receiving the FCG compared to more than ten times that number in 2015 (ILO 2016a). This increase results in part from orphans being placed in foster care, making them eligible to receive the grant. The majority of the orphans who benefit from FCGs live with grandparents or other close relatives (Budlender and Woolard 2012).

Other transfer programmes are noteworthy due to their potentially transformative impact. The Care Dependency Grant is provided to caregivers of severely disabled children based on the assessment that these caregivers have limited opportunity to earn money given the intensive care needs of the children. An Old Age Grant (OAG) is provided for the elderly (Budlender and Woolard 2012).

Cash transfers in South Africa do not create disincentives to work and save. To the contrary, households receiving old age pensions have labour force participation rates 11–12 percent higher than non-beneficiary households

and employment rates 8 to 15 percent higher because a pension received by one household member enables other unemployed household members to search for jobs (Borgarello, Figazzolo and Weedon 2011, 89; see also Plagerson and Ulriksen 2015).

South Africa's social protection system has an impact on gender inequality, although it is not framed or targeted as such. Its grant system reaches far more women than men. The OAG reaches more women than men because women tend to live longer and to be poorer, and therefore more likely to pass the means test. The child grants reach more women than men because women are more likely to be the primary caregivers for children. Indeed, fewer than 40 percent of all South African children live with their biological fathers. The CSG could be seen as addressing gender inequality to the extent that it recognizes the unpaid care work of women implied by having primarily or sole responsibility of caring for children. With the absence of fathers, women often bear this burden alongside having to find income to provide for the children. The Maintenance Act states that fathers have a duty of support, regardless of whether they were ever married to the mother. In practice, however, many fathers are unable to provide because they are unemployed. Also, the whereabouts or identity of many fathers is unknown. Where fathers are known and earning, the act is so poorly implemented that maintenance amounts are either very low or not paid at all. In this situation, the small CSG provides some relief. In any case, inequality arises as children living with their mothers are often as poor as children living with neither parent, but the latter are eligible for a higher value grant than the former if they are orphans (Budlender and Woolard 2012).

Public Works Programmes

Public works programmes are a prevalent social protection measure in Africa, where 39 countries have them (World Bank 2015b, 9). Public works programmes engage participants in manual labour involving building and rehabilitating community assets and public infrastructure. They are often designed to improve the day-to-day lives of for poor and food insecure segments of the population or in the context of addressing high levels of unemployment and natural disasters (Tanzam and Gutiérrez 2015). Examples of public works programmes include the Expanded Public Works Programme in South Africa

(EPWP), the biggest such programme in Africa, and the Ethiopian Productive Safety Net Programme (PSNP).

The EPWP in South Africa is aimed at providing income and poverty relief through temporary work for the unemployed and expanding services and infrastructures. Since 2004, the programme has in three phases generated more than five million work opportunities (South African Government 2016). It did so while also reaching its target participation quota of 55 percent women (Tanzarn and Gutiérrez 2015, 17). Though the EPWP was designed taking into consideration poor women's time poverty and unpaid care burden, the programme's implementation did not in all cases translate this into practice. This often meant longer working days for many women due to an increased paid and unpaid work burden (Tanzarn and Gutiérrez 2015, 30).

The EPWP also points to the challenges of integrating the social sector in public works programmes. The EPWP early childhood development component is basically a skills-training initiative that supports ECD workers while they are trained, but provides no support in the form of jobs or help with placement after they receive their qualifications. Publicly funded ECD centres have not expanded sufficiently, nor have the subsidies to support demand for private providers to keep them functioning. At the same time, high fees exclude children of poor families from attending ECD facilities. The centres' wages are below the EPWP training stipend, which is an incentive to continue training rather than entering the workforce. When successful trainees do find employment, they tend to be moved up to serve children in older age groups, where the pay is better, so the initial policy intent of adding skilled ECD workers is only partially fulfilled (Pareeze and Budlender 2015).

Ethiopia's PSNP is the largest such programme in East Africa and one of the largest on the continent. It is a social protection intervention that effectively integrates public works and unconditional cash or food transfers (Tanzarn and Gutiérrez 2015, 1). The PSNP bridges the response gap between emergency relief and long-term development aid and supports local communities through providing transfers of cash and food. At least 85 percent of beneficiaries receive cash transfers as wages for labour on small-scale public works projects, and the approximately 15 percent direct support beneficiaries (disabled, elderly, pregnant or lactating women) receive

unconditional transfers. The PSNP is responsive to women's roles in agriculture and food security and is aware of women's specific needs and vulnerabilities. It includes provisions of gender-specific lifecycle needs, supports women's access to credit and is sensitive to women's involvement in decisions related to public works labour (Holmes and Jones 2011, 12–13). The PSNP is considered a unique case of good gender equality-enhancing practices (Tanzarn and Gutiérrez 2015, 21).

Labour Policies and Care

Labour policies have improved in many African countries. In Côte d'Ivoire, for example, public servants and employees in the private sector are entitled to 14 weeks of maternity leave and one hour of breastfeeding time per day for one year. In addition, Côte d'Ivoire grants three days of paternity leave. Gender equality is guaranteed in the «code du travail» (Republic of Côte d'Ivoire 2014).

In Nigeria, a Labour Standards Law was passed in 2010 that includes a 16-week maternity leave provision for women in federal public service as well as in the private sector (Republic of Nigeria 2014, 38). This is in line with the recommendation of Convention 183 of the Maternity Protection Convention of 2000. Yet, about 75 percent of the population work in the informal sector. As in most of Sub-Saharan Africa, including Côte d'Ivoire, economic growth in Nigeria has not absorbed its enormous labour force, and an estimated 50 million youth are unemployed (Holmes and Akinrimisi 2012, 9). This economic reality means that for the vast majority of women, labour policies do not apply.

In many countries of Sub-Saharan Africa, only a small proportion of the working population is formally employed. According to *Women in Informal Employment: Globalizing and Organizing* (WIEGO), informal employment as non-agricultural employment by sex is as high as 74 percent for women, and 61 percent for men. On average, the proportion of informal workers in Sub-Saharan Africa is 66 percent. Regional rates vary widely. The numbers are lowest in South Africa, at 33 percent, and highest, at 82 percent in Mali (WIEGO 2013). This means that labour policies, including maternity and paternity leave, old age pensions and family allowances, are limited to a formal worker minority (Folbre 2014; Aboderin and Beard 2015).

In Sub-Saharan Africa, only 16.9 percent of the people benefit from old age pensions compared to 51.5 percent globally (Arza 2015). The coverage rate for maternity protection in Sub-Saharan Africa is also comparably low. As women's formal employment is low, effective maternity leave coverage stands at below 15 percent for female workers (ILO 2016b, 35). Some countries have introduced pensions for informal workers. In Ghana the Social Security and National Insurance Trust introduced the Informal Sector Fund (SIS) in 2008. Based on voluntary contributions, it provides informal workers with options for retirement savings and other financial services (World Bank 2012a, 9).

Women's labour force participation in Sub-Saharan Africa has increased by 3.2 percentage points over the last two decades. The reasons behind this increase and the convergence in participation gaps include the fact that poverty does not allow women to stop working (ILO 2016b, 5). According to UNECA (2014, 22) cultural impediments constrain women, and limited economic opportunities push them into informal and vulnerable employment. This problem persists due to abundant labour supply and is exacerbated in the absence or weakness of social protection. Such vulnerable circumstances, and no alternative means of livelihood, make it difficult for low-skilled and poor workers, particularly women, to exit labour markets (UNECA 2014, 22). This traps women in poverty and is problematic, as decent employment is one of the most promising routes to other roles and women's control over resources (Fultz and Francis 2013, 34). Hence, for informal workers, extension of such state protection as universal pensions and health coverage is essential (Alter Chen 2012, 18).

Mobilization Around Care

Care as a priority tops the agendas of such large networks as Solidarity for African Women's Rights (SOAWR) and the African Women's Development and Communication Network (FEMNET). Their claims are directed towards national, subregional or international bodies. Women's organizations in Sub-Saharan Africa face struggles in working towards gender equality, especially because of the resistance they face from conservative forces in society as well as government. Subsequent to an earlier wave of optimism and change on the continent (Tripp 2013), after 2013 the subregion experi-

enced increasing retrogression, coupled with declining numbers of women occupying political positions. For example, Nigeria ratified any number of international protocols and instruments, but used this as a way of shutting down movements. At the same time, the implementation of these instruments remained limited and the localization of protocols challenging (SOAWR 2015, 9; Wanyeki 2012).¹⁷

Sub-Saharan Africa has been »NGOizing« and women's movements de-politicizing. NGOs are strongly funded by international actors, taking over state functions, especially after privatization and cuts in public expenditures as a result of neoliberal policy approaches.¹⁸ Today, women mobilize on a range of priorities, such as violence against women and girls, health (including HIV/AIDS-related care issues and sexual and reproductive health) and women's empowerment (Mohamed 2015; Wanyeki 2012).¹⁹ Yet, unpaid care and domestic work of women as a dimension of inequality is mostly absent, and when present, a low priority on the agendas of women's movements most Sub-Saharan African countries.

Not everyone, however, is silent about care. FEMNET and SOAWR are examples of how care can fit on the agendas of African women's movements. Noteworthy are the efforts of FEMNET at the continental level. In a statement on the SDGs and their relevance for women in Africa, the group called on African leaders to demonstrate political will in implementing Agenda 2030 and to emphasize the importance of women's rights (FEMNET 2015c).²⁰ FEMNET is also urging governments to recognize women's burden of unpaid care and domestic work, among a range of other claims (FEMNET 2015c). In a position paper, »The Africa We Want,« FEMNET calls for the elimination of all barriers that prevent women's access to

17. On the influence of conservative forces at the international level, see for instance, Goetz 2015 and Kabeer 2015b.

18. There is a range of literature on the role of civil society and the de-politization of collective action into »NGOization« in the 1990s. See for example Haberson, Rothchild, and Chazan 1994.

19. On education in Niger, see ANED 2014; formation and economic empowerment in Sénégal, REFDAF 2016; women's rights and environment in Ghana, Nigeria and Kenya, NETRIGHT 2012, ECOWA 2016 and WomanKind Kenya 2016.

20. The seven points are end discrimination and gender-based violence; end child marriage and female genital mutilation; ensure access to sexual and reproductive health care services and education for all; protect women's and girls' reproductive rights; recognize and value the burdens of unpaid care work on women and girls; expand women's economic opportunities and ensure their rights to resources; and eliminate gender disparities in schools and ensure equal access to education (FEMNET 2015c).

information, technology, infrastructure, credit, employment and markets and for recognition and redistribution of women's unpaid care and work (FEMNET 2015b). FEMNET emphasizes the importance of recognizing both parents' responsibility for the upbringing and development of children and stresses that this is a social function for which the state and the private sector have secondary responsibility (FEMNET 2015b, 2015c). Its »Strategic Plan, 2014–2018« calls on governments to redistribute the unpaid care burden to men, boys, the state and the private sector against a backdrop of recognizing women's important role in the economy (FEMNET 2014, 10).

SOAWR, in »Breathing Life into the Maputo Protocol,« highlights a range of advances and challenges in the push for women's rights. One of the four key challenges it identifies is the continuously side-lined reduction, redistribution and valuing of unpaid care work despite its acknowledged importance (SOAWR 2015, 13).

FEMNET and SOAWR are large and internationally connected movements. There are also a number of smaller NGOs and international actors that sensitize, mobilize and train local NGOs and activists on issues around care. One example is MenCare, a global fatherhood campaign that aims to promote equitable, nonviolent fatherhood and caregiving. This international NGO collaborates with Promundo, Sonke Gender Justice, MenEngage and others. Active in 35 countries, it is mobilizing men to engage in care (in particular, of AIDS patients), including in Sub-Saharan Africa (MenCare 2015). Its initiatives work on a small scale, such as at the local level, targeting individuals and communities with the goal of bringing about behavioural change in regards to gender norms and stereotypes.

Network for Women's Rights in Ghana (NETRIGHT), an established organization that provided national shadow reports on Beijing+10 and Beijing+15, organized a discussion on gender inequalities, including unpaid care work, in New York as preparation for the Beijing+20 review process (NETRIGHT 2016). This is an example of how internationally connected organizations can include women's unpaid care and domestic work on their agendas on par with the local issues they prioritize.

There are, as one would expect, regional differences in regards to mobilizing around care. South Africa, for example, has a longer history of women's movements, and


accordingly, quite institutionalized political movements. Gender Links is an NGO promoting gender equality and justice across 15 countries in Southern Africa (Gender Links 2016). Resources produced by Gender Link include materials on women's unpaid care and domestic work (Gender Links 2011), but care has not been a priority.

Small women's organizations exist in most African countries. They promote awareness and protection of women's rights, which include the right to health care and infrastructure such as WASH (water, sanitation and hygiene), and issues such as environmental protection in the context of climate change (WomanKind Kenya 2016). Mobilization at the grassroots emerges in cases of emergencies, like epidemics, which often have care-related impacts. During Ebola emergencies, for example, mobilization emerged for recognition of local organizations and for substantive funding for them. As a result, local organizations received support from a range of international organizations.²¹ The work of local grassroots organizations, often women's organizations, typically complements that of the large aid organizations and international NGOs. Whereas the latter set up clinics and provide supplies, the local organizations reach out to individuals and communities, especially hard-to-reach communities (Mutima, Gitomer and Hobson 2015). Given the weakness of public institutions, policies and implementation, claims of these organizations are not directed towards governments, but the international donor community.

Social movements, including women's, have mobilized in Africa in the context of the HIV/AIDS epidemic, demanding state action and contesting public policies (WHO 2015, 32). In South Africa, the AIDS movement helped advance HIV/AIDS policy and offered essential support to people living with HIV/AIDS. This significantly affected women, as they were and remain the primary caregivers. Yet, poor political leadership and »AIDS denial« hampered effective collaboration between the state and the AIDS movement. These challenges slowed policy progress and access to treatment, care and prevention measures (Nunn et al. 2012).

The international movement ActionAid supported the mapping of policies related to care and trained women,

21. Open letter, »A Call to Fund In-Country Grassroots Organizations Addressing the Effects of Ebola,« March 23, 2015, <https://docs.google.com/forms/d/1s11kZbW-CwwR4GXqVshbudh18Wt-wOC6zUN6jjsM0cM/viewform>.



their families and communities about women's unpaid care and domestic work in a piloted programme in Nigeria, Uganda and Kenya. Among the aims was to create awareness and encourage women to make demands for quality public services. A range of forums were created to build advocacy strategies (Nesbitt-Ahmed and Chopra 2013). ActionAid organized group discussions with government officials to examine possible national policies on care, to raise awareness and to provide data to the government. Time-use surveys and diaries led to valuable data and increased women's awareness about their unpaid care work. As a consequence, women began to question their burden and to demand that men and leaders recognize it and get men involved in the tasks they perform. In some communities, women began mobilizing and asking government to provide public services to support them (ActionAid 2013a, 5).

Asia and the Pacific

Context

The Asia and Pacific region is demographically and economically heterogeneous, with many levels of economic, infrastructural and social development. There are vast differences in the status of gender equality and cultural backgrounds among Asian and Pacific countries and within them. The region is also diverse in ecological settings and the impacts of climate change therein.

Countries in Asia and the Pacific are at quite different demographic stages. Some have very large and very young populations, in particular countries in southern and western Asia (UNFPA 2014, 3).²² India has the world's highest number of 10–24 year olds, with 356 million (UNFPA 2014, 5). Other countries, especially middle to high income, face demographic transitions towards ageing populations. Asia will experience an increase of more than 60 percent of older people (+60 year olds) until 2030. Coupled with decreasing fertility rates in many countries, this will lead to an increasing share of older people in the population (UNDESA 2015a). Critical in these countries will be the provision of elder care, which will be significantly challenging for China, where the baby-boom from the 1950s to the 1970s and the consequences of the one-child policy have led to changing family structures. In combination with out-migration, China faces increasing care needs (Hopkins 2016; Scheil-Adlung 2015). In-migration holds the potential to balance some of these demographic changes by increasing the supply of working-age persons and caregivers (UNDESA 2016).

In terms of economic performance, the Asian and Pacific region spans from the economically strong — e.g., Japan, China and South Korea — to the very poor — e.g., Bangladesh, Nepal and Myanmar. Asia is experiencing rapid growth and industrialization. India and China are among the largest and fastest growing economies in the world.²³ Less economically strong Asian countries — for

instance, Cambodia, Laos, Myanmar and Papua New Guinea — have economic growth rates of more than seven percent (World Bank 2015b). Most economies in East and Southeast Asia rely on manufacturing and trade. Many women are employed in the labour-intensive garment industry, often under vulnerable conditions (WIEGO n.d.).

Many countries with strong economic growth also have very poor population segments. With high level of socioeconomic inequalities, India faces a range of poverty-related problems, including malnutrition among poor children and a range of infrastructural challenges in areas where the poor live, in both rural and urban areas (Republic of India 2015). In many Asian countries, urban growth and urban poverty has led to multidimensional problems, in particular when coupled with inadequate infrastructure and service provision. Asia has 60 percent of the world's total slum population, and many more urban poor living in slum-like conditions (Asian Development Bank 2014). Poverty is perpetuated when coupled with a lack of economic opportunities. Despite economic growth, many Asian and Pacific countries, such as Papua New Guinea (UNDP 2013b), have high rates of unemployment. In such contexts, women also face multiple challenges, such as the negative effects of climate change and a range of other issues that fall back on them. High rates of teenage pregnancy, for example, overburden women, as they lack the means to adequate care for these young mothers and their children (Asian Development Bank 2016).

Rigid norms and stereotypes hinder the achievement of gender equality in many ways in Asian and the Pacific. Discriminatory sociocultural roles hamper effective violence prevention and protection and access to justice systems for women (UNESCAP 2015a). Patriarchal systems of landownership, family laws and access to productive resources constrain women and their livelihoods (Kelkar 2016). In many areas, in particular in South and Southwest Asia, UNESCAP has identified the need to address the »discriminatory, prejudicial and confining norms« stemming from patriarchy, a long-term endeavour towards achieving gender equality (UNESCAP 2015a, 12). In poor countries, for example the Republic

22. China (1.367 billion people, July 2015) and India (1.251 billion people, July 2015) have the highest populations worldwide. See Central Intelligence Agency: *The World Factbook*; <https://www.cia.gov/library/publications/the-world-factbook>.

23. India is among countries with the fastest growth rate, currently 8 percent (Republic of India 2015, 80).

of Marshall Island, women's roles coupled with heavy burdens as caregivers restrain their participation in public life (Republic of Marshall Islands 2015, 22). Inequalities based on ethnicity, religion, caste and other factors strongly affect women. Those of lower castes and of rural or ethnic minority backgrounds face discrimination and stigma (Republic of India 2015, 33; Government of Nepal 2014, 12). They are often marginalized by service providers and employers of domestic workers (see for example UN Women 2015c, 34, 50).

A significant challenge in the Asian and Pacific region is climate change and the related negative effects of natural disasters. In 2015, the region experienced 160 disasters, mostly in South Asia, accounting for 47 percent of all 344 disasters worldwide that year. They resulted in more than 16,000 fatalities and more than 45.1 billion US dollars in economic damage (UNESCAP 2016). Climate change coupled with resource-constrained environments and inadequate and unequal access to infrastructure and services increase the unpaid care burden of women (UNDP 2015, 121). In developing countries, women are particularly vulnerable to climate change due to their high dependency on local resources for their livelihoods (UNDP 2013a). Climate change and natural resource management figure high on women's movements claims towards national and international actor's agendas (ESCAP 2015a).

The Asian continent has and continues to suffer the consequences of a number of wars and protracted crises. Afghanistan and Nepal are currently severely affected by the fallout of violent conflict. Afghanistan ranks very low in human development, but despite its manifold conflict-related challenges, it has in recent years experienced some progress in the advancement of women's rights and gender equality (Islamic Republic of Afghanistan 2014; Save the Children 2012; UNDP 2015).

Policies, Frameworks and Challenges in Gender Equality

Three main areas of progress stand out at the institutional level in Asia and the Pacific: working towards gender equality in national government bodies and governance, addressing violence against women and promoting women's political participation and leadership (UNESCAP 2015, ix).

All regions of Asia and the Pacific have achieved some level of progress in moving towards gender equality, but with differences due to countries' differing political histories and settings. Political orientations of governments and their public policies have had a strong influence on women's empowerment. Mongolia and Viet Nam for example have a political history of socialism and high women's labour force participation. Countries in Asia and the Pacific recognize the importance of women's economic participation and have taken major steps towards women's economic empowerment through reform legislation, introduction of flexible working arrangements, delineation of minimum wages, provision of childcare services and access to financial services and credit (UNESCAP 2015a, 10–11). Many governments also recognize the importance of women in private enterprises. Valuing entrepreneurship as critical drivers of job creation and economic growth, a number of governments have been introducing and revising policies to foster entrepreneurship among women (UNESCAP 2013).

Despite progress in achieving gender equality, a number of issues remain. At the subregional levels, various and interrelated challenges include violence against women, meagre political participation and leadership, low women's economic empowerment, lack of adequate health care services and environmental challenges that negatively affect women's livelihoods and well-being (UNESCAP 2015a).²⁴ Many of the problems are related to a lack of adequate funding to fight gender inequalities. Patriarchal ideologies remain a further challenge and affect priority setting for national agendas and the allocation of pertinent budgets. In poor countries such as Papua New Guinea and the Marshall Islands, there are few gender policies, and relevant institutions for implementation are underfunded. There are even fewer policies related to women's unpaid care and domestic work (e.g. Republic of Marshall Islands 2015).

There is increasing awareness by policymakers that the effects of climate change are not gender-neutral and that women need to be included in decision-making processes related to climate change programmes and policies (UNESCAP 2016; UNDP 2013a). Women's movements are pushing for concrete action on this front.

24. UNESCAP (2015a) lists a range of challenges for all subregions regarding normative frameworks, institutional mechanisms, and obstacles pertaining to policy and legislation formulation, implementation and monitoring, technical capacity and availability of data and statistics.

Situating and Framing of Care Policies

Policies related to unpaid care and domestic work of women are often part of, or cut across, policy frameworks addressing economic, infrastructural, health and climate change-related issues. The way care is explicitly or implicitly addressed in policies can determine its transformative potential. In many Asian countries, emphasis on women's labour force participation is intertwined with the importance of economic growth. Women's labour force participation varies across Asia and the Pacific. Many countries have public and labour policies that enable women's participation in paid labour, including childcare policies. To shape a conducive environment for economic growth, there must be investment in women and girls in order to achieve gender equality (UNESCAP 2015a). This investment includes the allocation of tangible resources to society at large. Thus, care policies are an investment and part of the toolset of policies enabling women's labour force participation, argued as a necessity for economic growth.

Childcare services are one of five improvements that have been made in the context of economic participation and women's empowerment in Asia and the Pacific (UNESCAP 2015a, 11). The framework of gender equality within the economic growth discourse contains such measures as parental leave and maternity protection for working women. A few countries are implementing pertinent policies. Viet Nam for example has one of the longest paid maternity leave policies, allowing six months paid at 100 percent of a woman's salary. The Beijing+20 report highlights the enactment of the Strategy on Vietnamese Family Development with the goal of »building prosperous, progressive, happy Vietnamese families.« The economic growth framework is coupled with a familialist take emphasising the family as »truly one's sweet home or cozy nest« in the context of accelerating industrialization and modernization (Socialist Republic of Viet Nam 2014, 4). The importance of the family is recognized, as the source for reproducing the labour force, but without further reflection on the division of labour within families. Pro-economic growth policies do not always lead to policies that reduce women's unpaid care and domestic work. For example, in China, public childcare provision was reduced in the context of neoliberal reforms (Cook and Dong 2011).

In many countries, care is not an explicit policy priority on the agendas of national governments. Those coun-

tries that have explicit care policies often have a particular political context. Due to their history of social welfare systems, some countries, such as Mongolia and Viet Nam, have specific care policies designed to allow women's participation in the economic and social life. Mongolia has subsidized preschool (Begzsorem and Aldar 2014), and Viet Nam has quite comprehensive, egalitarian health and education policies (Socialist Republic of Viet Nam 2014). A second example is India, which has a particular history of bottom-up efforts by feminist movements pushing for gender policies for more than thirty years. This has resulted in a range of care policies (Rao 2016). India's care and maternal health policies are framed as anti-poverty (in particular rural women's poverty), aimed at reducing child malnutrition (Republic of India 2015).

Meanwhile, Afghanistan and the Marshall Islands have rather few priorities related specifically to prevalent issues of gender inequality. Due to their challenging contexts due to high poverty rates, poverty-related issues, such as health care services and measures related to violence against women, are prioritized.

A challenge remains that many care-related issues are expected to be resolved within families, meaning by the women and girls in them. Some governments, among them Mongolia's, aim to strengthen families and enhance their role through welfare policies and encouraging people to have children in the context of traditional gender relations. The long duration of unpaid childcare leave, often primarily taken by mothers, and limited involvement of fathers in childcare illustrate this (Dugarova 2016, 36). As noted, Viet Nam's functionalist take on families emphasizes the importance of the family as the space for reproducing a productive workforce. Elder care in China was traditionally organized on the logic of Confucian norms of filial piety. Several laws reinforce as a moral obligation that children, i.e., daughters and daughters-in-law, are responsible for the care of their parents in old age (Cook and Dong 2011, 953). Only recently has there been an increase in state provision of elder care (Scheil-Adlung 2015, 31).

Cultural and social norms restrict women from full enjoyment of rights and participation in social, political and economic life in many regions of Asia and the Pacific. In Afghanistan, such norms restrict women's mobility and livelihoods, and violence against women is the result of

»inappropriate culture and tradition« (Islamic Republic of Afghanistan 2014, 32). Changing such views is a difficult, long-term issue and the biggest challenge for Afghan women (Islamic Republic of Afghanistan 2014).

Even in economically strong countries where women's political and economic participation is encouraged, many challenges remain, in particular due to patriarchal corporate culture. It demands long working hours from employees and therefore often prevents women from continuing to work during pregnancy and after childbirth. In addition, care is predominantly considered a women's issue, regardless of their participation in the formal economy. Public childcare facilities are insufficient to afford women equal access to paid work (APWLD 2014, 12).

Care Services

The Asian and Pacific region generally fares better than Sub-Saharan Africa in regards to public care service provision, but worse than Latin America and Caribbean (Neumann, Josephson and Chua 2015, 24). Care policies and care service provision varies strongly within the sub-region and among countries. The reasons are diverse, as outlined above.

Coverage of early child development and care services for pre-school children is higher in East Asia and the Pacific than in other regions around the world. Still, there are notable differences in regards to coverage and efficient implementation within the countries, in particular between rural and urban areas, depending on population groups' socioeconomic status, language, ethnicity, gender and for children with disabilities. Even where public services are provided, the quality varies greatly. Most countries in South and West Asia have increased pre-primary enrolment rates since 1999. Yet rates are very low in some countries, for example, Bangladesh and Afghanistan. Among the many challenges of the region is a shortage of pre-primary education teachers, a problem that has worsened as enrolment has grown in recent years (Neuman, Josephson and Chua 2015). Kazakhstan was the first country in Central Asia to implement a policy of a year of compulsory pre-primary schooling. This has contributed to equality by guaranteeing access to children from poor families and to girls (UNESCO 2015, 59).

India's Integrated Child Development Services (ICDS), or Anganwadi, has grown into one of the world's largest ECDC programmes. It addresses challenges related to maternity and childcare of its poor population, in particular in rural areas in a comprehensive way. Due to widespread poverty-related maternal and child malnutrition and other issues, the ICDS was designed to focus on malnutrition and ill health, but also gender inequality, for example by providing girls the same resources as boys (Republic of India 2015, 4). The scheme seeks to reach out directly to pregnant and nursing mothers and to children under 6 years of age through an integrated programme of early childhood education, health and nutrition. The various services are provided through ICDS centres (UN Women 2012). Women from poor households use them to access supplementary nutrition for children, and female daily wage earners and domestic workers use the centres as crèches. In addition, the centres provide health services where primary health care is not easily accessible (UN Women 2012). In the course of improving services, ICDS were placed close to primary schools, which was an effective way to improve girl's school attendance and facilitate children's transition from the centres to first grade (UN WOMEN 2012, 32).

Yet, public care services are insufficiently provided in India (Rao 2016). A comparison of attendance in different Indian states reveals diverging attendance rates. In some states, 20 percent of children were attending Anganwadis, in others, the rate was 85 percent. At the same time, there was an increase in private pre-primary school attendance across the various regions (UNESCO 2015, 65). There have been substantial budget reductions for Anganwadis in recent years, and repeated strikes by care workers (Parakh 2016), whose salaries are insecure and below the minimum wage (UN Women 2012).

In Mongolia, the provision of ECDC decreased greatly after 1990. Little attention was given to pre-primary school children, and until recently, less than 70 percent of Mongolia's children attended early childhood development programmes (UNICEF 2015b).²⁵ An Integrated Early Childhood Development policy was adopted in 2005, aimed at improving inter-sectoral collaboration and coordination of childcare services. In 2016, a law on

25. The number of children enrolled in preschool stood around 97,000 in 1990, sank to 64,000 in 1995, and began to raise after the millennium, to 90,300 in 2003, 122,100 in 2010 and 183,000 in 2014 (Dugarova 2016, 25).

childcare was enacted to provide preschool services for all children 2–6 years old. Efforts from private childcare providers will help overcome the shortages of public preschool centres (Dugarova 2016, 27).

Mongolia faced additional challenges in reaching children of disadvantaged groups, such as those in rural areas and children with disabilities. UNICEF (2015b), as well as the World Bank in league with the Global Partnership for Education, supported a programme to address inequalities facing nomadic children. Mobile kindergartens have led to an increase in enrolment rates for children in remote and rural areas and helped them prepare for school (World Bank and Global Partnership for Education 2014). Studies do not, however, show how these programs have impacted women's unpaid care work, although female herders' workload and their lack of time to prepare children for school is an identified problem (UNICEF 2015b).

The experience of China offers evidence on how availability of public childcare services affects women's choices and their engagement in income-generating and other activities. In the course of implementing neoliberal reforms in the 1980s, China reduced public spending on childcare services. With this decrease in state support, a range of privatized care services emerged and grew. As these private services are unregulated, however, their care is of questionable quality. Women's employment declined as a consequence, and women engaged increasingly in informal work (Cook and Dong 2011; Alfors 2015).

Health challenges are many, and among them is the impact of health services on women's unpaid care and domestic work. Such services have been advanced in many countries of Asia and the Pacific, and there have been improvements in maternal and child health services. Variability in maternal mortality rates is, however, high between subregions and between countries in them. The 2013 maternal mortality rate for war-affected Afghanistan, for example, was as high as 400 deaths per 100,000 live births, compared to 29 per 100,000 in Sri Lanka, also a conflict-affected country. In South-east Asia, the maternal mortality rates vary from 200 per 100,000 in Myanmar to 6 per 100,000 in Singapore. Access to health care services provided by skilled professionals, especially in antenatal care, have a strong impact on reducing maternal mortality and improving mother's and child's well-being (ESCAP 2015, 36).

Afghanistan has reported improvements in regards to health care services for women. The government's commitment to the increased provision of health services has resulted in better access by a factor of ten between 2001 and 2015. Women's life expectancy increased from 45 to 62 years, and the maternal mortality rate decreased fivefold, but it still remains one of the highest worldwide. Child mortality also decreased significantly due to better services. A food for education programme by the World Food Programme helps children in instances of food deficits (World Food Program 2015). Care services have also been developed for female drug addicts (Islamic Republic of Afghanistan 2014; Save the Children 2012).

The Lady Health Workers Programme (LHWP) in Pakistan is a public sector initiative designed to provide reproductive health care for women. Its home visiting services deliver basic maternal and child health services, facilitate registration of births and deaths, distribute medicine and expand on other national health initiatives (Zhu et al. 2014). Furthermore, the programme provides nutrition education and supplementation, psychosocial support and other services relevant to childcare. Apart from the health benefits it provides for women and children, and time-savings for caregivers, it also offers employment opportunities for more than 100,000 women and has had a positive impact on health workers' decision-making, women's mobility patterns and gender norms at large (Green 2013). Maternal and infant health increased significantly, with the positive impact of the programme being the greatest among poor families (Zhu et al. 2014). Though a successful programme, job security and salary payments for workers have been problematic, resulting in protests and campaigns. A further challenge is the irregular supply of medication and equipment (Zhu et al. 2014).

Another example of improvements, but also problematic policy implementation in maternal and child health, can be found in the Philippines. Though there have been improvements in child health, the country's maternal mortality ratio reduced at a slower pace and even increased in 2011. The Philippines missed the Millennium Development Goal 5 of reducing the maternal mortality ratio by 75 percent (Philippine Commission on Women 2015, 5). The country enacted the Responsible Parenthood and Reproductive Health Law in 2012, after

13 years of negotiations in parliament. It has been in force since 2014 and guarantees universal access to all methods of family planning, fertility management, sex education and maternal health care, which is urgently needed. Implementing the law is challenging, in particular due to opponents within society and problems reaching the poorest women (Philippine Commission on Women 2015, 15).

Demographic transition and ageing are challenges in a number of Asian countries, especially Japan and China. Policies for elder care need to be improved to cover the increasing demand for care services. Japan offers universal, nationwide elder care provisioning in public institutions as well as through home-based care services (Scheil-Adlung 2015, 31). The government has also enacted the Act on Arrangement of Relevant Laws for the Promotion of Overall Security of Local Medical Care and Long-Term Care (Japan n. d.). Japan has also introduced »time credits« for providing care for older people. Fureai Kippu, »ticket for a caring relationship,« is a system of mutual support networks that emerged from urban grassroots mutual-help groups, such as the Help of Daily Living Association in Tokyo and the Kobe Life Care Association. Through Fureai Kippu, people offer care to elderly or disabled people in their homes, bringing them meals and helping with shopping. In return, the caregivers receive electronic tickets in a computerized savings account. They can save these Fureai Kippu for their own future use or transfer them to a person of their choice, typically a parent or other family member. The system helps older people avoid or postpone moving to an expensive retirement home and improves their quality of life (Hayashi 2012).

Unlike Japan, China had very little state provision of elder care until 2009 (Scheil-Adlung 2015, 31), only providing public support for elderly persons without children, incomes or relatives (the »three no's«). Since then, there has been an increase in the provision of elder care homes by the private sector, mainly in urban areas (Feng et al. 2012). Yet care is mainly provided under vulnerable conditions by rural, migrant women, whether from the community, private or state run institutions (Rao 2016). In rural areas, elders often have important roles as caregivers: at the beginning of the 2010s, 38 percent of children are taken care of by their grandparents, because their parents have migrated to cities for work (UNFPA 2012, 35).

Care-relevant Infrastructure

Asia and the Pacific have seen a range of improvements in the provision of infrastructure, in particular those relevant to women's unpaid care and domestic work, such as access to drinking water, sanitation and hygiene. Despite the progress made, some 663 million people worldwide still use unimproved drinking water sources, one-fifth of them in South Asia (UNICEF and WHO 2015, 7). Also, despite the generally better development of infrastructure in Asia compared to other developing regions, the World Bank rates the infrastructure gap in South Asia at 2.5 trillion US dollars (Andrés, Biller and Herrera Dappe 2013).

There are vast differences in infrastructural development within the region. Afghanistan, Nepal and Bangladesh, for example, have very low levels of infrastructure provision. Sri Lanka and the Maldives on the other hand are more advanced (Andrés, Biller and Herrera Dappe 2013). Afghanistan or Nepal have a different starting point in the (re)construction of their infrastructure due to violent conflict and protracted crises. Access to improved sources of drinking water in Afghanistan has, however, increased by 54 percentage point since 1990, from covering 1 percent to 55 percent of the population (WHO, JPM and UNICEF 2015a, 3).

Now standing at 27 percent, coverage of improved water sources has increased significantly in East Asia. Since 1990, access has increased in South and Southeast Asia by 20 and 19 percent, respectively (UNICEF, WHO 2015, 7–8). There are differences in the challenges of water provision in urban and rural areas. In many cities of Southeast Asia, only about 50 percent of the urban population has access to piped water connections (McIntosh 2014, vi).

Viet Nam has progressed in urban water supply through corporatization, full cost recovery and connection fee waivers. The state invests heavily in the water and sanitation sector, and between 1990 and 2012 increased access to drinking water by 33 percent, to 98 percent in urban areas and 94 percent in rural areas. In 2009, the government introduced the socialization, or equitization, of water supply companies (Canales Trujillo, Xuan Nguyet Hong and Whitley 2015, 12). The outcomes of these policies, however, are uneven, as there are vast differences in improvements and availability of infra-

structure and services between urban and rural areas (UN Women 2016a).

In Cambodia, the publicly owned Phnom Penh Water Supply Authority has been running Clean Water for Low-Income Families for more than ten years as part of the government's poverty-reduction policy. The programme has significantly reduced the cost of water for more than 30,000 poor households and contributes to time savings for the women and children in those households (Kingdom of Cambodia 2013).

An Asian Development Bank report on women's time use and infrastructure found that Sri Lanka's Third Water Supply and Sanitation Project facilitated women's tasks of fetching water and increased the time at their own disposal. The project evaluation found that 82 percent of respondents found it easier to collect water after the project, and 57 percent increased their monthly incomes due to the time saved in water collection and its reallocation to income-generating activities. A further improvement from the project was a significant reduction in waterborne diseases among the beneficiaries (Asian Development Bank 2015, 12).

A water supply project in Vanuatu had a significant impact on the reduction of the burden of unpaid care and domestic work on women, in particular leading to qualitative improvements in childcare. Women stated that due to the improved water supply, they could reallocate more time to childcare, which in turn had a positive effect on children's health. The project was highly valued not only by the women, but also by men who increasingly supported women in hygiene- and cleaning-related tasks in the home (Willets et al. 2010). According to the Asian Development Bank, there is little data or analysis available on infrastructure and time use in the Pacific other than this study on Vanuatu (Asian Development Bank 2015, 12).

Sanitation also figures high up on infrastructural development agendas in Asia and the Pacific, and like water, sanitation has a strong impact on women's unpaid care and domestic work, the well-being of women and those with care needs. In South Asia alone, 953 million people do not use improved sanitation facilities. Though there have also been significant improvements in many countries, progress varies across regions. In South Asia, use of and access to improved sanitation facilities doubled

from 22 percent in 1990 to 47 percent in 2015 (UNICEF and WHO 2015, 13).

In Bangladesh, sanitation poses a challenge due to the continued strong increase in urban populations, and environmental precariousness. The capital of Dhaka is growing by 500,000 people every year due to economic push and pull factors, in particular due to employment opportunities in Dhaka's garment industry. This population growth challenges the city's infrastructure, especially its water and sanitation systems. Due to regular flooding, there is also a constant danger that latrines and other facilities will lead to a spread of disease. The organization Water and Sanitation for the Urban Poor (2016) has built improved and elevated sanitation facilities in the city and has helped to mobilize funder support and city sanitation management. Government investment in improving sanitation facilities increased the provision of toilets, helping make good overall progress (WHO, JPM UNICEF 2015a, 6). In 2014, only 3 percent of households had no toilets, compared to 11.3 percent in 2005 (People's Republic of Bangladesh 2014, 23).

Social Protection and Care

Social protection systems — including social transfers, public works, social security and universal health care — contribute to a basic level of economic and social well-being for all. Among Asian and Pacific countries, the coverage and diversity of programs varies widely. Central Asia, rated in the same category as Latin American and the Caribbean and Eastern Europe, has a high diversification of programme portfolios, whereas diversification is lower in East Asia and the Pacific. Social protection and care programs cover about 1.9 billion people around the globe, a high number due in part to very large programmes in China and India (World Bank 2015d).

Cash Transfer Programmes

A number of Asian and Pacific countries have long experiences with social protection programmes. Many target vulnerable sections of the population like poor and rural women. There are a range of health-related cash transfer programmes directed towards pregnant and lactating women (Jehan et al. 2012; ESCAP 2014, 36) that

have an impact on women's unpaid care and domestic work due to recognition of their needs and the time- and money-saving potential.

Nepal has a long history of social protection schemes and civil society engagement to improve their design and implementation. Schemes in place include allowances for single women, elderly people, widows, the disabled and indigenous groups, as well as child grants, scholarships for members of disadvantaged groups and various employment programmes (Koehler 2011; Nesbitt-Ahmed and Chopra 2014). The government augmented its expenditures for social protection programmes from 0.5 percent of GDP in 2004 to more than 2 percent in 2009, with a strong increase after the 2006 peace agreement (Das 2011). This is remarkable, as developing countries normally spend around 1.6 percent of GDP on social protection (World Bank 2015d, 21). The lack of an overall strategy, weak institutional capacity at the central and local levels and lack of access to more inclusive public goods and services affect the effectiveness, delivery and accessibility of social protection measures in Nepal (Nesbitt-Ahmed and Chopra 2014).

India has a variety of transfer schemes designed for the poor, with a focus on women. Transfer programmes include the Rural Housing Scheme, which gives priority to unmarried women and widows, and the Indira Gandhi National Widow Pension Scheme (IGNWPS), for widows living below the poverty line (Republic of India 2015, 26). The National Family Benefit Scheme provides an unconditional cash transfer upon the death of a family's primary breadwinner.

Several Indian cash transfer schemes focus on pregnant and lactating women. The conditional maternity benefit of the Indira Gandhi Matritva Sahyog Yojana programme provides cash incentives to improve the health and nutrition of pregnant and nursing mothers. The scheme attempts to compensate part of women's income loss due to pregnancy and after birth. It was implemented on a pilot basis in 53 selected districts using the platform of the ICDS. Women have to register their pregnancy at an Anganwadi centre to become eligible, and conditionalities include exclusively breastfeeding their child for six months. Government and public sector employees are excluded from the scheme, as they are entitled to paid maternity leave (Republic of India 2015). Despite the increasing use of maternal health services, critiques

indicate that there is no proven evidence for improved maternal health outcomes for the programme, as they do not substantively relieve the causes of the inequalities that lead to women's poverty and malnutrition. Furthermore, capacities to reach the poorest women, in particular in rural areas, is lacking (Jehan et al. 2012). Positive impacts are also often hampered due to the scant skills and lack of empathy of public health services providers, overburdened health workers and shortages of essential drugs (Fultz and Francis 2013, 21).

Bangladesh piloted a maternal health voucher scheme in 2004 to reduce the demand-side barriers of poor women to health care. The vouchers provide free access to antenatal care, safe delivery care, emergency care in case of obstetric complications and postnatal care. The transfers are implemented through comparably generous cash subsidies that include transport costs to health care facilities and emergency transportation. Women are only eligible for the vouchers for their first and second births and only if they practice family planning between the two births (Nguyen et al. 2012). About 522,000 women had benefited from the programme by 2014. The scheme had positive impacts on poor women's and children's well-being, and there has been a decrease in stillbirths and increased health facility visits (Van de Poel et al. 2014; Center for Health Market Innovations 2016).

The voucher scheme originated with a range of operational problems. First and foremost, vouchers do not increase the quality of services, and guaranteeing good quality care was a major challenge to the potential impact of the voucher scheme. Further challenges included enforcing the criteria of poverty, practicing family planning between the first and second child and issues with timely reimbursements for the providers and disbursements for the women. In addition, the supply-side investments have not kept up with increased demand, resulting in long waiting lines, poor provider attitudes and medication shortages (Nguyen et al. 2012).

The Philippines has progressed on gender equality and is listed among the 10 most gender-egalitarian countries, as measured by the Social Institutions and Gender Index and the Gender Development Index (Philippine Commission on Women 2015, 1). Yet, poverty remains a hard-to-solve issue in the Philippines and has a gendered dimension, as women are over-represented in

vulnerable forms of paid as well as unpaid work (Philippine Commission on Women 2015, 23). To reduce poverty, three major social transfer programmes have been put in place.

The National Community-Driven Development Program aims for the comprehensive and integrated delivery of social services. It is a community-driven development programme that seeks to empower through enhanced participation in local governance and in community-driven development projects. It provides funding for community-identified and -driven infrastructure projects, such as school buildings, health centres, farm-to-market roads, foot-bridges and water systems. The Conditional Cash Transfer Program is a rights-based programme for poor households, focusing on human capital investment through the provision of health, nutrition and education. Poor households with children 0–18 years of age and mothers, especially those pregnant or lactating, are eligible. Almost all beneficiaries are women. The CCT programme seeks to enable poor households to meet certain human development goals and break the intergenerational cycle of poverty. Programme evaluation showed that the intervention provided women with additional income to cover the family's basic needs and alleviated some of their care work burdens. It empowered them and increased their financial independence from their husbands. The programme has increased the number of women accessing prenatal and postnatal care and health care for their young children, in particular in regards to monitoring, immunization and periodic check-ups. The Sustainable Livelihood Programme provides capital assistance and capability building for income-generating programmes. Half of the beneficiaries who participated between 2011 and 2013 were women (Philippine Commission on Women 2015, 10).

Fiji, a middle-income Pacific state, has a range of social protection programmes to address poverty and inequality, in particular, to reach universal primary education, reduce child mortality and improve maternal health. Ramping up its social protection programmes in 2012, Fiji introduced a comprehensive range of measures aimed at the poorest 10 percent of households. Among the initiatives introduced was a poverty benefit scheme, an old-age pension scheme, a child protection allowance for single mothers and a food voucher programme for pregnant mothers (Chand 2015). Fiji further

improved its programmes and added such components as transportation for elderly and disabled persons, tuition-free education for children aged 1 to 13 and tuition waivers for pre-school and technical and vocational education. Eligibility criteria for social protection include an annual income threshold, a level of benefit capped per month, and a maximum of four family members who can receive support for up to three years (Chand 2015). The Care and Protection Allowance, a relatively new component of the social protection programme, reaches out to children-specific familial categories, mainly single-parent and prisoner-dependent families, and foster families living in poverty (UNICEF 2015a). UNICEF rates the Care and Protection Allowance an important income contribution to poor families, but there are challenges in its implementation. Yet, the budget allocated to the Care and Protection Allowance is underspent and the cash transfer only reaches a small number of eligible recipients (UNICEF 2015a).

Afghanistan suffers from widespread poverty, including food insecurity that affects about 7.6 million people. One in five women of childbearing age is underweight (WFP 2015). Responding to the needs of a population affected by the complex, protracted crisis and environmental challenges, the government of Afghanistan launched social protection initiatives, including a pilot safety net programme. Operated by the Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD) and funded by the International Development Association, the Safety Net Pilot Programme provides unconditional cash transfers to selected high-risk groups to increase food security during the most difficult period of the year. The transfer size is determined by the food poverty line. The amount of the transfer, however, is too small to impact nutrition standards (Save the Children 2012).

With strong support from donors, the government of Afghanistan has installed the Martyrs and Disabled Benefit Programme, the largest national cash transfer programme in the country. It accounts for about 0.2 percent of GDP and provides unconditional cash benefits to the families of martyrs (war victims) as well as individuals with war and landmine-related disabilities (Save the Children 2012). According to the World Bank the programme was updated broadening its target population to the poorest families. It aimed to reach 265,000 beneficiaries by 2014 (World Bank 2015d, 88).

Yet despite this programme a range of challenges remain. Of an estimated 700,000 widows in Afghanistan (United Nations Assistance Mission in Afghanistan 2011), a few hundred receive financial aid from the government (Islamic Republic of Afghanistan 2014, 20), and most widows do not get support (Carter 2015). Afghanistan's public spending depends heavily on donors, and as a consequence state-funded social protection only reaches a small amount of beneficiaries. Non-state actors fill the gaps of service provision, but with little coordination, bypassing the government and achieving limited effectiveness (Save the Children 2012, 3).

A problem for local NGOs and governments in poor countries such as war-affected Afghanistan is their dependency on donor funding. The Afghan case is telling in this respect. Social protection coverage is inadequate, and the number of households at-risk of poverty is high. Donor-funded programmes, however, are often of small scale, have limited coverage and tend to focus on rural areas, where informal social protection mechanisms prevail. Increasing social protection coverage requires long-term domestic financing strategies complemented where necessary by long-term funding commitments from donors. Poor countries' heavy dependence on donor support makes longer-term planning difficult, as strategies must constantly be realigned with changing donor priorities. Despite these challenges, such organizations as Save the Children recommend that donors continue to provide social protection where war, poverty and other challenges make this necessary. Donor aid and social transfer programmes are effective policy tools to combat hunger and malnutrition (Save the Children 2012).

Public Works Programmes

Public work programmes are particularly prominent in lower-income countries, and among these countries' populations, they provide cash and in-kind income opportunities for the poorest segments of the population. Public works programmes are frequently implemented in poor countries in South Asia (World Bank 2015d, 10).

India's Mahatma Gandhi National Rural Employment Guarantee Scheme is among the biggest public works programmes in the world, reaching out to 58 million people, about a quarter of all rural households in India

(World Bank 2015d, 10). It entails a legislated right to work for a total of 100 days to adult persons volunteering to do unskilled labour. If the state fails to provide work, it is required to pay unemployment allowances (Fultz and Francis 2013, 10). The programme is mandated under the National Rural Employment Guarantee Act (NREGA), which targets particularly marginalized groups, including women, and aims at local development through building infrastructure. Unlike many public works programmes around the world, it recognizes women's unpaid care and domestic work and has a tailored component on childcare provision for working women. Day care services are not sufficiently provided, however, and are often of questionable quality. This sometimes leads to women withdrawing from public work projects (Rao 2016). On the positive side, wages are higher than market wages, in particular for women (Zimmermann 2014, 7), and evidence shows that women working in public works projects make use of the generated income for improved health care for themselves and their families, often in private clinics (Fultz and Francis 2013, 21). One challenge posed by project implementation is their susceptibility to corruption. Critiques also raise the fact that programmes are rarely fully implemented in practice (Fultz and Francis 2013, 11), and where it is, it is often insufficient to make a difference (Rao 2016). Still, NREGA is credited with raising 60 million rural residents above the national poverty line (Fultz and Francis 2013, 16).

Nepal also has expanded its public works programmes. The Karnali Employment Programme (KEP) was launched in 2006 and based on the Indian NREGA model, with the aim of creating rural employment and enhancing infrastructure development in socially and economically disadvantaged areas. This »one family, one job« programme — i. e., its only open to one person in each household — offers social protection through short-term employment, thereby creating and preserving social and economic assets. The programme consists of paid employment granted for 100 days at 180 to 530 rupees per day. KEP aims at including identified groups of all castes, but is weak on women and youth employment (Koehler 2011, 12). The performance of KEP has been mixed. An evaluation pointed to limited employment creation, bad quality of work and low payment to recipients. Women's participation improved from 23 percent (Interactions n.d.) to numbers almost equal to those of men (Beazley 2014).

Afghanistan has several food-for-work and food-for-assets programmes, which are a means of transferring resources through temporary employment generation. The programmes target members of poor households while at the same time building or repairing local infrastructure and community assets (Save the Children 2012). Afghanistan also runs the National Skills Development Program, which provides training in different marketable vocational skills to a range of vulnerable groups. At least 35 percent of beneficiaries are required to be women from chronically poor, female-headed households with small children. Nutrition promotion modules are included in training programmes (Save the Children 2012). Afghanistan also runs the Horticulture and Livestock Project, which is funded by the World Bank. A key component of it is the Backyard Poultry Project (2009), which trains largely women in rural villages to increase poultry and egg productivity to improve nutrition while also reducing poverty. The project also has a dairy production component that targets women and is designed around local dairy cooperatives to improve household food security and income (Save the Children 2012).

Public works programmes are particularly used to support vulnerable populations dealing with shocks, for example after natural disasters (Zimmermann 2014). An emergency public works programme was established subsequent to cyclone Nargis, which struck Myanmar in 2008. The Emergency Livelihood Project introduced practical community-based, early recovery projects that served as a basis for temporary employment, training and income generation in the storm's aftermath. It also contributed to the reconstruction of basic infrastructure, especially for transport (ILO 2009). Female participation stood at about 39 percent in the pilot phase, but declined to 30–25 percent in the actual project. This was largely due to norms related to forms of work and divisions of labour (ILO 2009). Detailed accounts on the impact on women's unpaid care and domestic work is not available.

Labour Policies and Care

Advances in formal labour policies, including maternity protection and leave policies, have been achieved in many Asian and Pacific countries, with of course differences in availability and implementation. Papua New Guinea for example is one of two countries in the world

with zero days of paid maternity leave (ILO 2014b, 19). Overall, however, more women are benefiting from labour policies. Women's shift from inactivity to wage and salary employment has been particularly remarkable in Eastern and Southeast Asia and the Pacific. In East Asia, the shift of women to wage and salary work doubled from 26.3 percent in 1995 to 55.3 percent in 2015. In Southeast Asia and the Pacific, the share of women in wage and salary work rose from 30.4 percent in 1995 to 40.2 percent in 2015 (ILO 2016b, 9).

A unique case of advancing labour policies is Viet Nam. The country rose to become a middle-income country around 2011 and reduced its poverty rate from 58.1 percent in 1993 to 9.6 percent in 2012. In 2013, it had a female labour force participation rate of 73.2 percent, one of the highest in the region (UN Women 2015d). Effective gender mainstreaming resulted in a range of changes in the fields of employment and labour law (Socialist Republic of Viet Nam 2014, 4). In 2013, a number of provisions were made for female workers, including an increase in maternity leave to six months, the longest in Asia. According to the ILO, leaves that are too short make women drop out of the workforce due to their concerns over their child's welfare. Too long periods, on the other hand, hinder women's attachment to and advancement in paid work and may lead to discrimination against female workers. The challenge of reaching informal workers remains. Maternity leave policies only cover about 30 percent of the workforce because of the predominance of women engaged in the informal sector, including agriculture (ILO 2014a).

Viet Nam introduced a paternity leave policy in 2016. It grants male employees five days of paternal leave, which can be extended to 14 days if the child is born early or in other circumstances, such as the mother have a C-section. Furthermore, in cases of adoption, one parent receives paid leave until the baby is six months of age (Vi 2015).

Mongolia is known for a range of gender-egalitarian policies. This is reflected in its top rankings in the category of economic participation and opportunity in the Global Gender Gap Report (Begzsuren and Aldar 2014, 20).²⁶ Offering 120 days of leave at 70 percent of former earn-

26. Indicators include the labour participation gap, the remuneration gap and the advancement gap (World Economic Forum n. d.).

ings, Mongolia has one of the longest maternity leave policies in Asia (ILO 2014b). A father is entitled to five days of paternity leave as an unwritten administrative provision, rather than law or policy (Dugarova 2016, 23). Mongolia is also one of three Asian countries that grants parental leave of up to 156 weeks (ILO 2014b, 154).²⁷ Yet, women's responsibilities for unpaid care work, insufficient provision of childcare facilities and a range of social rights are significant factors that hinder women's full participation in the labour force. Free or affordable childcare is scarce due to inadequate provision of such services. This restricts women's opportunities to re-enter the labour market after having children (Begzsuren and Aldar 2014, 21).

In economically strong Asian countries, measures are in place to promote women's participation in paid work and gender equality. In the Republic of Korea, maternal leave paid at 100 percent is granted for a period of 90 days. Furthermore, the country has a parental leave policy that grants leave paid at 40 percent of previous earnings for up to one year in total to care for children aged 6 and younger (ILO 2014b, 64). There are some dilemmas women face that hamper the implementation of these labour policies.

A survey showed that pregnant women fear discrimination if they take maternity leave. As a result, a third of them decide not to take it (ILO 2014b, 74). Further challenges include a patriarchal corporate culture that demands long working hours from employees, which often discourages women from continuing to work during pregnancy and after childbirth. Often women's jobs are not secured after maternity leave, and the glass ceiling still persists for women. Care is predominantly considered a private issue, for the women, and public childcare facilities are insufficient to facilitate women's equal access to paid work (APWLD 2014, 12).

Mobilization Around Care

Whereas feminist activists have been consistently and successfully mobilizing around violence against women, political participation and other issues, the thematic of unpaid care work has not been a high priority on the

agendas of women's movements in Asia and the Pacific. There is not always agreement within the movements about the political importance and priority of recognition, redistribution and reduction of unpaid care work by women to their agendas. According to Rao (2016), this could be an issue of strategic framing, as problems such as violence against women or political participation have a greater potential to raise attention in the political and public domain. Nevertheless, there are a number of organizations that push for issues surrounding the unpaid care burden of women, and care is quite well articulated by movements in Asia and the Pacific.

A historical moment that raised the issue of women's unpaid care and domestic work and its significance on the agendas of women's movements marked the context of Beijing+20 reviews and debates about Agenda 2030. The international feminist advocacy organization ISIS International raised its voice and criticized the dominant development model as reliant on women's unpaid social reproductive work to cover cuts in public services and women's un- or underpaid care work to meet the demands of the care economy, fulfil the requirements of trade agreements and balance states' economies. The group, therefore, demanded a gender-sensitive labour policy applicable regardless of migrant status and that provides full rights for workers according to ILO core labour standards. Such a policy should value the essential role of low-wage labour by paying living wages, ensuring access to social protection for all (ISIS International 2014b). Furthermore, they pushed for governments to expand means of social protection and market regulation to address social inequalities, especially in uncertain times, such as global financial meltdowns, conflicts, natural disasters and the growing effects of climate change (ISIS International 2014a).

Another noteworthy network is the Asia Pacific Forum on Women, Law and Development, the biggest network of feminist organizations and advocates in the region. Women's rights organizations and movements from Asia and the Pacific gathered at the Asia Pacific Beijing+20 Civil Society Forum in Bangkok, 14–16 November 2014, to call for government accountability for the commitments made on the Beijing Plan for Action. The 480 women participants raised a range of concerns and priorities for women in the region regarding implementation of the Beijing Plan for Action and the post-2015 development agenda and beyond. Apart from general claims for women's rights in regards to information, ed-

27. Of the countries studied, only Mongolia, Korea and Nepal had parental leave provision in 2013 (ILO 2014b, 64).

education and fighting violence against women, the forum made strong claims for care and interrelated policies — involving infrastructure, health and other services — supported by all of its five regional sections — the South Asian, East Asian, Pacific, Southeast Asia and Central Asian Caucuses (APWLD 2014).

The South Asia Caucus emphasized concern about violence against women in its many forms, including acid violence, dowry violence, honour killing, human trafficking and witch hunting, all indicators of discrimination against women. The caucus stressed the interplay of these forms of violence with rising religious fundamentalism and extremism. In addition to apprehension over forms of violence, the South Asia Caucus raised concern about neoliberal economic policies with externalities that include degradation of the natural environment, and retrogressive laws. This complex analysis of the interplay of economic, social and cultural dimensions by the caucus concluded that women and girls bear the burden of unsustainable economic growth. The consequences are large-scale economic displacement and disempowerment of women, disruption of the social fabric and increased burden of work, including unpaid care work. According to the South Asian Caucus, the feminization of poverty had increased disproportionately in South Asia due to the implementation of macroeconomic policies and withdrawal of the state from its responsibility in the core social sectors. The caucus explicitly demanded that states commit to recognizing, reducing and redistributing women's unpaid care and domestic work and to ensuring access to full employment, decent work and social protection floors for all (APWLD 2014, 11).


The East Asian Caucus recognized that much was being done and achieved, in particular in China, Korea and Japan, in regards to gender equality. The caucus highlighted the need to strengthen government linkages with civil society and pointed to persisting challenges in achieving gender equality due to patriarchal corporate culture. Such a culture is not conducive to gender equality, as it demands long working hours and prevents women from continuing work during pregnancy and after childbirth. Women's jobs are not secured after maternity leave, and the glass ceiling for women persists. In addition to the inequalities and discrimination that women face in the formal economy, women continue to be the primary caretakers of the family, including children, the sick and the elderly. This is problematic, according to the

caucus, as women bear the burden of the unpaid work regardless of whether they are active in the labour force (APWLD 2014, 12–13).

The Pacific Caucus did not have explicit claims in regards to women's unpaid care work. It highlighted the high levels of violence against women and climate change, which negatively impact women's rights and lives. The caucus emphasized that violence against women is a deep-rooted problem in many countries of the Pacific. Also problematic is the instability of governments, coupled with the dominance of corporations and extractive industries. The caucus called on governments to take action on furthering women's political participation, access to sexual and reproductive health and rights and climate change and disaster risk management, which have strong negative effects on women's livelihoods (APWLD 2014, 14).

The Southeast Asian Caucus raised urgent issues related to poverty, women's health, sexual and reproductive rights, access to justice and the rise of religious fundamentalism, among others. The caucus recognized the need to work with national and international mechanisms and institutions to enhance gender equality (APWLD 2014, 14). The Central Asian Caucus recognized states' political commitments to gender equality and women's rights. States have ratified international conventions and reformed domestic laws, but gaps remain in the realization of women's rights within the Central Asian subregion. Political will has not translated into implementation, financing and accountability. The caucus called on governments to continue to support national gender equality plans, in particular in regards to women's full participation in decision-making, ending violence against women and girls, women's economic empowerment and entrepreneurship (especially those in rural areas) and adequate funding for intergenerational social, cultural, development, environmental, economic, civil and political rights and justice. The caucus also called on governments to ensure women's access to water, sanitation, energy and other services and infrastructures, in particular in the context of climate change and for disaster risk reduction (APWLD 2014, 14–15).

Apart from women's movements, child rights activists have been mobilizing for care. In regards to India, Rao (2016) emphasizes the role of the Alliance on Right to



ECD and the Forum for Crèches and Childcare Services (FORCES). The activists have voiced demands for recognizing women's unpaid care work quite strongly, albeit from a child right's perspective. At centre stage of their agenda is children's care and well-being. Some international movements also have unpaid care work on their agenda in Asia and the Pacific. ActionAid does work on awareness and training on the topic of unpaid care work in a range of countries. Its goal is to generate knowledge, creating awareness about the necessity for women to raise their voices and take action to claim their rights and free them from the burden of unpaid care work. ActionAid conducts workshops in Viet Nam, Nepal and a range of other countries (ActionAid 2015).

In short, mobilization for care is visible in documents of women's movements and even policy documents of the Asian and Pacific subregion. Women's movements in Asia and the Pacific have care explicitly or implicitly on their agenda formulated with different words and articulated in the context of criticizing economic policies, state priorities and human rights. A Global Care Advocacy Workshop was held in early 2015 in Bangkok. Organized by the Asia Pacific Forum for Women Law and Development, ActionAid International, Helvetas Nepal and the Institute of Development Studies, it aimed at mapping national initiatives and connecting to global advocacy opportunities, identifying key strategies and targets for a collective agenda on care work and women's labour rights and outlining key next steps and possible collective advocacy actions. Although not much information on the participants and outcomes is available, it indicates that the Asian and Pacific women's movement is a suitable context for hosting care debates, and for mobilizing their national, regional and international contacts to raise the visibility of care.

Latin America and the Caribbean

Context

Latin America and the Caribbean is a region still characterized by high income inequality. The ratios of income inequality measured with the Palma Ratio range from 21.4 in Honduras to 6.6 in Uruguay, the region's least unequal country (ECLAC 2015c, 14).²⁸ Measured by the same indicator, inequality declined slightly in the region as a whole, from 15.6 to 14.0 between 2010 and 2014. Despite this decline, the per capita income of people in the richest decile was still 14 times that of those at the bottom four deciles (ECLAC 2015c, 13). The Gini coefficient tells a similar story: it fell from 0.507 in 2010 to 0.491 in 2014, i.e., at a yearly rate of -0.8 . The largest reductions were observed in Uruguay (-2.7 percent a year), Argentina (-2.3 percent) and Ecuador (-2.2 percent).

Latin America as a whole had a poverty rate of 28.2 percent and an extreme poverty rate of 11.8 percent in 2014. Poverty rate had fell in the great majority of the countries during the period 2010–2014 as a result of rising household incomes, with the largest declines in Uruguay (at an annual equivalent rate of -14.9 percent), Peru (-9.8 percent), Chile (-9.1 percent) and Brazil (-7.9 percent) (ECLAC 2015c, 11).²⁹ Improvements in living conditions have been the result of better labour market indicators supported by anti-poverty policies, including cash transfer programmes, and by a sustained expansion of public social spending (ECLAC 2015b, 9).

Economic performance in Latin America has been lower than the global average and previous years, exhibiting an increase of only 1.2 percent in average GDP growth in 2014, the poorest economic performance since 2009 (ECLAC 2015c, 9). Despite the economic slowdown, the unemployment rate decreased from 6.2 percent in 2013 to 5.9 percent in 2014 (ECLAC 2015c, 9). Where the economy weakened, deterioration in the labour markets

led to rising employment in informal, low-productivity sectors (ECLAC 2015a, 12). Informal employment is still a significant share of non-agricultural employment in Latin America, ranging from 40 percent in Uruguay to 75 percent in Bolivia (ILO and WIEGO 2013, 8).

Calculated as share of GDP, total public spending rose from 12.6 percent in the early 1990s to 17.8 percent in the mid-2000s and 19.5 percent in 2014 (ECLAC 2015c, 21). The gradual increase in social spending included in particular old age-related social security. Most often, financial sources stemmed from contributory social security systems, but solidarity mechanisms were introduced that led to an increase in GDP spending for pensions. The other notable increase in social spending was in the education sector. Many countries, particularly the poorest, increased coverage and access to primary education, while in other countries, spending on secondary and post-secondary education increased (ECLAC 2015c, 21–22). This is reflected in educational attainments. By 2013, 92 percent of the population aged 15–19 had completed primary education, and the proportion of young people of secondary school-leaving age who had in fact completed the secondary level rose from 37 percent in 1997 to 58 percent in 2013 (ECLAC 2015c, 15).³⁰ Yet, as a result of the slowdown of Latin American economies, fiscal revenue constraints emerged, reducing the scope of social spending. Financing of social policies in the future will require new sources of financing and mechanisms to support programmes to expand social protection, education and health care and care services (ECLAC 2015c, 21).

Poverty and income inequalities affect gender inequalities, particularly in terms of labour market indicators. The more vulnerable the households in which working-age people live, the broader the gaps between men's and women's labour force participation rates. The poorest women struggle the most to enter labour markets, and in turn, this is a key obstacle to women's efforts to exit poverty (CEPAL 2015b, 29). In 2013, the regional female unemployment rate (7.2 percent) remained higher than the male rate (5.3 percent), and women were more likely

28. Inequality is analysed here by the proportion of income received by each different group. Two groups in particular are considered — the lowest-income 40 percent of households and the highest-income 10 percent, corresponding to deciles 1 to 4 and decile 10 of the per capita income distribution, respectively (ECLAC 2015c, 13).

29. For the same period, the poverty rate rose in Venezuela (4.9 percent), Mexico (2.9 percent) and Honduras (2.3 percent) and remained unchanged in Costa Rica (ECLAC 2015c, 11).

30. The two sectors with the least increase in social spending were housing (including water and sanitation) and health (ECLAC 2015c, 21–22).

to be unemployed than men across all socioeconomic strata (ECLAC 2015c, 30). Also, 54 percent of all women employed in non-agricultural employment were informal, as compared to 48 percent of men (ILO 2016b, 11). Women employees were overrepresented among paid domestic workers, who typically get low remunerations and meagre social protection (ILO 2013b, 25).

Demographic transition in Latin America and the Caribbean is presently characterized by a working-age population that is growing relative to the dependent section of the population, a phenomenon called a demographic bonus (Coelho Fernandes 2016). This decrease of the dependency ratio is, however, expected to change after 2019. Of all the regions in the Global South, Latin America and the Caribbean will experience the fastest growth in population of persons aged 60 and above, with an anticipated 71 percent increase over the next 15 years (UNDESA 2015b, 1). With 25 percent of the population, Latin America and the Caribbean will have the highest share of older persons of all the regions in the Global South (UNFPA 2012, 13). In many countries of Latin America and the Caribbean, older persons are over-represented among the poor (UNFPA 2012, 41). Compared to other regions of the world, however, 55 percent of the elderly poor receive some form of pension.

Latin America and the Caribbean is one of the regions that has advanced impressively in regards to the health of its population. Specifically, it reduced rates of infant and child mortality, and increased maternal health and overall life expectancy between 1990 and 2015. By 2013, it had reduced the mortality rate of children under age 5 by two-thirds. In 2015, the infant mortality rate was the second lowest in the developing world, with 15 per 1,000 live births (ECLAC 2016, 52). Health, however, is another dimension in which access is uneven and unequal across Latin America and the Caribbean. Health-related inequality manifests itself, for example, in fertility rates that are higher among indigenous women, and prenatal and maternal health care which is less accessible to them due to geographical, cultural and linguistic constraints (ECLAC 2016, 27). Rural areas are systematically disadvantaged in regards to access of services, including health and social protection (ECLAC 2016, 31), and there, poverty-related issues cumulate in such correlations as chronically malnourished children with low achievements in schooling (ECLAC 2016, 54).

Latin America has one of the highest rates of infrastructural development in the developing world: 94 percent of the population had access to electricity; 96 percent had access to improved water, and 81 percent had access to improved sanitation in 2011 (Andrés, Biller and Herrera Dappe 2013). Improvement in the region took place in the last 20 years from already high levels: It increased the supply of piped water from 73 to 89 percent and decreased unimproved water sources from 8 percent to 4 percent between 1995 and 2015 (WHO, JPM and UNICEF 2015a, 21). In 1990, shared or improved sanitation facilities covered 72 percent of the population, and in 2015 surpassed 90 percent of the population (WHO, JPM and UNICEF 2015a, 52). These developments mean care-related infrastructure if not a priority in Latin America, with the exception of rural and remote areas. For this reason care-related infrastructure will not be addressed here.

Policies, Frameworks and Challenges in Gender Equality

The advances in gender equality are many in Latin America, as reflected in the Beijing+20 regional review (ECLAC 2015b). Albeit to varying degrees, country reports show progress in women's political participation and women in leadership positions in all state spheres, a presence that has translated into some degree of gender mainstreaming. Bolivia, Brazil, Colombia, Chile and Cuba have had gender equality plans in their national development plans (ECLAC 2015b, 30). Anti-discriminatory laws are also in place across the region; some countries consecrate gender equality by law (Dominican Republic), and in others gender has become a recognized legal category, as in Argentina's gender identity law. There are several policies in place to counter violence against women, even if figures on violence, in particular on femicide, are worryingly high (PNUD and ONU Mujeres 2013; Small Arms Survey 2014). Twelve countries in the region have machineries for the advancement of women at the highest executive level (ministries and secretariats of state), recognizing their political role and allocating them budgetary funds, and eight others have some institutional framework in place, even if not sufficiently strong (ECLAC 2015b, 25, data for 2013).

In spite of the region's general improvements in poverty reduction, labour market indicators and social

protection coverage over the last decade, several of these indicators show biases against women. For example, with the exception of Panama, the reduction of poverty rates in all the other Latin American countries has been accompanied by an increase in the poverty femininity ratio (ECLAC 2015b, 33). Costa Rica, El Salvador and Paraguay have managed to substantially reduce gender wage gaps (ILO 2016b, 29), but they persist for the region as a whole, particularly among the least and the most educated (ECLAC 2015b, 42). The motherhood wage gap — between women who are mothers and women who are not — is particularly high, at around 20 percent in Mexico, Peru, Brazil, Uruguay, Chile and Argentina (ILO 2016b, 58).³¹ The expansion of non-contributory pension systems in the region that made it possible to extend coverage has indeed reduced the gender gap in pensions remarkably but has not eliminated it (ILO 2016b, 31; Arza 2015). As the ECLAC Beijing+20 report concludes, «When the situation of women is compared with that of men in the same socioeconomic, demographic and cultural category, women always appear at a disadvantage, and women living in poverty experience a concentration of the negative effects of all forms of discrimination» (ECLAC 2015b, 24).

This might well be the result of gender blindness in policy design — in particular in macroeconomic and labour market policy — but it is also related to the framing of gender mainstreaming in the region. As ECLAC notes, as many as thirteen Beijing+20 country reports address women as a «vulnerable group,» along with children, youth, indigenous peoples and persons with disabilities, which contributes to creating «an image of women as a vulnerable ›other« (ECLAC 2015b, 47).³² Also, country reports hardly address women's partaking in the labour market, focusing at best on regulatory aspects and remaining silent on labour force participation, sectoral segmentation and gender wage gaps. The emphasis is, in many cases, on microcredit as the way out of poverty,

31. ILO (2016b, 58) notes that methodological differences preclude pairwise comparability.

32. ECLAC (2015, 47) notes the language of the Rio+20 Declaration as an example of this umbrella group of vulnerables: «women, children, youth, persons with disabilities, smallholder and subsistence farmers, fisherfolk and those working in small and medium-sized enterprises» (paragraph 58(k)). In comparison, a review of Agenda 2030 shows progress in the language. Such lumping of women and broad vulnerable groups does not occur anywhere in the text. Mention is made of women as part of vulnerable groups (women in vulnerable situations, migrant women, small-scale food producers, etc.), «women and men» and of women's empowerment and gender equality.

under the assumption that it is the lack of credit that is keeping women in poverty (ECLAC 2015b, 48). These examples show that policies have focused on remedying unequal outcomes without challenging the structural causes of those outcomes, i.e., the current economic paradigm (ECLAC 2015b, 62; Esquivel 2016). The language of agency and empowerment and the intersectionality of gender inequality are far less prominent in the country reports.

Situating Care Policies

Care policies figure high on the regional agenda. Almost a decade ago, the agreed conclusions of the 10th Regional Conference on Women in Latin America, the Quito Consensus (ECLAC 2007), used language similar to the Beijing Plan for Action framework, as countries agreed to «adopt measures (...) to recognize unpaid work, its contribution to families' wellbeing and to countries' economic development» (Agreement xiv), but linked the measuring of unpaid care and domestic work, its visibility and recognition with the «design of economic and social policies» (Agreement xxiii).

The Brasilia Consensus, the result of the 11th Regional Conference on Women in Latin America (ECLAC 2010), goes even further, considering «care as a universal right, which requires strong policy measures to effectively achieve it, and the co-responsibility of the society as a whole, the state, and the private sector» (ECLAC 2010, 2). Indeed, the Brasilia Consensus proposed a detailed agenda for the redistribution of unpaid care and domestic work through care policies. In Brasilia, state members committed to the following:

- 1) Adopt all necessary social and economic policy measures in order to achieve the social valuation and recognition of the economic value of unremunerated work performed by women in the domestic and care sphere;
- 2) Foster the development and strengthening of care and universal services policies, based on the recognition of care as a right of all persons and the notion of shared delivery by the state, the private sector, the civil society, and the households, as well as between women and men, and to strengthen the dialogue and coordination of all stakeholders;

- 3) Adopt measures to establish or extend parental leaves, as well as absence permissions to care for sons and daughters, in order to contribute to the [re]distribution of care tasks between women and men, including non-transferrable paternity leave, in order to progress towards co-responsibility [of care].
- 4) Push for the establishment of unpaid care and domestic work satellite accounts within [the countries'] national accounts;
- 5) Push for changes in legal and programmatic frameworks that recognize the productive value of unremunerated work in the national accounts, in order to design and implement cross-sectoral policies;
- 6) Promote and contribute to pass legislation that makes labour rights of domestic workers equal to other [wage] workers, regulating their protection, promoting their work's social and economic value, and eradicating child labour;
- 7) Promote the ratification and implementation of ILO Convention 156 [Workers with Family Responsibilities Convention]. (ECLAC 2010, 2, original in Spanish)

The citation at length is worth the read, as the text is binding politically. The mixing of old and new language is evident. The Beijing Plan for Action concepts are still there (UN Women 1995), like »unremunerated work« and the emphasis on household sector satellite accounts. The relationship between the »accounting for women's work« project and the design of policies, already established in Quito, is also there (Esquivel 2011a). A novelty of the Brasilia Consensus, however, is that it adopts the Triple R framework, identifying care policies as a way of redistributing care, in particular universal care services and labour market policies (parental leaves and other provisions for workers with family responsibilities). The plight of domestic workers, prior to the adoption of ILO Convention 189, is also relevant in a region where more than 17 percent of women in employment are domestic workers (ILO 2013, 20). The text also frames care as a right, and mentions »shared delivery« of care services and »co-responsibility« in care provision.

This regional care agenda is clearly reflected in the Beijing+20 regional review report. It uses strong language on care, framing it within the Beijing Plan for Action's

progressive take on economics, emphasizing the linkages between the paid and unpaid work spheres and noting that »the biggest challenge, though, lies in redistributing dependent care responsibilities among the State, the market and adult male household members« (ECLAC 2015b, 32).

Country reports reflect these commitments, views and challenges to varying degrees. Enormous progress has been made in the collection of time-use surveys, and Colombia, Costa Rica, Guatemala, Ecuador, Mexico and Uruguay report having done so with the intent to quantify the total work done by women and men in order to develop care and labour policies (ECLAC 2015b, 45). Measuring the economic value of unpaid care and domestic work is constitutionally or legally mandated in the Bolivarian Republic of Venezuela, Colombia, Ecuador and the Plurinational State of Bolivia, while Colombia, Ecuador and Mexico have already calculated household sector satellite accounts.

Progress in the actual implementation of care policies is less clear. In their Beijing+20 reports only Chile, Cuba, Costa Rica and Uruguay refer to care policies in their achievements and challenges.³³ Among these, Costa Rica highlights that »care has become a strategic priority policy« and refers to its implementation of RedCUDI, the National Child Care and Development Network (INAMU 2014, 17). Uruguay refers to the challenges to implementing the National Care System, which was only put in place in November 2015 (República Oriental del Uruguay 2014).

Countries in addition to the four mentioned also have care policies in place beyond those associated with labour market regulations. Many have early childhood education and care policies, have progressed in care-related infrastructure (although not a priority given current levels of coverage) and have an array of social protection policies. The absence of care policies in these countries' Beijing+20 reports is indicative of the fact that care policies are not framed within a gender equality framework, which might also mean that they do not take women's needs into account. One reason behind this lack of gender awareness could be the low hierarchy

33. Colombia mentions the Care Law, which mandates the National Statistical Office to collect time use data and build a household sector satellite account (DANE 2014).

of women's machineries, which are unable to influence sectoral policies (erroneously) considered to fall beyond their purview, such as education, infrastructure or social protection.³⁴

Framing Care Policies

The Quito Consensus and Brasilia Consensus both take a rights-based approach to care. Both political agreements are clearly anchored in women's rights, deriving inspiration from the Beijing Plan for Action. They also are the result of the development over many years of a regional language that has supported, and pre-dates, the international agreements reflected in Target 5.4.³⁵

The rights-based approach to care recognizes both women and care receivers as rights holders, and positions the state as a duty bearer, forming a powerful framework to pose claims upon the state (Sepúlveda Carmona and Donald 2014). At least two other normative developments have lent support for the progress of the care agenda in the region. One is the strong rights-based approach to social protection, which provides a broad umbrella under which to situate care policies (Sepúlveda Carmona 2014, 60). The extension of social protection systems in the region has in fact allowed for the inclusion of care policies within them (Cecchini et al. 2015; ECLAC 2015c), as exemplified by the Uruguayan Integrated National Care System (SNIC), which aims at being «Uruguay's fourth pillar of the social protection system, along with health, education and social security» (EUROSOCIAL 2015).

The other normative framework is the concept of social co-responsibility for care, which gained traction in the region after the International Labour Organization and the United Nations Development Programme proposed in 2009 «new forms of reconciliation with social co-responsibility» to balance work and family life (ILO and UNDP 2009). Similar to the «redistribution» of care within the Triple R framework, this proposal goes beyond «reconciliation,» which typically means women having to reconcile paid and unpaid work (Faur 2006), to propose labour market policies and care services that would support women's labour force participation and decent

employment. In contrast to the rights-based approach to social protection and its emphasis in social policies, however, the social co-responsibility argument centres on the labour market, and on women's partaking in it (Blofield and Martínez-Franzoni 2015). The advance of labour market regulations noted by the Beijing+20 regional review reflects this view, which has also been behind the development of the Costa Rican care network RedCUDI.

Institutionalizing Care Policies: The Cases of Costa Rica and Uruguay

Chile, Ecuador, El Salvador and Mexico have implemented care policy coordination mechanisms within government, including officials from social development ministries, who specifically focus on children, women and persons with disabilities, and representatives from the education, health and social security sectors (CEPAL 2016, 103). The cases of Costa Rica and Uruguay stand out, as these countries have established by law care systems or care networks as coordination mechanisms for the care services provided to different dependent population groups. Indeed, promoting the development of «care systems for children, older persons, and people with an illness or disability» in order to close «the gender gap in terms of time use and labour [force] participation» has gained traction in the regional agenda (UNDP 2016).

Costa Rica's RedCUDI is an early childhood care policy for girls and boys under seven years of age. Established in March 2014, RedCUDI incorporated existing initiatives, policies, private and public care services and the work of NGOs devoted to early childhood development and care with the aim of universalizing integral early childhood care and development services (Guzmán León 2014, 26). RedCUDI is overseen by a Technical Secretariat and coordinated by the Inter-institutional Technical Commission (CTI), in which all incumbent public actors take part, including the Ministries of Social Development and Education, the National Institute of Women (INAMU) and several agencies charged with developing carers' skills, childcare centres' infrastructure, and supporting community-based childcare centres (Guzmán León 2014, 33–35).

The RedCUDI is rights based, framing early childhood care services as every child's right. It aims at promoting social justice, equality and equity, including gender

34. Sexual and reproductive health and rights, violence against women and social policies would fall within their purview (Montaño and Sanz Ardaya 2009, 88).

35. The regional women's conferences began in 1972.

equality. Indeed, among the stated programme objectives is that of ensuring that the provision of childcare services will allow both fathers and mothers to work for pay or engage in education (IMAS 2016). It is decentralized in its organization, directly administered by municipalities but funded by the national government. Several sources of »solidarian« funding, administered by the central government, support the universalization of childcare services while guaranteeing uniform and high quality standards (Guzmán León 2014, 39, 28).

Beyond children's rights, the social co-responsibility framework also played a strong part in the consensus-building around RedCUDI, as the progressive universalization of childcare services would support women's ability to engage in employment, especially those who head households, and would generate employment for care workers and thus improve women's employment prospects. This gender perspective is reflected in the Costa Rican Beijing+20 report, where the care network is positioned as a strategic component of the National Gender Equality and Equity Plan (INAMU 2014). Yet, during the political process that led to passing the RedCUDI law, children's rights gained prominence and women's rights were »complementary« (Guzmán León 2014, 46, 63).

In comparison, the Uruguayan Integrated National Care System is even broader in scope than RedCUDI, including both existing policies on health, education and social security and new policies for priority populations, in particular dependent adults, including persons with disabilities, and early childhood. For the latter, the SNIC aims at providing universal care services coverage for three year olds and growing coverage from 0–2 year olds, including the extension of parental paid leave and the possibility of part-time work over the newborn's first six months for both mothers and fathers (Sistema de Cuidados 2016).

The SNIC is based on the principle of co-responsibility of the state, the community, the market and families, as well as both women and men, in the provision of care. Among its explicit objectives are changing the sexual division of labour within households and the social (re) valuation of paid care work in the market sphere. Other principles are solidarity in the distribution of care work and its financing, the autonomy of care recipients and universality both in coverage and in the level of quality,

irrespective of the provider (Piñeiro 2015). The SNIC aims at providing »an array of alternatives, strengthening the supply of public services and regulating private supply, guaranteeing quality standards and providing training to caregivers,« but has explicitly excluded from these alternatives any direct payments to family care providers, which would boost household (and women's) care provision, particularly in poor households, and limits state responsibility to cash provision (Scagliola 2014).

The SNIC was created by a law passed in November 2015. Among other features, the law established the National Care Secretariat within the Ministry of Social Development as the inter-ministerial coordination body. Incumbent ministries and secretaries form the SNIC »board,« which establishes broad policies and priorities.³⁶ An advisory board with members of civil society, academia, private providers and care workers also interacts with the board and the secretariat (Sistema de Cuidados 2016).³⁷

The National Care Secretariat was originally envisioned as a coordinating body, but it has since been allocated a budget to expand childcare services, in a move to give it political traction. Over time, the care services provided by other ministries and state agencies should fall under the SNIC budget allocation, a move that might generate resistance.³⁸ Indeed, under the SNIC different conceptual frameworks co-exist — including the competing »targeting the poor« and rights-based approaches — as do institutional traditions involving entrenched sectoral views on education and health taking pre-eminence over systemic views. These will constitute a challenge in SNIC's implementation phase from 2016 onwards. Also in tension are the universalist ambition of the system and the targeted policies that might not be easily scaled up. In addition, although it is a great achievement that the gender perspective is endorsed by the law, the National Women's Institute must nonetheless strengthen its position on the SNIC board to guarantee that gender mainstreaming takes place in policy design and implementation (Espino and Salvador 2014).

36. These include the Ministries of Social Development, Education, Labour, Health, Finance, and the office of the budget, the public education administration, and the pension system state administrator (Banco de Previsión Social).

37. See also Fassler (2009, 110) on the need of participatory mechanisms and technical expertise to steer the SNIC.

38. For the SNIC budget, see its webpage <https://www.mef.gub.uy/innovaportal/file/16500/4/ix.sistema-de-cuidados.pdf>.

Care Services

Latin America and the Caribbean have the highest rates of early child development and care in the developing world, 74.5 percent (3/4–5 years of age, depending on the country), a rate equal to that of Central and Eastern Europe (Neumann, Josephson, and Chua 2015, 24). This is the result of pre-primary education being compulsory and freely provided in many of the region's countries, particularly for children aged 4–5. Coverage for five year olds is almost universal (around 95 percent) in Mexico, Uruguay, Chile and Ecuador, but for four years olds it drops to 80 percent in Uruguay, 75 percent in Chile and 30 percent in Ecuador. Only Mexico keeps it at near-universal levels (Giacometti and Pautassi 2014, data circa 2011). Coverage for children 0–3 years of age is much lower, dropping to 18 percent in Mexico, 14 percent in Uruguay and Ecuador, and ten percent in Chile (Rossel and Filgueira 2015, 107).

The rates, however, mask regional differences within countries, particularly in those in which service provision and budgets are decentralized (Marco 2014). They also mask differences in access rates by socioeconomic status, as access varies greatly with household income. For example, in Uruguay and Mexico, the coverage of 4 year olds in the first income quintile was approximately 75 percent, while it was more than 90 percent in the fourth and fifth quintiles. In these two countries, differences were even more striking at younger ages, reflecting the ability of well-off families to resort to private childcare services (Giacometti and Pautassi 2014).

It is only when public policy pays particular attention to overcoming these inequalities that the provision of ECDC enhances and equalizes children's capacities. This is the case in Chile and Ecuador, two countries with coverage rates fairly similar across family incomes in comparison to other countries (Giacometti and Pautassi 2014, 52, 59). In Chile, the early education programme, Chile Crece Contigo (Chile Grows with You), which guarantees a place in a crèche, or kindergarten, for children from low-income families, explains this outcome. Chile Crece Contigo kindergartens are publicly provided or subsidized for children 0–3 years of age, covering two-thirds of total enrolment in the first and second income quintiles, 60 percent of total enrolment in the third income quintile and 45 percent of total enrolment in the fourth quintile (Staab 2012). In other words, only the

very rich opt-out. Similarly in Ecuador, the Centros Infantiles del Buen Vivir provide childcare services for children of working mothers, and the plan is to universalize access and improve quality (Staab 2015, box 2).

Some governments that have not been able to expand early childhood education (and invest accordingly) have opted for supporting family-based day care facilities, like for instance the Colombian Community Mothers programme (Staab 2015). The quality of services may, however, be compromised by poor training and low workers' wages. The existence of two types of ECDC centres (or three types, if private centres are taken into account) can trigger quality segmentation and prompts the emergence of two- or three-tier ECDC system. This is the case with Argentina, where Early Childhood Development Centres (CeDIS), managed by the Ministry of Social Development, were created to reach poor populations, runs parallel to free public kindergartens, managed by the Ministry of Education, which do not sufficiently cover poor neighbourhoods (Faur 2015, 232). In Uruguay, the Centros de Atención a la Infancia y a la Familia (CAIF) are community-based childcare centres operating in poor neighbourhoods. Managed by social organizations but fully funded by the state, they serve children 2–3 years of age, while public kindergartens serve children 4–5 years of age (Rossel, Nieves Rico and Filgueira 2015). The differing quality standards between CAIF centres and public kindergartens have prompted the Uruguayan SNIC to aim at guaranteeing uniform levels of quality in early childhood education irrespective of the nature of the provider. Indeed, issues of quality in ECDC service provision are increasingly part of the agenda (Marco 2014).

For public ECDC services to work for women — that is, redistribute some of their unpaid care work and make it possible for them to engage more fully in the labour market — the expansion of coverage has to be coupled with the extension of full-time hours. Full-time hours in 0–3 ECDC services are universal in Brazil and Cuba, and reach low-income children in Colombia, Chile and Ecuador (Blofield and Martínez-Franzoni 2015, 18). Beyond socioeconomic criteria, working mothers are an explicit target of the policy in Chile, Ecuador, Guatemala, Honduras, Mexico, Panama and Peru (Blofield and Martínez-Franzoni 2015, 18). As elaborated here, mothers' (and fathers') labour force participation is also an explicit policy objective in Uruguay's SNIC and Costa Rica's RedCUDI.

Social Protection and Care

Latin American countries advanced enormously in the development of their social protection systems after the turn of the 21st century, extending population coverage and attempting to reduce segmentation in the quality of and access to social protection policies. The rights-based approach to social protection is widely accepted, at least in rhetorical terms. Of importance from the perspective of this report, new policies have been put in place, in particular conditional cash transfers programmes directed at families with children, and care services included as part of early childhood protection (Cecchini et al. 2015). In contrast, public works programmes, which saw their heyday in the early 2000s as »buffers« in times of crises, are less widespread and have changed in nature to support social and solidarity initiatives.

Cash Transfer Programmes

Conditional cash transfer programmes have expanded considerably in Latin America and the Caribbean, where they reach about 133 million people, or 21.5 percent of the total population. They were launched in the mid-1990s in Mexico and Brazil, and 20 years later, 20 countries in Latin America have some kind of CCT (ECLAC 2016, 73).³⁹ The impacts of CCTs on reducing poverty are significant, in particular in countries with broad coverage and sufficiently high transfers — as in Argentina, Brazil, Ecuador, Jamaica, Mexico and Uruguay — although CCTs have been more effective in raising household incomes closer to the poverty or indigence thresholds than in surpassing them (ECLAC 2016, 72). In turn, the positive impacts of CCTs on human capacities (i.e., education, health nutrition) have been extensively documented, but are associated with the provision and quality of public services, they are not the sole result of the transfer or of the conditionalities imposed (ECLAC 2016, 76).

There is consensus that CCTs have been successful in disincentivizing child labour (ECLAC and ILO 2014, 20), but beyond this positive effect, debates continue in the region about the possible negative impacts of CCTs on the labour market via disincentives to employment

formalization and to labour market participation. Yet, studies are non-conclusive and, in some cases, these effects have been attributed to faulty design (ECLAC and ILO 2014, 21). There is increasing recognition, however, of the need to support a transition from being a programme beneficiary to being employed (after finalizing secondary school), and several countries are putting measures in place to do so (ECLAC 2016, 75; OIT, CEPAL and OEA 2011).

There is vast literature pointing to the gendered effects of the CCTs in the region. For example, CCTs have had several positive impacts on poor women beyond improving their incomes. Among them, women being the recipients of the transfer, improves their intra-household bargaining power, and their physical and even political autonomy. Receiving the transfer also changes the relationship between women and public policies, between women and social protection systems and, ultimately, between women and the state (ECLAC 2014, 48).

Yet, CCTs exhibit several weaknesses from a gender equality perspective, many of them in relation to care (Martínez-Franzoni and Voorend 2012). CCTs programmes generally take for granted that women will fulfil the care duties implicit in conditionalities, like getting children to school or to medical check-ups, failing to recognize women's unpaid care and domestic work (Molyneux 2006). Time spent in complying with programme obligations can jeopardize women's ability to participate in paid work or skill development (Gammage 2010). For example, the time spent complying with conditionalities seems to be behind a reduction of paid working time by Bolsa Familia's female beneficiaries in Brazil, an effect not noticeable among men (ECLAC, ILO 2014, 19). As a result, both Bolsa Familia and Mexico's Prospera have begun to offer complementary kindergarten schemes for beneficiaries (Fultz and Francis 2013; Rossel, Nieves Rico and Filgueira 2015), a move similar to public works programmes in India, proving the need for complementarity of care policies.

Public Works Programmes

In contrast to CCTs, which exist virtually in every Latin American country, public works programmes are very few in the region. The World Bank counts 17 in 2014, with differing degrees of coverage (World Bank 2015d,

39. The countries are Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Bolivia, Trinidad and Tobago, and Uruguay.

11). Among those with better coverage are the Brazilian Plano Nacional de Economia Solidária (Solidarity Economy), the Mexican Programa de Empleo Temporal Ampliado (Temporary Employment Programme), the Haitian PRODEP (National Project of Community Participation Development), the Panamanian Public Works Programme and two Argentinean programmes, Plan de Empleo Comunitario (Community Employment Programme), run by the Ministry of Labour, and Argentina Trabaja (Argentina Works), run by the Ministry of Social Development (Deux Marzi and Hinze 2014; World Bank 2015d, annex C). Most of these initiatives have the traditional format of direct (and temporal) employment creation, with work schedules and activities state organized. Others, most notably in Brazil and Argentina, support cooperatives and associative work initiatives.

Argentina's Plan Jefes y Jefas de Hogar Desocupados (Household Heads Programme) — which ran between 2002 and 2009 and was implemented in the aftermath of a deep economic crisis — is frequently cited as the first full-fledged PWP in the region (Zimmermann 2014). It comprised construction, rehabilitation and maintenance of small infrastructure facilities and community services, including care services like day care (Kostzer 2008).⁴⁰ More than 70 percent of beneficiaries were women, 90 percent of whom complied with the required 20 hours of weekly work, although compliance rates fell over time (Tabbush 2009).

The tasks performed by women and men reinforced existing labour segregation patterns, with men devoting themselves to construction and maintenance activities while women primarily performed care-related tasks, in many cases in response to the crisis, like running communal kitchens and organizing community childcare. These were self-organized experiences, however, as the plan did not provide on-site childcare and, in general, was not particularly responsive to the needs of women (Esquivel and Faur 2012). On the contrary, women who could not enrol in the plan due to their care responsibilities were left out in the long run, as applications were received for only a few months during 2002.

Some small-scale initiatives in the region have been gender-responsive and included the provision of day care cen-

tres with paid baby-sitters in their design, as in the case of the Guatemalan Programa Conjunto Post San, which ran during 2005–2006 (Tanzarn and Gutiérrez 2015, 53). Other programmes have been responsive to women's infrastructure needs, including the PWPs devoted to water and sanitation infrastructure creation in Nicaragua and Panama, both in place between 2009 and 2012 (Tanzarn and Gutiérrez 2015, 63). The Panamanian programme is worth noting, as beneficiaries were indigenous women who through construction microenterprises improved their communities' water and sanitation infrastructure. The programme addressed women's time poverty — by taking as its starting point the time needed for carrying water many times a day — and challenged gender stereotypes by promoting a more equitable intra-household division of labour and supporting women's leadership positions (Tanzarn and Gutiérrez 2015, 64)

Some ongoing programmes recognize that the provision of childcare services through PWPs contributes to women's labour force participation (supply-side argument) and employment (demand-side argument), and in addition promotes social investment in early childhood education. The Brazilian Plano Nacional de Economia Solidária (2015–2019), for example, aims at gender mainstreaming and supporting the provision of childcare (and other dependents' care) in order to allow women's full participation in the programme (Conselho Nacional de Economia Solidária 2015, 35), but it is too soon to evaluate whether and how these stated objectives will be implemented. In contrast, Argentina Trabaja explicitly excluded childcare services from the community services supported by the programme, effectively relinquishing support to community-based care initiatives, some of which had been born at the time of (and supported by) Plan Jefes (Fournier 2017).

Labour Policies and Care

The Beijing+20 regional report reviews in detail the labour market regulations countries have put in place in relation to care, in particular anti-discrimination laws for pregnant women, maternity protection (Mexico and Uruguay) and rights to maternal leave, which all countries have adopted, the extension of paid paternity leaves in the cases of Peru, Puerto Rico and Uruguay⁴¹

40. The programme also included vocational training, although only four percent of beneficiaries engaged in them (Kostzer 2008).

41. In the case of Uruguay, paternity leave is paid by the employer, which can jeopardize take-up rates (Blofield and Martínez-Franzoni 2015, 13).

and shared parental leave in the cases of Cuba, Mexico, Bolivia and Uruguay (ECLAC 2015b, annex 6.1 and 6.2, in Spanish).⁴² Regarding maternity leaves, it should be noted that most countries cover twelve weeks, rather than the 14 as internationally recommended (Rossel and Filgueira 2015). Given widespread informality, legally mandated paid leaves only cover 40 percent of women in employment (ILO 2016, 34), a dimension that is frequently overlooked when focused only on regulations.

Argentina, Chile, Costa Rica and Uruguay have reported the passing of laws improving the legal status of domestic workers, a move in line with the Brasilia Consensus and ILO Convention 189. Indeed, after the Beijing+20 report was published, Argentina, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Nicaragua, Panama, Paraguay and Uruguay all ratified the convention.⁴³ Brazil has reported having extended maternity leave rights to domestic workers without, however, fully recognizing their labour rights. Ratifying the convention is a first step, but not enough. Progress is needed to improve domestic workers' situation in the labour market, particularly their registration, given that roughly 70 to 80 percent of them are still informal in the region.⁴⁴

Mobilizing Around Care

That care policies are high on the public agenda in several countries in Latin American and the Caribbean is certainly an achievement of the feminist movement. It reflects the evolution of the movement, which has become professionalized, has forged alliances with other social movements and has increasingly engaged with the state to influence public policies (Montaño and Sanz Ardaya 2009). It also reflects the contribution of feminist academics, who have succeeded in framing care as a public issue and politicized it (Esquivel 2015; Rodríguez Gustá and Madera 2015). Feminist academics were behind the efforts to collect time-use data in Buenos Aires (2005) and in Colombia (2010), measures that were mandated by law and inspired by the Beijing Plan

for Action (Esquivel 2009; Senado de Colombia 2011). More recently, feminist NGOs have envisioned strategies to explicitly position care on public agendas. This is the case with the Argentinean initiative *El Cuidado en la Agenda Pública: Estrategias para Reducir las Desigualdades de Genero en Argentina* (Care on the Public Agenda): Strategies to Reduce Gender Inequalities in Argentina,⁴⁵ which combines knowledge production and incidence intervention, and the Uruguayan Gender and Family Network, which sparked the debate on care in Uruguay. Mobilization behind the cases of Uruguay and Costa Rica deserve special attention because they illustrate the crucial role of women's movements' engagement in political processes, moving far beyond the (sometimes technocratic) engagement with women's machineries.

Mobilization in Uruguay

Uruguay's SNIC was the result of extensive and stepwise negotiations and a weaving of broad alliances to bring care policy to the public debate. Its conception spanned more than seven years and three progressive presidencies (Aguirre and Ferrari 2014).⁴⁶ Against the backdrop of a human rights approach to social protection, expanding it beyond minimum protection floors and including a strong gender perspective, the debate grew in Uruguay sparked by time-use evidence showing women's and men's unequal unpaid domestic and care work and important variations depending on the presence of dependents.⁴⁷

The SNIC began from an alliance of the women's movement, social movements, women politicians, and feminist academics, organized as the Gender and Family Network, an NGO that set in motion an incidence strategy to make care prominent on the public agenda (Fassler 2009). Crucially, however, it was the alliance's engagement with the ruling political party and government actors that allowed care to become a political issue, not simply a public or policy matter. As a result, by 2008 the

42. Annex 6.2 also lists income security policies, such as protection for persons with disabilities and child income support.

43. Uruguay was the first to ratify the convention and was among its promoters. The list of countries that have ratified ILO Convention 189 can be found in ILO 2013c.

44. Tokman's estimate was more than 80 percent for 2008 (Tokman 2010, 9).

45. See ELA 2016.

46. Aguirre and Ferrari (2014, 6) examine the process of consensus building around the SNIC in Uruguay focusing on conceptual frameworks, including knowledge and data generation; actors; enabling/disabling factors; and policy results.

47. The time-use evidence was produced by Universidad de la República and then taken on board by the National Statistical Office (Aguirre and Ferrari 2014).

National Care System figured in the electoral campaign programme of the ruling Frente Amplio for the period 2010–2015.

The first institutional step was taken in 2010, with the establishment of a governmental working group within the Social Policy Cabinet (whose members are now part of the SNIC board). The working group defined the broad guidelines of the SNIC, the target populations and the care policies comprised by the system and drafted a formal proposal for the SNIC in 2012 (Aguirre and Ferrari 2014). In other words, the working group made possible the institutional development of the SNIC, providing a platform for state institutional actors to develop ownership. Meanwhile, a phase of national debate took place, with the aim of raising awareness about care, sharing information and incorporating local realities into the design of SNIC. The national debates, with their broad-based participation and high visibility, gave all actors involved the credibility and support to continue to push for the SNIC.

The national debates also revealed a variety of interpretations of what care is (or is not). Care appeared contested by early education teachers, who understood care as different from education and therefore non-professional work. The debates also saw a departure from the strong feminist foundation that sparked the SNIC in the first place and a stronger presence of dependent persons' associations and their claims (Aguirre and Ferrari 2014, 37). The care workers' perspective was also absent. This led feminist actors to fear that the rights of caregivers would be diluted in the final SNIC proposal and the gender perspective overlooked. The situation was partly due to a relatively weak women's machinery but also by the difficulty in more strongly articulating the care agenda as also being a women's agenda (Espino and Salvador 2014). At this point, the Gender and Family Network came together in a »pro-SNIC« network in 2013 to mobilize support, while the government working group continued to draft the more detailed aspects of the SNIC design (such as funding, required regulations and care workers' training).⁴⁸ As at the onset of the process, network involvement proved key in guaranteeing that strong gender language remained in the law and bringing to the fore the »other« SNIC target population — paid and unpaid care workers.

48. UN agencies actively supported the government and civil society organizations in the process (Aguirre and Ferrari 2014).

Mobilization in Costa Rica

Costa Rica's experience with RedCUDI has several points in common with Uruguay's SNIC: the open dialogue channels with NGOs and academic experts, including from the National University, which conceptualized and provided technical support for the care network format; the support of social movements, which as early as 2009 listed early childhood care and development as the top social policy priority; the creation of formal inter-institutional coordination spaces, in particular the Action Plan pro-RedCUDI, 2012–2014, whose members would become part of both the Technical Secretariat and the Inter-institutional Technical Commission; and the inclusion of care in an electoral campaign programme — which in Costa Rica is compulsory and becomes the National Development Programme for the party that takes office — that politicized childcare provision. In contrast to the case of Uruguay, however, RedCUDI's final, timid emphasis on women's labour force participation, and women's rights in general, could be attributed to low-intensity involvement of women's movements in the run-up to the RedCUDI compared to civil society actors' support of children's rights (Guzmán León 2014, 64; Blofield and Martínez-Franzoni 2015, 26).

The Way Forward

The case has been made here that there are many policies around the world in the Global South — Sub-Saharan Africa, Asia and the Pacific and Latin America and the Caribbean — that contribute to the reduction and redistribution of women’s unpaid care and domestic work and are transformative in the sense that they can contribute to change structural inequalities. Many of these policies are not called care policies or do not explicitly aim at having an impact on how care is provided or by whom. Care policies are situated within a variety of policy frameworks, explained by countries’ and regions’ different political, economic and social contexts. In Sub-Saharan Africa, for example, care is implicitly addressed as part of poverty reduction policies, whereas in many countries of the Asian and Pacific region, care policies are more explicit and often framed as social investment and enhancing women’s economic empowerment, a necessity for economic growth. In Latin America, care policies are explicitly framed in social co-responsibility and Triple R frameworks.

With the exception of Latin America, care policies are often separate from social protection policies. When they are in place, the emphasis lays on child development or on health care, often with an instrumentalist view. Though not explicitly designed to reduce or redistribute women’s unpaid care and domestic work, a number of these policies have the potential to do so if there is political will and funding channelled to institutions and actors to implement such policies.

Early child development and care policies are among the most widespread care policies in the Global South, most commonly and best implemented in Latin America and the Caribbean, but also prevalent in Asia and the Pacific. As care is redistributed from the private to the public spheres, it has an impact on women’s unpaid care and domestic work, even if the policies are primarily designed to satisfy the needs of children and not of their mothers or families. Early child development and care programmes are the most frequent care policies implemented in Sub-Saharan Africa, yet as this report shows, the quality of ECDC services is often poor, and coverage is insufficient to respond to care needs.

The availability and quality of infrastructure has a great impact on women’s unpaid care and domestic work. Access to improved water in particular has proven crucial in reducing the drudgery and to saving some of the time devoted to unpaid care and domestic work. This is significant, as women and girls, especially among the poor, are often those with the least access to clean water in Sub-Saharan African countries. In Latin America and the Caribbean, the provision of water is so advanced that its provision is hardly found in regional or national policy documents. In comparison accessibility in Asia and the Pacific lies between the other two regions, with huge sub-regional variations.

Cash transfer programmes are a popular means of poverty reduction. They have been implemented in a range of countries, with some interesting variations. Unconditional cash transfer programmes are increasingly being piloted in Sub-Saharan Africa. Despite the low coverage, evaluations have shown that they are a way to reduce extreme poverty. The examples of cash transfers to caregivers, for example those caring for HIV/AIDS orphans or living in extremely poor households, have shown that the programmes often do not take into account gender dimensions, at least explicitly. Usually, however, they do have a positive gendered impact, because most of the receivers, the caregivers, are women. Conditional cash transfers are widespread in Latin America and the Caribbean and Asia and the Pacific. The evaluation of the results of conditionalities is mixed, and it is frequently the case that they overburden women. In some cases in Latin America, conditional cash transfer programmes have started to offer complementary care services to avoid disincentivising women’s labour force participation.

Public works programmes are a way of generating income and food for work for poor men and women while at the same time building and improving infrastructure. These programmes are also a form of disaster relief. The prevalence of such programmes depends on the region — that is, the extent of poverty and level of disaster exposure. They are often found frequently in Sub-Saharan African countries and in India. In contexts of social norms where gendered divisions of labour define women as caregivers, however, the burden

of women's paid and unpaid care and domestic work needs to be redistributed, for example by a childcare component, to allow poor women equal access to the programmes, as the cases of India and South Africa show. Otherwise, women either withdraw, as in India, or experience an increase in their total number of work hours, as in South Africa. Similar to Latin American CCT programmes, some PWPs have offered complementary child care and health services. The attempt to incorporate childcare as a dimension of public works programmes in South Africa — i.e., as a form of investment in social infrastructure — seems not to have been wholly successful, as training of programme participants to be certified child-carers has not been met with sufficient demand for their skills.

Labour market policies have progressed in many regions of the world. An economy with an integrated workforce is important for efficient poverty reduction. Where this occurs, laws and regulations promoting adequate maternity and paternity leave policies enable women (and sometimes also men) to reconcile formal employment and having a family. Formal employment opportunities in turn generate pension, maternal protection and paternity leave entitlements. Even if labour rights are enshrined in law, in many countries this is insufficient to guarantee that women and men enjoy them. This is particularly the case in poor Sub-Saharan African countries, where most women work in the informal sector, but other regions are not exempt from high informality rates. Care policies, in particular care service provision, are increasingly being framed as a way to generate conditions for women to engage in paid work.

This report points to the importance of women's movements articulating care claims and ensuring that care policies are high on national political agendas. Cases in Latin America and the Caribbean indicate the pathways for doing so. Though initially a top-down issue, care has been taken up by women's movements, which have forged alliances with other social and political actors. The accomplishments realized through mobilization have taken the form of policy implementation through a care (or sometimes a gender) lens. In Asia and the Pacific, care figures differently on women's movements agendas, but with country-level variations. Whereas it has been a high priority in India for many years, care is almost absent in other countries. In Sub-Saharan Africa, claims articulated around the burden of women's

unpaid care and domestic work are almost non-existent. In poor countries in particular, issues such as violence against women, political participation and leadership and a range of other often poverty-related issues are the priorities. Yet unpaid care and domestic work become a priority where large, internationally connected women's movements, like FEMNET and APWLD, are active. In Latin America, the cases of Uruguay and Costa Rica exemplify the powerfulness of women's and social movements engaging with political parties and state officials to advance their agendas, and more generally, the importance of framing care policies within a human rights framework.

In sum, this report's review of country-based reports and the academic literature reveals that care policies, including their prioritization and implementation, are not a matter of technocratic fixes. State engagement and support — starting with a feminist approach to policy design all the way to the allocation of sufficient funding for implementation, monitoring and evaluation — makes a difference in reducing women's unpaid care and domestic work burdens, in empowering women and in achieving gender equality. For that to happen and move the care agenda forward, the concerted efforts of women's movements as well as other social and labour movements are indispensable. Progressive framings and situating care policies within strong gender equality mechanisms at the international, regional and national drive progress will be necessary to turn the promise of Target 5.4 into reality.



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