

Care Policies: Realizing their Transformative Potential

Children in the village of Dumbravita, Moldova benefit from a kindergarden heated by biomass.

Framing public care services, basic infrastructure and social protection policies under the umbrella of care policies is a game changer. It promotes gender equality, allows for policy complementarity and coordination, improves the situation of care workers and has visible positive macroeconomic impacts. Transformative care policies emerge if a human rights-based approach to care policies is adopted, when broad political alliances are formed, and when evidence is used in an innovative way to inform policy design and monitoring.

Chapter 3 addresses implementation of SDGs



1. Introduction

An important aspect of the “social turn” that has elevated the role of social policy in government and political agendas is the growing recognition of the need for care policies. For too long, care provision has remained off the radar of policy makers, under the assumption that unpaid care and domestic work (box 3.1) would be provided by women in the private sphere of the home or the community. While most developed welfare states have adopted policies that support care provision, the same cannot be said of the majority of governments around the world. Care is required by all, but when public care provision is absent, it is only the better-off who can resort to private care services.

Care policies are public policies that allocate resources in the form of money (including income), services or time to caregivers or people who need care. They include direct provision of care services or subsidies to access them, payments to hire care workers, regulations, and complementary service provision such as transportation, water and sanitation, and energy. They also include labour regulations, such as maternity protection, and parental leave, and the regulation of paid working time.¹ Care policies therefore encompass policies developed for different sectors, such as health and education, as well as labour and social protection policies.

Care policies are starting to feature more prominently in international development discourse, triggered by increasing recognition that the unequal distribution of unpaid care and domestic work between women and men (figure 3.1) is a powerful driver of gender inequality in the economic and social realms. Care policies serve a range of different objectives, including poverty reduction, enhanced women’s labour force participation, employment creation and the expansion of future generations’ human capabilities. Because care policies mould the ways in which care is provided and funded, and can determine who provides and receives care, they have the potential to contribute to gender equality and mitigate other dimensions of inequality such as class, caste, ethnicity or sexual orientation. They can contribute to the fulfilment of women’s human rights, particularly the rights of women living in poverty.² But if poorly designed and implemented,

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they can also reinforce inequalities and undermine the rights of women, children, older persons and persons with disabilities.

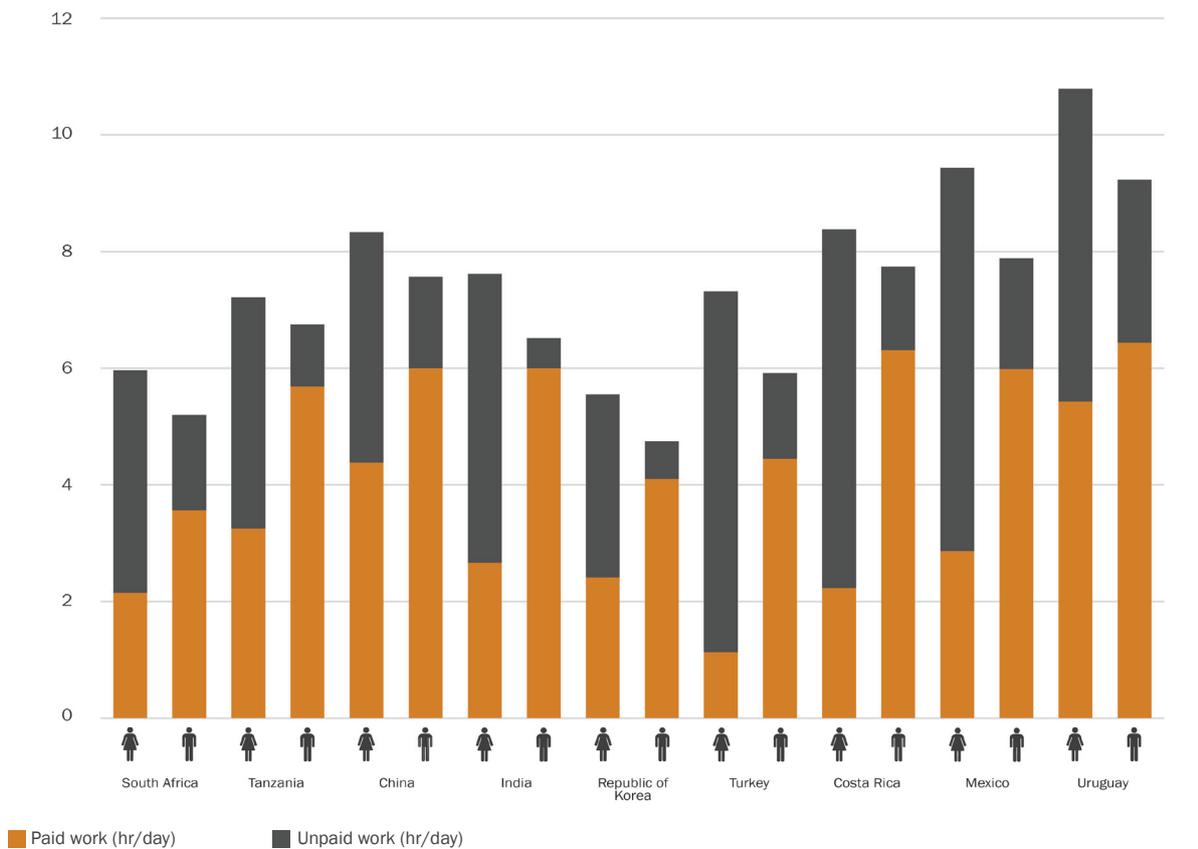
Years of conceptual work, developing normative frameworks and building political momentum are behind the inclusion of unpaid care and domestic work in Sustainable Development Goal (SDG) 5, “Achieve gender equality and empower all women and girls”. Target 5.4 not only recognizes and values unpaid care and domestic work³ but also indicates the ways in which this recognition should take place, namely: “through the provision of public services, infrastructure and social protection policies”.⁴ Unpaid care and domestic work, therefore, must be recognized, reduced and redistributed by means of care policies (see also box 3.3).

The explicit inclusion of unpaid care and domestic work in the 2030 Agenda for Sustainable Development brings with it the potential to elevate transformative care policies within national policy agendas, and represents an opportunity for women’s movements and other social actors to support, shape and hold governments accountable with regard to policy implementation. From a social justice perspective, transformative care policies simultaneously guarantee the rights of care receivers and caregivers, as well as their agency, autonomy and, ultimately, well-being.⁵

The rights, agency, autonomy and well-being of caregivers and receivers are frequently presented as being in opposition to each other. For example, care services are particularly labour intensive, and care workers’ wages and working conditions can impact on service affordability, and therefore access.⁶ On

Unpaid care and domestic work must be recognized, reduced and redistributed by means of care policies

Figure 3.1. Paid work and unpaid care and domestic work, by sex



Note: Year of data: South Africa (2010), Tanzania (2014), China (2008), India (1999), Republic of Korea (2009), Turkey (2006), Mexico (2009), Ecuador (2012), Uruguay (2013). Sources: Charmes 2015; for Uruguay, INE 2014; for Costa Rica, Esquivel 2011.

the other hand, the wages and working conditions of care workers are positively associated with the quality of care services.⁷ Care policies aimed at persons with disabilities can guarantee that they exercise their legal capacity and right to make their own decisions⁸ or, on the contrary, position carers as substitute decision makers. Providing for the care needs of children frequently makes women—the main unpaid care providers—both income and time poor,⁹ and can carry long-term labour market penalties if they interrupt their employment careers in order to provide care (box 3.1). Moreover, caregivers and care receivers are not fixed, immutable roles, as illustrated by the childcare provided by parents with disabilities or the fact that children can become care

From a social justice perspective, transformative care policies simultaneously guarantee care receivers' and caregivers' rights, agency, autonomy and well-being

providers of their parents living with HIV/AIDS or of their younger siblings.¹⁰

How do care policies manage to solve these and other trade-offs without reinforcing inequalities? What are the innovations that can arise when a “care lens” informs social policies? And what political conditions have supported the advancement of a *transformative care agenda*?

This chapter explores both whether and how care policies bring about transformative outcomes, and the conditions that get them onto political agendas and support their implementation. The evidence provided in this chapter points to three main conclusions.

- Care policies encompass policies developed for different sectors such as health or education, serve a range of different objectives and have a variety of impacts, including at the macro level. In the framework of the 2030 Agenda, transformative care policies complement each other, bridge sectoral divides and allow

for cross-sectoral coordination mechanisms, have a strong gender focus, and bring in the perspectives of caregivers and care receivers.

- Transformative care agendas have gained notable international policy attention, even if priorities differ according to regions. However, care agendas are still weak at the national level.
- Transformative care policies emerge out of political processes. The concerted efforts of women's movements, as well as other social and labour movements, have proved to be crucial for the advancement of transformative care agendas and their implementation. The smart use of evidence has helped to make the case for care policies. Progressive framings, including a rights-based approach to care policies, have proved powerful in building consensus.

Section 2 below defines care policies and situates them in the context of developing countries, briefly showing their coverage and design. Section 3 reviews the policy innovations and transformative outcomes that can arise when a care lens is applied, including policy complementarity, cross-sectoral coordination and a strong gender perspective. Section 4 identifies key elements that have supported transformative care policies, and situates these in the context of the

2030 Agenda. Section 5 summarizes the main policy implications.

2. Care Policies

Care policies lie at the intersection of the social, the economic and even the environmental dimensions of sustainable development (figure 3.2). They include:

- early childhood education and care (ECEC) services, and care services for sick, disabled and older persons—policies that redistribute some of the caregivers' workload from the private to the public sphere;
- the provision of infrastructure that reduces women's and children's workloads, such as communal wells and piped water;
- an array of income security and social protection policies, including cash transfer programmes, public works, pensions and income security for children and their families; and
- labour market policies, including maternity benefits and parental leave.

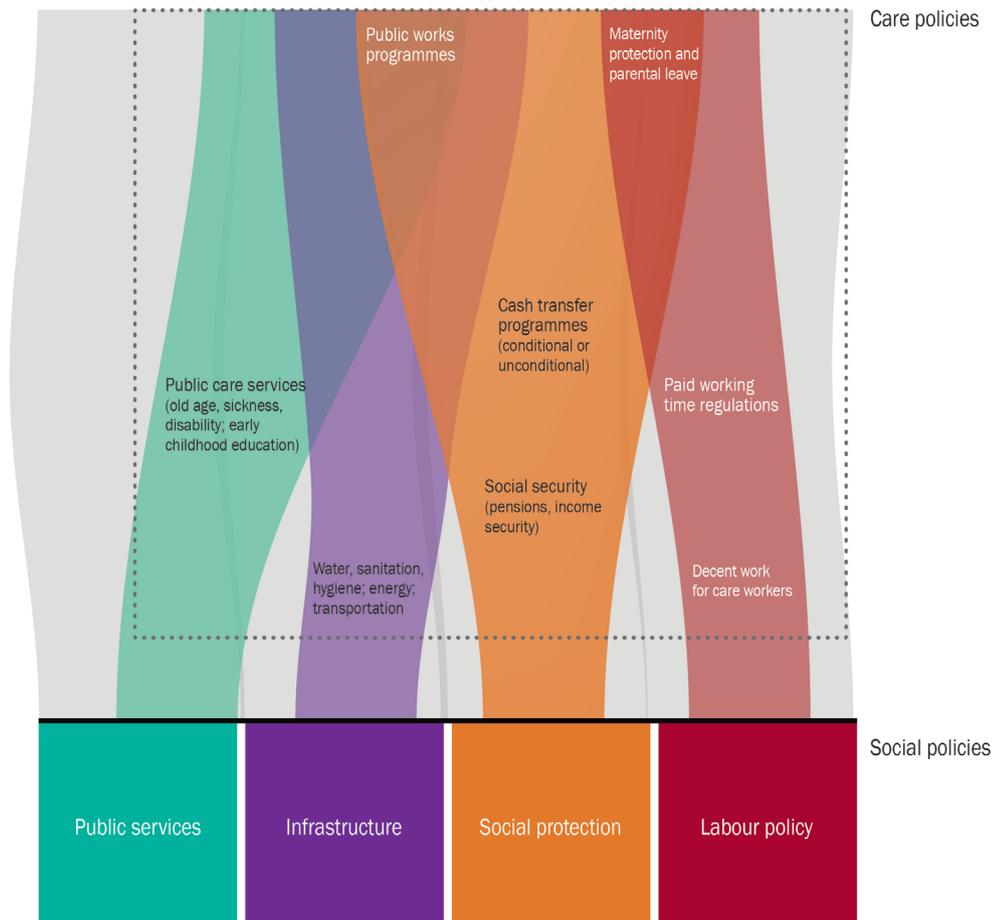
Box 3.1. Unpaid care and domestic work

Unpaid care and domestic work comprise household activities, such as cooking, fetching wood and water, and cleaning, as well as direct care of family and community members performed outside market relations.^a Care is crucial for well-being—we all need to be cared for throughout our lives in order to survive and thrive. At the macro level, it is an essential part of social reproduction, sustaining the current labour force and reproducing human capacities.^b

But the provision of care is unequally distributed not only between women and men and girls and boys, but also between rich and poor, between those living in urban and rural areas, within different family arrangements, or belonging to different castes and ethnicities, and between households, the state, the community and the private sector.^c Women all over the world disproportionately bear the costs of care. These include forgone opportunities in education, employment and earnings, in the enjoyment of labour, social and political rights, and regarding the time available for other activities, not least leisure.^d Furthermore, the labour market often penalizes mothers for having taken time out of employment or relegates them to the most vulnerable segments of the labour market if paid work and care are to be "reconciled".^e It should not, however, be up to individual women and families to reconcile this situation. Government and other institutions have a key role to play in solving the tensions between the productive and reproductive spheres.

Notes: ^a Razavi 2007; Folbre 2014; Esquivel 2013. Fetching firewood and water are activities included in GDP calculations (UN 2008). The 19th International Conference of Labour Statisticians resolution concerning statistics of work, employment and labour underutilization (ILO 2013b) includes unpaid care and domestic work in the definition of "own-use production work"—therefore confirming it as a form of work. ^b There are several definitions of social reproduction, most of them associated with the material conditions of reproducing the labour force (Elson 2000; Picchio 2003). It is a concept sometimes used interchangeably with the "care economy", although the latter also brings in paid care workers (Esquivel 2014). The material reproduction of the labour force includes the expansion of human capacities (Braunstein 2015; Picchio 2003). ^c That is to say, the "care diamond" (Razavi 2007). ^d Antonopoulos et al. 2012. ^e ILO 2016.

Figure 3.2. Care policies bridge sectoral divides



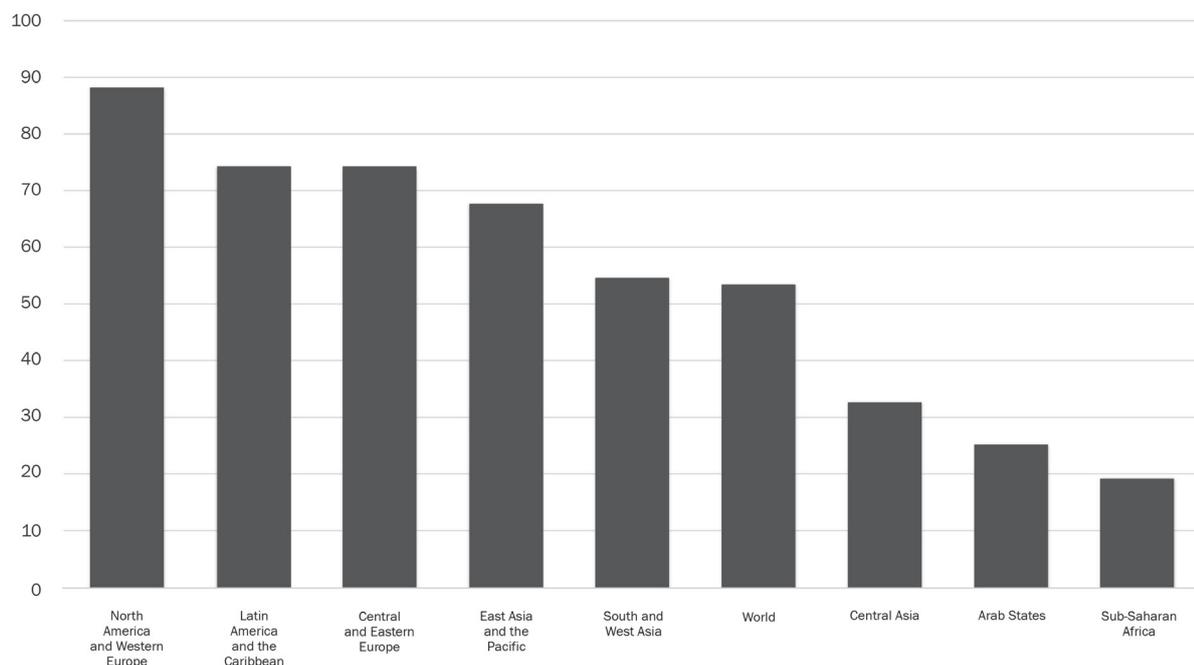
Care services cater for persons with specific care needs

Care services are those devoted to persons with specific care needs, such as pre-school age children, older persons and persons with disabilities. ECEC services cater for children up to 5 or 6 years of age—that is, day care and pre-primary education (figure 3.3). Enrolment is increasing in all regions of the world but still varies widely between and within regions. In Central and Eastern Europe, and Latin America and the Caribbean, enrolment is high due to a historically strong public education sector. In Central Asia, the Arab States and sub-Saharan Africa, enrolment rates are very low, although there are some intra-regional variations. Even in regions with better coverage, the inclusion of marginalized populations is still a challenge. Access to services and their quality vary strongly within countries, as ECEC programmes are often concentrated in urban areas, and rural populations are under-

serviced.¹¹ Average coverage figures usually hide major variations between rich and poor households, depending on the level of fees, subsidies or the existence of public provision.¹² The private sector, including non-governmental organizations (NGOs), for-profit services, churches and individuals, is a significant provider in regions with low coverage of public care services. In the Arab States, private providers cover almost half of all enrolment and in Africa around 60 percent. In contrast, in Latin America public provision reaches 75 percent while in Central and Eastern Europe and Central Asia the private sector is virtually absent as a provider.¹³

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Figure 3.3. Global pre-primary enrolment rates (percentage)



Note: Pre-primary education coverage based on countries' own definition of the number of years of pre-primary schooling, usually ranging from 1 to 3 years and covering ages from 3 to 7. Source: UNESCO 2015:25, based on data from 2012.

SDG target 5.4 makes clear the importance of *public* care services, as only states are able to ensure universal access to services and guarantee quality standards.¹⁴ Yet public provision faces several challenges. In Kenya, for example, the government programmes target children aged 4 to 5 years, even though the policy framework identifies children within the 0 to 5 age range as intended beneficiaries. The insufficient number of centres and trained teachers, poor remuneration and weak enforcement of standards are among the challenges acknowledged by education authorities.¹⁵ Alternatively, some countries arrange for family-based day-care facilities, as occurs in the Colombian Community Mothers programme. In such cases, service quality may be compromised by poor training and wages.¹⁶ To solve similar problems, a programme in Ecuador is planning to recruit childcare professionals and implement training for childcare workers.¹⁷ Along similar lines, beneficiaries of social transfer programmes in Mexico and Brazil receive subsidized childcare services.¹⁸ Other states prefer to subsidize demand by partially covering the cost of private childcare services, as in the case of the Republic of Korea's Child Care Subsidy programme, which in 2013 became universal.¹⁹

Care services for older persons, in the form of long-term care institutions, are extremely scarce worldwide. The exception is found in rich countries,²⁰ but

even they are moving away from institutionalized care toward home-based services.²¹ Care services increasingly work with older persons to improve their capabilities, as in the case of the Chilean Day Centres.²² In Africa, however, the lack of services leaves the majority of older people, who live in rural areas, to be cared for by their families, in particular by female household members.²³

Attention to care policies for older persons in developing regions mirrors demographic trends. Latin America and the Caribbean will experience an increase of more than 70 percent, and Africa and Asia over 60 percent, in the number of older persons by 2030. An already older population puts this figure at 23 percent in Europe.²⁴ In contrast, the demographic transition is at an early stage in most sub-Saharan African countries, so the share of the population over 60 years of age is still, and will continue to be, small.

Health care services are also crucial for persons with disabilities, but they have less access to them²⁵ and are over 50 percent more likely than people without disabilities to cite cost as a reason for not accessing needed health care.²⁶ Social care and formal care support, including transfers that allow persons with disabilities to hire the care they need, are therefore key. Finally, the HIV/AIDS epidemic led to a range of

policies to stop the spread and address the health-related consequences of the disease.²⁷ Though it is widely recognized that women's and girls' unpaid care and domestic work increases with the presence in the household of persons living with HIV/AIDS, and that the time to care for them requires women to take time off paid work and girls to stay out of school, there are few policies designed to alleviate and redistribute this increased burden. In South Africa, for example, state-supported home-based care services have been scaled up, but they are insufficient to cover all-day care needs.²⁸

Infrastructure supports care provision

Infrastructure deficits in water, sanitation, electricity, roads and transportation increase women's and children's unpaid care and domestic workloads and make it harder for caregivers and care receivers to access care services.

Water, sanitation and health are closely interrelated, as inadequate water, sanitation and hygiene negatively impact health, in particular of children under 5.²⁹ Moreover, the presence of persons living with HIV/AIDS can double the amount of water needed for adequate care.³⁰ Today, about 663 million people use unimproved water sources; nearly half of them live in sub-Saharan Africa, and one-fifth in southern Asia.³¹ In southern Asia, almost half of the population has access to improved sanitation facilities, but in sub-Saharan Africa coverage is only 30 percent.³²

Lack of water and sanitation infrastructure in rural areas creates heavy workloads in fetching water, which is a time-consuming activity typically done by women and girls. Therefore, expanding safe water and basic sanitation infrastructure saves women's time³³ and reduces water-related illnesses.³⁴ In Tanzania, for example, the hours spent fetching water amount to the equivalent of over 640,000 fulltime jobs for women and 120,000 jobs for men.³⁵ Yet higher costs associated with providing necessary infrastructure in rural areas mean they remain underserved, and investment in water and sanitation tends to be concentrated in urban areas.³⁶

Similarly, lack of access to electrical power and modern fuel for cooking across sub-Saharan African countries means women and girls spend long hours

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each day collecting firewood and other biomass, and laboriously processing food. Initiatives to expand electricity supply to rural areas and improve stoves reduce drudgery and have a potential environmental payoff too, when they replace polluting and deforesting wood-fuelled cooking with cleaner, greener options (chapter 5).³⁷ Transportation improvements reduce the time women spend marketing goods, and they also improve women's access to health and care services.³⁸

Social protection policies have the potential to recognize and redistribute care

SDG 5 includes the call to recognize unpaid care and domestic work through social protection policies (chapter 2), that is, in cash transfer programmes, social security and social protection floors.

Social protection floors include universal health care systems, which not only improve health outcomes but also reduce the amount of time women and girls care for other household members. They also include basic income security throughout the lifecycle, including for persons with disabilities. Basic income for children, in particular, should facilitate access to education and care.³⁹ Child and family benefit programmes are available in 108 countries, but 75 countries have no programmes at all. On average, governments spend 0.4 percent of their GDP on such programmes. The amount varies greatly: Western Europe allocates 2.2 percent, but the proportion is as low as 0.2 percent in Africa, Asia and the Pacific.⁴⁰ In contrast, little is known in developing countries about whether persons with disabilities are being adequately included in existing social protection programmes or about the impacts of these programmes on persons with disabilities.⁴¹

Cash transfer programmes, whether conditional (CCTs) or unconditional (UCTs), contribute to family budgets and lessen the depth of income poverty, though they do not necessarily enable families to get out of poverty or diminish women's poverty rates relative to men.⁴² UCTs, CCTs and public works programmes (PWP) currently cover 718 million people.⁴³ PWP are now implemented in 94 countries, many of which are in Africa.⁴⁴ CCTs have expanded considerably in Latin America and the Caribbean, where they cover about 133 million people.⁴⁵ In turn, Africa saw a strong increase in the number of cash transfer programmes after the year 2000, and in particular between 2010 and 2014, when the number of sub-Saharan African countries that have UCT programmes doubled to 40 (chapter 2).⁴⁶

Unconditional cash transfer, conditional cash transfer and public works programmes currently cover 718 million people in the world

Cash transfers have improved women's and children's nutrition,⁴⁷ facilitated girls' access to education and can leverage women's bargaining power within households.⁴⁸ Cash transfer programmes, however, generally take for granted that women will fulfil the care duties implicit in conditionalities,⁴⁹ failing to recognize women's unpaid care and domestic work. Time spent in complying with programme obligations can jeopardize women's ability to participate in paid work or skill development.⁵⁰ Evidence on the effect of conditionalities is mixed. "Hard" conditionalities have had positive effects on children's school enrolment in some contexts,⁵¹ but in others the results of conditional transfers for children are often no better than unconditional ones⁵² or are associated with the existence and quality of public services.⁵³ Moreover, women's time and efforts to meet conditionalities bring no additional social benefits.⁵⁴ The loss in women's well-being imposed by conditionalities can be greater than the cash benefit, as evidenced in the case of Guatemala.⁵⁵ This provides support for the removal of conditionalities.

Lack of recognition of women's unpaid care and domestic responsibilities frequently leaves women out of the reach of PWP. For this reason, the Indian

Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), which provides rural households with the right to 100 days per year of unskilled employment, establishes that childcare has to be provided at worksites and organized by women workers. In practice, however, this requirement has been difficult to implement.⁵⁶ Programmes in other countries, such as the South African Expanded Public Works Programme (EPWP), have incorporated the social sector, and within it home- and community-based care, and early childhood development, as a way of providing job opportunities to women.⁵⁷

Around the world, only 52 percent of all people over pensionable age receive a pension (figure 1.7 in chapter 1). Where sex-disaggregated data exist, statistics show that coverage for women is lower. This is particularly the case in countries with contributory pension systems, as women's low and intermittent formal employment patterns make them less able than men to make payroll contributions.⁵⁸ In contributory pension systems, a way of recognizing unpaid care and domestic work is through credits. In Chile, for example, a child credit was introduced in 2008 to improve women's pension benefits. The credit consists of a contribution of 10 percent of the minimum wage for 18 months per child (plus interest), financed by the state, which is deposited in women's accounts.⁵⁹ Nonetheless, credits may be insufficient to counterbalance all the above-mentioned negative effects. Non-contributory pensions are more effective in lifting older women out of poverty.⁶⁰

Care policies are increasingly becoming part of broader social protection systems beyond national protection floors. For example, the Uruguayan National Integrated Care System (Sistema Nacional de Cuidados/SNIC, see below) was created in 2015 to implement and coordinate care policies for adults with specific care needs, including persons with disabilities, and for small children. The SNIC aims to be the fourth pillar of Uruguay's social protection system, along with health, education and social security.⁶¹

Care policies are becoming part of social protection systems beyond national social protection floors

Care policies are also labour policies

Care policies have direct impacts on employment creation, and can potentially improve the working conditions of care workers, most of whom are women

Women's unpaid care and domestic work responsibilities explain their relatively low labour force participation compared to men and their weaker attachment to the labour market (figure 1.5 chapter 1). The “motherhood penalty”—the time women take off from employment to care for their children—partly explains women's lower wages over working years.⁶² In formal labour markets, maternity protection and parental leave allow parents to devote time to care. And the more similar (and generous) they are for mothers and fathers, the more they contribute to redistributing care within households. However, across the globe only about 40 percent of women in employment are covered by maternity protection (57 percent if voluntary coverage is included, for example, for self-employed women).⁶³ The percentages are lower in Asia and the Pacific, Latin America and Africa. Of all member states of the International Labour Organization (ILO), only 55 percent provide at least 14 weeks of maternity leave.⁶⁴ About 830 million women are without adequate maternity protection and other social protection, such as maternal and child health care, and the overwhelming majority of them are found in countries in Africa and Asia.⁶⁵ To reach these women, the Indian 2013 National Food Security Act, for example, established a maternity benefit over six months to support maternal and child nutrition and well-being. Yet the amount paid is less than the minimum wage, and far less than the average amount received by formally employed women.⁶⁶

Care policies also have direct impacts on employment creation,⁶⁷ and can potentially improve the working conditions of care workers, most of whom are women.⁶⁸ The ILO Domestic Workers Convention, 2011 (No. 189) shows that a progressive regulatory framework can contribute to improving the working conditions of a significant share of the care labour force that works for households. Frequently they are migrants in “global care chains” who take care jobs

but leave behind family members with care needs, whose care provision they financially support while delegating it to other women such as grandmothers, aunts or elder daughters.⁶⁹

3. Policy Innovations and Transformative Outcomes: Seeing Better Options with a “Care Lens”

Framing public care services, basic infrastructure and social protection policies under the umbrella of care policies is a game changer—it brings in a strong gender perspective; it allows for complementarity and coordination in social policy, improving outcomes for caregivers and care receivers; it caters for care workers; and it brings to the fore drivers and impacts that sometimes go unnoticed in sector-based policy debates, design and implementation.

The gender perspective is central to care policies

ECEC services are perhaps the most widespread policy area that can redistribute some of women's care workloads and allow them to engage more fully in the labour market. At the same time, however, their design and implementation has focused very little on women's and families' needs. There are several reasons for this, including the different agendas and expertise of sectoral practitioners,⁷⁰ the stated objectives of ECEC services—whether day-care facilities to support mothers' employment, or educational services to build children's capacities, which usually provide shorter hours—and even a view of mothers as conduits for their children's education and care, with little attention to mothers' own rights and needs.⁷¹

Framing public care services, basic infrastructure and social protection policies under the umbrella of care policies is a game changer

Yet, it is possible to sidestep this (artificial) children/women divide and cater to the needs of both caregivers and care receivers. This has occurred, for example, in the case of the Costa Rican Care Network (Red de Cuido).⁷² Launched in 2014, the programme is universal in ambition, rights-based, aims to guarantee access to childcare services to all children up to 6 years of age, and includes different providers and alternatives.⁷³ 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.⁷⁴ This strong 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.⁷⁵

The fact that fetching water is generally women's and children's work makes improvements in water and sanitation essential (SDG 6) because they enhance children's health and lower care requirements as a result.⁷⁶ When women are involved in the design, implementation and monitoring of water sources, this can result in time savings and better water resource management (box 3.2). This has been documented in El Salvador, Nigeria, Pakistan and Togo.⁷⁷ Yet when women are not allowed to participate, these gains fail to materialize. Barriers in the form of social norms may make women's participation "unpopular"⁷⁸ or meetings may be set according to men's time schedules.⁷⁹ In the case of Tanzania,⁸⁰ feminist pressure groups have advocated for women's representation in Water Committees, and in Rwanda,⁸¹ for the establishment of women's quotas in decision-making bodies, to help remove the obstacles to women's participation.

In turn, the recognition of the role of women as caregivers in cash transfer programmes is a double-edged sword. Women receive and administer the cash, and comply with conditionalities—all of which reaffirms social expectations about their role as caregivers, without necessarily contributing to the redistribution of care.⁸² As discussed earlier, this lends support to unconditional cash transfers, as is the case of the South African child-support grants.⁸³ Most beneficiaries are women, because they are usually the primary caregivers, but the absence of conditionalities means they do not have extra care loads as a result of the programme.⁸⁴

Care policies complement each other

Care policies do not exist in isolation, and the impacts of any care policy depend on whether other care policies are in place.⁸⁵ Complementarity in policy design and implementation is a common challenge for countries advancing care agendas. In the case of India, for example, the old-standing Integrated Child Development Services (ICDS), the Anganwadi Centres (AWCs), cater for children under 6 years of age and their mothers in rural areas. Run by the Ministry of Women and Child Development, AWCs serve multiple purposes, including overseeing nutrition and children's and mothers' health, but also as crèches that allow women and girls to work or attend school.⁸⁶ The AWCs are more effective when placed close to schools, and for this reason, the Ministry of Education's ECEC programmes should be implemented in conjunction with the ICDS centres of the Ministry of Women and Child Development.⁸⁷ The ICDS registries have also served as platforms to implement a CCT programme to cater for pregnant and lactating women.

The case of the South African EPWP shows the challenges of integrating the social sector—and care in particular—in public works programmes. The EPWP Early Childhood Development component is basically a skills development and training initiative that supports ECEC workers while they are being trained, but after they get their qualifications it provides no support, either in the form of jobs or help with placement in ECEC centres. Publicly funded ECEC centres have not expanded sufficiently, nor have the subsidies to support demand for private providers, which are crucial to their functioning. At the same time, user fees mean that most poor children are excluded. The wages paid by these centres are below the EPWP stipend, which acts as an incentive to continue training. Because EPWP training extends beyond the 0-4 year age category, more highly trained workers end up serving older age groups, where the pay is better. As a result, the initial policy intent of increasing the skills of ECEC workers is only partially fulfilled. Crucially, these problems will not be solved without cooperation between ECEC policy and EPWP, and the opportunity to provide ECEC and work opportunities for women in areas where most poor children reside will be missed.⁸⁸

In the case of Brazil, time spent complying with conditionalities seems to be behind a reduction of the paid working time by Bolsa Família's women beneficiaries, an effect not noticeable among men.⁸⁹ Acknowledging this effect, both Bolsa Família and Mexico's Prospera have started to offer complementary crèche schemes to beneficiaries.⁹⁰

These cases demonstrate the need for an integrated approach to care policies, even if investments are prioritized according to most pressing needs. They also point to the fact that budget restrictions are not the only (or even the main) reason limiting policy complementarity, as lack of coordination and planning, competition between programmes and institutional path-dependency also play a role.

Decent work for care workers opens up the “high road” to care

In the cases of India and South Africa discussed above, care workers are underpaid and their working conditions unsatisfactory. In India, Anganwadi workers receive an “honorarium”—not a wage—and its level is below the minimum wage. The work is regarded as voluntary, and working conditions are casual.⁹¹ In the case of South Africa, the pay levels of ECEC workers do not allow them to move out of poverty. Sometimes ECEC workers enrol in training, topping up their incomes with the EPWP stipend. However, when the training ends, they have higher skills but the same remuneration as before.⁹² Poor worker remuneration is also common in ECEC programmes in other African countries, like those reviewed in Kenya⁹³ and Nigeria. In the case of Nigeria, the limited implementation of the Integrated Early Childhood Development policy means that the early childhood education sector is dominated by private practitioners who, without proper supervision and regulation, neither guarantee minimum standards of quality in provision, nor employ trained staff or pay decent wages.⁹⁴

Other care workers are in similar or even worse positions. Although they form only a small proportion of India's women workers, domestic workers are even less protected than Anganwadi workers.⁹⁵ In contrast, in South Africa, as in most of Latin America, domestic workers make up a sizable proportion of all women workers (between 8 and 17 percent).⁹⁶ They frequently come from marginalized

backgrounds, are mostly engaged in informal work and tend to earn less than the minimum wage. Improvements in national legislation in South Africa and Uruguay, and the ratification of the ILO's Domestic Workers Convention (No. 189, 2011) in many other countries, are slowly ameliorating their working conditions. But the very fact that they work for households limits enforcement. When domestic workers are migrant workers, mobilization and better labour protection are even harder to achieve.⁹⁷ Migrant nurses and other care professionals who are part of the “global care chain” face the situation of having to provide care work in receiving countries without necessarily having solved their own care responsibilities—although the fact that their skills are recognized and they provide care in structured sectors tends to improve their situation vis-à-vis other care workers.⁹⁸

Care workers are underpaid and overworked across the world,⁹⁹ and their undervaluation stems in part from the social undervaluation of care. The examples above illustrate other drivers, in particular the role of the state in providing care services and in regulating market or community provision. ECEC in developing countries shows that private provision does not by itself produce positive outcomes. As in the case of rich countries, lack of state regulation drives fees up and care workers' wages down, thereby excluding the poor. Sometimes, the appearance of intermediaries, like employment agencies for domestic workers, also drives prices up without improving working conditions.¹⁰⁰ A “high road”¹⁰¹ to care provision is one that does not exploit care workers in order to keep care services going, and provides quality care—two sides of the same coin. In line with SDG target 5.4, this requires state involvement in providing care services, funding them and/or subsidizing demand, as in the cases of Costa Rica, Ecuador or the Republic of Korea mentioned above.

Seeing social policies through a “care lens” makes cross-sectoral coordination possible

Many countries in Latin America, like Chile, Ecuador, El Salvador and Mexico, have implemented care policy coordination mechanisms, whereby officials responsible for the implementation of policies focusing on children, women and persons with

disabilities, and representatives from the education, health and social security sectors, sit at the same table. Conceptualizing sectoral social policies as care policies brings about the possibility of building strong institutional coordination mechanisms.¹⁰²

The Uruguayan Integrated National Care System (SNIC), created in 2015, illustrates this point. The SNIC includes both existing policies on health, education and social security and new policies for priority populations, in particular adults with specific care needs, including persons with disabilities, and young children. The National Care Secretariat within the Ministry of Social Development is the interministerial coordination body. Incumbent ministries and secretaries form the SNIC “board”, which establishes broad policies and priorities. An advisory group made up of civil society, academia, private providers and care workers interacts with the board and the secretariat.¹⁰³ The National Care Secretariat was first envisioned purely as a coordinating secretariat, but to give it political room for manoeuvre, it was allocated a new budget to expand childcare services.¹⁰⁴ Over time, the care services provided by other ministries and state agencies are to be moved under the SNIC budget allocation. The design stage focused more on the establishment of coordination mechanisms than on the detail of policy design. At the implementation stage, which started in 2016, these coordination mechanisms, and in particular strengthening the position of the National Women’s Institute within the SNIC board, will be crucial in maintaining a strong gender perspective.¹⁰⁵

Care policies have macro drivers and positive macroeconomic impacts

Demographics, and their impact on the labour market, have historically been among the main elements behind the emergence of care agendas in the public domain in the Global North.¹⁰⁶ Such drivers are starting to prompt reforms in several developing countries. A tight labour market might encourage governments to facilitate women’s labour force participation by providing childcare services or state subsidies for childcare, even if this clashes with more traditional family values, as was the case with the Republic of Korea’s Child Care Subsidy.¹⁰⁷ China’s recent reversal of its one-child policy seems to be a response to a shrinking labour force, and the

fact that postponing retirement age is not an option in China, given the significant share of the working population undertaking manual work.¹⁰⁸ Yet the policy might be ineffective if it is not complemented with support for childcare, as only well-off families can afford private services.¹⁰⁹ The case of Uruguay is also illustrative: underpinning efforts to guarantee care provision for both the older population and young children is an ageing population (the oldest in Latin America) and a tight labour market.¹¹⁰

The impacts of care policies on the labour market, however, extend beyond women’s increased labour force participation. Care policies can also have positive demand-side labour market impacts. They can generate employment, in particular women’s employment, and have the potential to create decent jobs at a higher rate than other public expenditures. Turkey is a case in point.¹¹¹ The supply of childcare services shows problems of accessibility and location, high prices and low quality, caused by lack of public provision or subsidies to cover the existing demand.¹¹² For the country’s offer of public childcare services to match OECD average pre-school enrolment, Turkey would have to invest 1.36 percent of its GDP annually. Such an investment in early childhood education would create (directly and indirectly) two and a half times the number of jobs (mostly women’s) that a similar demand injection would create if it were channelled (for example) to the construction sector. Almost 80 percent of expenditure would be recovered through increased government revenues, debunking the view that care policies (and social policies in general) only add to the expenditures side of the government budget. Labelling public expenditure in care as investment and not as public consumption would strengthen the case for mobilizing funds for care service provision.¹¹³

Care policies can impact long-run economic growth by raising economy-wide productivity, as is the case of public investment in physical and social infrastructure,¹¹⁴ and by building human capabilities. The latter channel is more than a linear impact on human capital that automatically feeds into greater future growth. Women’s participation in labour markets can occur at the expense of their unpaid care and domestic work, which can lower the production of human capabilities that ultimately impact growth—an effect that is frequently overlooked when women’s employment rises. The effect on growth will depend on whether women’s

Box 3.2. Care and environmental sustainability: Making the connections

Women's unpaid care and domestic work continues to be neglected in economic thinking, including that associated with green economy innovations and approaches, which are generally structured according to market transactions and paid work (chapter 5). Such approaches have been criticized for being gender-blind and taking for granted the unpaid care work and natural resources that are essential to the dominant economic system. Feminist scholars emphasize the need for structural change toward the more integrative and distributional approaches of sustainable development. They point, in particular, to the need for a sustainable and caring economy, where care is recognized and valued, and the burden is redistributed equally.^a This is essential, in particular for women in the global South who spend vast amounts of their time fetching firewood, fuel and water, and carry out other activities related to unpaid care and domestic work and smallholder farming (figure 3.1).

Effects of climate change and environmental degradation add to the care burden of women. Climate change, coupled with resource-constrained environments and inadequate and unequal access to infrastructure and services, reduce women's choices even further.^b In sub-Saharan Africa for example, many women are key actors in sustaining their families through smallholder farming, and hence are more vulnerable to the effects of climate change due to their reliance on natural resources, limited control of access to resources, limited participation in decision-making processes, and restrictive social and cultural norms.^c Due to gender inequality, women are often negatively impacted by water resource management and other natural resource provisioning systems and are often excluded from decision making.^d Myriad case studies highlight the positive impacts of women's participation on the outcome of projects securing sustainable safe drinking water and sanitation.^e

The complex topics of care and sustainability have yet to be bridged successfully.^f The interdependency between care and the environment, and care for the environment, have been given short shrift in both academia and public policy. Building a caring and sustainable economy requires a fundamental change of perspective and policy priorities.^g

Notes: ^a Schildberg 2014. ^b UNDP 2015. ^c Kanengoni 2015.

^d Wallace and Porter 2010. ^e UN DESA 2006. ^f Schildberg 2014.

^g Gottschlich 2012.

employment contributes to expanding domestic demand or, on the contrary, squeezes profits and investment.¹¹⁵ The estimated virtuous impacts of an expansion of ECEC in Turkey are an example of the former. The lack of childcare service provision in China is an example of the latter, where a profit-led model of growth—and the other side of the coin, low wages—leaves women workers to shoulder care responsibilities by themselves, resulting in their withdrawal from the labour force when they are not able to pay for care services or find replacement for their care during paid working hours.

4. Building Transformative Care Agendas

This review of care policy innovations makes clear that they can be a double-edged sword in terms of women's and care receivers' rights, agency and well-being. Care policies play out in a contested terrain, within particular institutional and political settings. The question is how to build transformative care agendas. This is fundamentally a political issue, as it involves caregivers' and care receivers' potentially conflicting rights as well as disputes over resources, both public and private.¹¹⁶

Care agendas are multiple and come from different normative and political frameworks

Care has become a political issue only recently.¹¹⁷ Very different normative positions underpin care agendas. Such positions define who should provide care, for whom it should be provided, who should bear which costs, and what institutions, economic structures, gender norms and public policies should intervene in their design and implementation.¹¹⁸ 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 in who benefits from care. They point out that these inequalities hinder women's enjoyment of their human rights¹¹⁹ and deepen already existing inequalities among care receivers. Such analyses call for the redistribution of care responsibilities and the universalization of access to good quality care,

in particular through active state interventions.¹²⁰ Actors adopting a *social investment* perspective, in turn, view care both as an input to care receivers' human capital formation and as an impediment for caregivers to engage in employment which, in turn, is a driver of poverty.¹²¹ These diagnoses focus on children (but not on other persons with care needs, or on adults in general), and on the efficiency gains of women's participation in the labour market when care services are publicly provided or subsidized. From this perspective, preferred interventions are those that focus on targeting "poor dependent groups".

The "Triple R" framework (box 3.3) has begun to galvanize progressive normative positions around care. This framework has become a diagnostic and advocacy tool in development circles,¹²² and has prompted a language change in UN reports, which up until very recently used only the Beijing Platform for Action formulation.¹²³ The final wording of SDG target 5.4, which avoids mentioning reducing or redistributing unpaid care and domestic work—even if the agreed indicator for this target will effectively monitor these trends¹²⁴—shows that the language of international agreements takes longer to change.¹²⁵ Indeed, a final proviso in target 5.4, "the promotion of shared responsibility within the household and the family as nationally appropriate" positions care as a cultural issue and can, potentially, jeopardize the advancement of the care agenda.

How care is framed varies considerably

Increasingly progressive perspectives on care have entered mainstream international development discourse in recent years. UN agency flagship reports now regularly profile the issue of unpaid care and domestic work.¹²⁶ Such recognition is far less apparent, however, at 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.¹²⁷

Country, regional and shadow reports that have evaluated progress and challenges since the Beijing Platform for Action offer the same bleak view, albeit with some regional differences.¹²⁸ In contrast to Africa and Asia, unpaid care and domestic work

Box 3.3. The "Triple R" framework

The Triple R framework, which calls for recognizing, reducing and redistributing unpaid care and domestic work^a expands the Beijing Platform for Action's call for recognition and valuation,^b typically interpreted as measurement, by adding 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 therefore involves 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 times 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.

Notes: ^a A reinterpretation of Nancy Fraser's (1997; 2000) "Triple R" framework for identity politics: recognition, redistribution, representation, which was proposed by Elson (2008). See Esquivel (2011b) for an elaboration and Esquivel (2013) for practical applications to policy. ^b United Nations Fourth World Conference on Women 1995.

figures prominently in Latin American country reports as a central dimension of gender inequality. Designing and implementing care policies that redistribute the paid and unpaid work between women and men, families, states, not-for-profit sector and markets are identified among the main challenges for gender equality in the region.¹²⁹

The apparent consensus on the importance of care for development within international development circles, coupled with the low priority of care agendas

Designing and implementing care policies that redistribute the paid and unpaid work between women and men, families, states, not-for-profit sector and markets are identified among the main challenges for gender equality in Latin America

at the national level, allows a possible reading of the care agenda as “Northern” or “Western” by developing countries. The risk is that a developed/developing country divide may break any consensus and provide an escape route to governments that do not prioritize compliance with SDG target 5.4.¹³⁰

Care ranks high in women’s movements agendas, albeit with caveats

The diverse approaches to unpaid care and domestic work adopted by women’s movements and organizations at international, regional and national levels mirror different care frameworks. Women’s movements and feminist organizations that took part in the negotiations of the SDGs as part of the Women’s Major Group (WMG) used the Triple R framework (box 3.3) to articulate policy claims around care, arguing forcefully from a rights-based perspective.¹³¹ When the language of “reduction” and “redistribution” was removed from later drafts, the WMG voiced strong opposition, though with little success.¹³² Women’s movements at regional levels, such as the Asia Pacific Forum for Women and Law Development, also articulated claims around care using the Triple R framework, linking it with the decent work and social protection for all agendas.¹³³

Yet the very concept of unpaid care and domestic work as used in international development discourse—including in SDG target 5.4—is not necessarily used by women’s movements at the national level. In China, India and Indonesia, for example, the concept of unpaid care and domestic work is rarely found in advocacy and mobilization.¹³⁴ This is sometimes a “strategic” decision, to frame advocacy in other political agendas that might gain more traction, as in the case of children’s rights. In other cases, pervasive norms that see women’s caring responsibilities as “natural” explain the absence of claims around unpaid care work. In India, feminist activists felt mobilizing around care was difficult, given how deeply internalized and “private” the distribution of care responsibilities is.¹³⁵ The same was deemed true in Nepal.¹³⁶

In contrast, in Latin America, demands for care policies, including care services and parental leave,

are mostly articulated by urban academic feminists, officials in labour ministries, women members of parliament and women trade unionists, whose main strategy has been to exert claims on the state (including local governments) to achieve policy change.¹³⁷ Such a strategy ultimately rests on a belief in the role of the state in regulating public and private life and in its capacity for service delivery. Where the public sector is absent or unreliable and communities lack basic infrastructure, health care and education, women’s movements are likely to find it hard to exert claims on the state for better infrastructure or childcare services.¹³⁸ In many cases, they engage in service delivery themselves with the help of international donors, as illustrated by the case of home-based workers caring for persons living with HIV/AIDS in several African countries.¹³⁹

Care is moving up the agendas of labour and care receivers’ rights movements

Beyond women’s movements, there are several other actors at the local level who also articulate care claims from the perspective of paid care workers, including trade unions and care worker activists, or from the perspective of care receivers, such as organizations for persons with disabilities, persons living with HIV/AIDS and children’s rights activists.¹⁴⁰ Progress related to domestic workers, for example, has been the result of strong mobilization at national and international levels.¹⁴¹ Informal worker activists are demanding the inclusion of childcare services in social protection floors,¹⁴² challenging the idea that childcare services are solely a demand of women working in the formal sector—a view that is supported by the ILO Recommendation on Transition from the Informal to the Formal Economy, 2015 (No. 204, para. 21). Child rights activists are also forcefully articulating demands for child care services.¹⁴³

These groups, however, do not always share the same views or agendas around care. In the run-up to finalizing the design of the Uruguayan SNIC, the government opened “national dialogues” to raise awareness and incorporate local realities into the design. Yet the dialogues saw a departure from the women’s movements’ agenda that sparked the process. Considerable networking and mobilization were necessary to re-establish its feminist agenda.¹⁴⁴

5. Pathways to Transformative Care Policies

What accounts, then, for the emergence of transformative care policies? These have generally emerged in contexts of progressive framings, broad political alliances and innovative uses of evidence.¹⁴⁵

Progressive framings advance transformative care agendas

Common understandings catalyse alliances and prevailing ideas on the role of women, and the political leaning of governments in power, matter for the advancement of transformative care policies. Some framings of care have proved more powerful than others in bringing progressive actors together. For example, claims framed around the recognition of care have made a dent in the discourse of national governments, particularly in African countries, but they do not automatically lead to policy change.¹⁴⁶

In contrast, the rights-based approach to social protection as an umbrella for a rights-based approach to care policies has proved a much more fruitful background for advancing the care agenda. This is apparent in several Latin American countries, such as Uruguay and Costa Rica.¹⁴⁷ A rights-based approach to care recognizes both caregivers and care receivers as rights-holders, and positions the state as a duty-bearer.¹⁴⁸ It is a powerful framework that can be used to exert claims on the state—albeit less powerful if the state is absent or mistrusted.

Broad alliances and engagement with the state are also needed

Several actors, including civil society, academics, labour movements, practitioners and politicians, have an interest in, and the power to, influence care policies. It is in dialogue with these stakeholders that government officials design, implement and monitor transformative care policies.

Transformative care policies have emerged as a result of broad alliances and consensus-building processes in which women's movements have actively engaged with state actors. In Nepal, for example, a coalition

Transformative care policies have emerged as a result of broad alliances and consensus-building processes in which women's movements have actively engaged with state actors

of actors ranging from groups representing women lawyers and journalists, as well as other social movements, engaged with academics and other activists to target and lobby decision makers to recognize unpaid care work in public policy.¹⁴⁹ In Nigeria, the Unpaid Care Work Coalition engaged with government officials. After much resistance, a framework for mainstreaming unpaid care work in national economic policy¹⁵⁰ was designed—a fact that was reported in the Beijing+20 Nigerian national review.¹⁵¹ However, less progress was made in advocating for the full implementation of ECEC policy, the other priority of the coalition.¹⁵² In both cases, progress was slow due to resistance of government officials and the fact that there were no “femocrats” (feminist bureaucrats) in the government administration to provide support and exert pressure from within.¹⁵³

The Uruguayan SNIC began with a broad alliance between women's and social movements, women parliamentarians and academics. Organized in the Red de Género y Familia, the first step was convening Care Dialogues, an advocacy strategy which aimed to raise the visibility of care on the public agenda.¹⁵⁴ But in contrast to the above-mentioned cases, it was the engagement with the ruling party, Frente Amplio, and the inclusion of the SNIC as part of the electoral campaign programme for 2010–2015 that proved crucial.¹⁵⁵ Care thus became a political, and not only a technical, public policy issue. Because the importance of unpaid care and domestic work had already been recognized, the discussion could centre on concrete policy design and implementation.

Broad alliances between women workers' organizations, social movements and (sometimes) labour unions have also supported efforts to engage with the state to change legislation and working conditions for domestic workers. However, there have been varying degrees of success depending on how claims are framed, and the degree of autonomy and representation conferred on women workers' associations.¹⁵⁶

Evidence supports care policies from “behind the scenes”

Evidence-based research on care has been influential in the policy process—from focus groups with women informal workers, which have helped raise the visibility of care,¹⁵⁷ to the collection of time-use data by national statistical offices,¹⁵⁸ which are increasingly used to support women’s claims on redistributing unpaid care and domestic work.

Since the 1995 Beijing Platform for Action and bottom-up pressure from women’s movements, as many as 125 countries have conducted time-use surveys (TUS).¹⁵⁹ These, in turn, have generated comparative time-use data at the international level.¹⁶⁰ Time-use data are increasingly used as evidence to support women’s care claims and monitor policy impact at the national and local levels. In India, for example, the findings of the 1998–1999 TUS confirmed the unequal distribution of paid and unpaid work in both rural and urban areas, and revealed care deficits, especially in poor households—a move that enhanced the demand both for maternity entitlements and for crèches at MGNREGA working sites.¹⁶¹ In Uruguay, initial time-use data collected by academics for Montevideo provided evidence to position care on the public agenda.¹⁶² In Tanzania, time-use data are used to monitor public expenditure on water and sanitation as part of gender-sensitive budgeting initiatives.¹⁶³ Time-use diaries are also part of donor agencies’ advocacy strategies. They can also raise women’s awareness about their time spent on unpaid care and domestic work and encourage mobilization around care claims.¹⁶⁴

It is to be hoped that the recent change in the ILO’s definition of work, which explicitly includes unpaid care and domestic work,¹⁶⁵ as well as SDG target 5.4, will reinvigorate time-use data collection¹⁶⁶ as countries will be required to conduct TUS at certain intervals to monitor progress toward reducing and redistributing unpaid care and domestic work.¹⁶⁷ Time-use data could also be used in innovative ways to inform future care policies. These data have yielded, for example, measurements of “time poverty”¹⁶⁸ and its relation with income poverty. In the cases of Argentina, Chile and Mexico, taking into account time poverty substantially increased the incidence of (time-adjusted) income poverty: from 6.2 percent to 11.1 percent in Buenos Aires

(Argentina), from 10.9 percent to 17.8 percent in Gran Santiago (Chile), and from 41 percent to 50 percent in Mexico.¹⁶⁹ These measures have also been used to evaluate the impact of specific care policies, such as the universalization of the childcare voucher programme in the Republic of Korea. Results have shown that the programme slightly reduced the incidence of (time-adjusted) income poverty from 7.9 percent to 7.5 percent.¹⁷⁰

6. Realizing the Transformative Potential of Care Policies

The analysis presented in this chapter points to the following main conclusions.

The gender perspective is central to care policies

Care policies serve multiple purposes. Central to them is the well-being of care receivers. Yet in their design and implementation, care policies can contribute to gender equality, or be detrimental to it. Recognition of women’s unpaid care and domestic work can act as an entry point to bring a gender perspective into care policies, and help reduce and redistribute care as a result.

Care policies complement each other

SDG target 5.4 lists public care services, infrastructure and social protection policies as ways to recognize women’s unpaid care and domestic work. These policy instruments need to be designed and implemented in ways that complement one another to realize their transformative potential.

Decent work for care workers opens up the “high road” to care

Care service quality is intrinsically associated with working conditions in care services, be they public, community- or market-based. A “high road” to care provision caters for care workers, including domestic workers and migrant care workers, who are usually women.

Seeing social policies through a “care lens” makes cross-sectoral coordination possible

The multiplicity of care policies means that they are formulated in several ministries and secretariats, have different political priorities, and sources of funding, and cater for different populations. They involve actors with various agendas and interests that may be in tension. Sector-oriented practitioners have little connection with each other, resulting in fragmentation, competition for policy space and slow progress of care agendas. Making care a cross-sectoral policy dimension has allowed the emergence of coordination mechanisms that avoid some of these drawbacks.

Care policies have macro drivers and positive macroeconomic impacts

Among other reasons, care policies emerge in response to structural challenges, such as ageing populations or tight labour markets. The impacts of care policies go beyond the well-being of care receivers and care providers to have macroeconomic consequences. Care policies can generate employment and impact long-term growth.

This chapter also shows that the emergence of a transformative care agenda is not a technocratic fix. Care policies are contested. Whether and how they are implemented, their design and institutional architecture, are politically determined.¹⁷¹ Progress depends on the complex interplay between ideas, interests, norms and values, and power relations; national and international institutional settings; and structural factors conducive or detrimental to the realization of a transformative care agenda.

The 2030 Agenda provides a platform for the advancement of care policies at the national level. This means bringing a care lens to public services, infrastructure and social protection policies. While in many cases it is highly effective, however, the care lens is not automatically associated with transformative change. Elements that have been decisive in making care policies transformative are progressive political framings, broad political alliances and innovative use of evidence. These are further supported by contextual factors such

as dynamic labour markets and increasing female labour demand, as well as availability of funding for care policies.

Transformative care policies are more likely to emerge when:

- channels for social dialogue are established with women’s and social movements, trade unions and dependent persons’ rights organizations, in order to set priorities and inform policy design;
- institutional coordination effectively bridges sectoral divides such as health, education, infrastructure and social protection;
- a strong gender perspective is built into the design and implementation of care policies, and decent working conditions are offered to paid care workers; and
- care policies are framed within a universalist, human rights–based approach to social protection.

Endnotes

- ¹ Other key rights at work that complement the right to maternity leave are non-discrimination and the right to breastfeed at work.
- ² Sepúlveda Carmona 2013.
- ³ This is the wording of the Beijing Platform for Action, agreed at the UN Fourth World Conference on Women 1995, Strategic Objective H.3, point [f] (UN Women 1995).
- ⁴ Other than in target 5.4, the 2030 Agenda explicitly refers to care policies in targets 3.7/3.8: universal health care, 4.2: care and pre-primary education for girls and boys, and in Goal 6: water and sanitation for all. Goal 8, on employment, does not mention parental leave or paid leave for caregivers, although they are arguably part of what the ILO calls “decent work”.
- ⁵ This understanding of autonomy and agency refers to the “capacity of self-determination rather than the expectation of individual self-sufficiency” (Williams 2014:102).
- ⁶ Tronto 2013.
- ⁷ Folbre 2006; Neumann et al. 2015.
- ⁸ In line with the UN Convention on the Rights of Persons with Disabilities (UN 2007).
- ⁹ Antonopoulos et al. 2012.
- ¹⁰ Evans 2014.
- ¹¹ Neumann et al. 2015:9.
- ¹² Esquivel 2011:20.
- ¹³ Esquivel 2011:27, 31.
- ¹⁴ Staab and Gerhard 2010.
- ¹⁵ Republic of Kenya 2012.
- ¹⁶ República de Colombia 2016.
- ¹⁷ Staab 2015.
- ¹⁸ Fultz and Francis 2013; Molyneux et al. 2016.
- ¹⁹ Peng 2012; Zacharias et al. 2014.
- ²⁰ Scheil-Adlung 2015.
- ²¹ UNECE 2015.
- ²² República de Chile 2016.
- ²³ UNFPA 2012. A recent Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Older Persons in Africa states in article 12 that countries should “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).
- ²⁴ UN DESA 2015:4.
- ²⁵ Between 35 and 50 percent of persons with disabilities in developed countries, and between 76 and 85 percent in developing countries received no treatment in the year prior to the study (WHO 2015b).
- ²⁶ Morgon Banks et al. 2016.
- ²⁷ UN Women 2015b.
- ²⁸ Makina 2009.
- ²⁹ WHO 2015a.
- ³⁰ Brown 2010:63.
- ³¹ UNICEF and WHO 2015:7.
- ³² UN DESA 2014.
- ³³ Brown 2015.
- ³⁴ UN Water 2012.
- ³⁵ Fontana and Natali 2008.
- ³⁶ Fontana and Elson 2014.
- ³⁷ African Development Bank Group 2015:13.
- ³⁸ Seguino and Were 2014:37.
- ³⁹ ILO 2012.
- ⁴⁰ ILO 2014:xxii.
- ⁴¹ Morgon Banks et al. 2016:1.
- ⁴² Fultz and Francis 2013:5.
- ⁴³ World Bank 2015.
- ⁴⁴ World Bank 2015:7.
- ⁴⁵ Estimate equivalent to 21.5 percent of the Latin American population for the year 2013 (Cecchini and Vargas 2014).
- ⁴⁶ Although they have low coverage (World Bank 2015).
- ⁴⁷ Save the Children 2012.
- ⁴⁸ Fultz and Francis 2013.
- ⁴⁹ Esquivel 2013; Sepúlveda Carmona 2014.
- ⁵⁰ Molyneux 2007; Fultz and Francis 2013.
- ⁵¹ Baird et al. 2013 cited in World Bank 2015:9.
- ⁵² Fultz and Francis 2013:34
- ⁵³ ECLAC 2016:76.
- ⁵⁴ Fultz and Francis 2013:34.
- ⁵⁵ Gammage 2010.
- ⁵⁶ Fultz and Francis 2013.
- ⁵⁷ Parenzee and Budlender 2015.
- ⁵⁸ ILO 2014:14.
- ⁵⁹ Arza 2012.
- ⁶⁰ Arza 2015.
- ⁶¹ EUROsocial 2015.
- ⁶² ILO 2016.
- ⁶³ ILO 2014.
- ⁶⁴ ILO 2016:80.
- ⁶⁵ ILO 2014:xiv.
- ⁶⁶ Rao 2016.
- ⁶⁷ Antonopoulos et al. 2012.
- ⁶⁸ Budig and Misra 2010.
- ⁶⁹ ILO (2015), cited by ILO (2016:70), estimates that of the total of 150.3 million migrant workers today, 11.5 million—or 17.2 percent—were domestic workers. The majority of them (73.4 percent) were women. Regionally, southeast Asia and the Pacific host 24.0 percent of female migrant domestic workers, followed by northern, southern and western Europe (22.1 percent) and the Arab states (19.0 percent). For reviews on global care chains, see Kofman and Raghuram (2015) and Pérez Orozco (2010).
- ⁷⁰ Chopra 2014.
- ⁷¹ A gender perspective on ECEC is usually translated into tackling gender discrimination in access to education, not women’s needs as caregivers (Fontana and Elson 2014; UNECA 2015).
- ⁷² Guzmán León 2014.
- ⁷³ IMAS 2016.
- ⁷⁴ IMAS 2016.
- ⁷⁵ INAMU 2014.
- ⁷⁶ Asian Development Bank 2015; Willetts et al. 2010.
- ⁷⁷ UN DESA 2006.
- ⁷⁸ Delgado and Zwartveen 2007 cited by Kevany and Huisingh 2013.
- ⁷⁹ De Nys et al. 2014 (the example, though, is for urban areas in Water Users Management organizations, not in rural areas).
- ⁸⁰ Kytölä 2009 cited by Fontana and Elson 2014.
- ⁸¹ UNEP et al. 2013.
- ⁸² Molyneux 2007; Fultz and Francis 2013; Plagerson and Ulriksen 2015.
- ⁸³ South Africa has an array of programmes to support children and their primary caregivers: the Child Support Grant, the Foster Child Grant, which has a higher stipend than the former for children that do not live with their parents, and the Care Dependency Grant, for severely disabled children (Budlender and Woolard 2012; Plagerson and Ulriksen 2015).
- ⁸⁴ Plagerson and Ulriksen 2015.
- ⁸⁵ Daly 2015.

- ⁸⁶ Palriwala and Neetha 2010; UN Women 2012.
- ⁸⁷ Republic of India 2015.
- ⁸⁸ Parenzee and Budlender 2015.
- ⁸⁹ ECLAC and ILO 2014:19.
- ⁹⁰ Fultz and Francis 2013; Rossel et al. 2015.
- ⁹¹ UN Women 2012.
- ⁹² Parenzee and Budlender 2015.
- ⁹³ Republic of Kenya 2012.
- ⁹⁴ Obiwelouzor 2015.
- ⁹⁵ Palriwala and Neetha 2010. However, the exact figure of Indian domestic workers is contentious. See “India: 2.5 or 90 million domestic workers?” in ILO 2013a:14.
- ⁹⁶ ILO 2013c.
- ⁹⁷ Kofman and Raghuram 2015:183.
- ⁹⁸ Kofman and Raghuram 2015.
- ⁹⁹ Razavi and Staab 2010.
- ¹⁰⁰ As is the case of France (Devetter 2013) or the United Kingdom, where approximately 56 percent of care workers are on zero hour contracts (TUC 2014).
- ¹⁰¹ Folbre 2006.
- ¹⁰² ECLAC 2016.
- ¹⁰³ República Oriental del Uruguay 2016.
- ¹⁰⁴ See the SNIC budget at <https://www.mef.gub.uy/innovaportal/file/16500/4/ix.sistema-de-cuidados.pdf>, accessed 24 February 2016.
- ¹⁰⁵ Espino and Salvador 2014.
- ¹⁰⁶ Bergman 2004 cited in Alfes 2015.
- ¹⁰⁷ Peng 2012.
- ¹⁰⁸ Hopkins 2016.
- ¹⁰⁹ In 2013, 46.1 percent of kindergarten and pre-school students in China were enrolled in private kindergartens, and fees covered more than half of the operating costs of the programmes (Song 2014 cited in Cook and Dong 2015).
- ¹¹⁰ PNUD 2014; Scagiola 2014.
- ¹¹¹ İlkkaracan et al. 2015.
- ¹¹² Muñoz-Boudet and Aran 2015.
- ¹¹³ ITUC 2016; UN Women 2015a.
- ¹¹⁴ Seguino and Were 2014.
- ¹¹⁵ Braunstein 2015.
- ¹¹⁶ Rao 2016; Daly 2015. Molyneux et al. (2016:9) make a similar point about cash transfer programmes.
- ¹¹⁷ Esquivel 2015.
- ¹¹⁸ Esquivel 2014:433.
- ¹¹⁹ Sepúlveda Carmona 2013.
- ¹²⁰ UNRISD 2010; Esquivel 2013.
- ¹²¹ Williams 2012.
- ¹²² ActionAid 2013a; Kidder and Pionetti 2013.
- ¹²³ Esquivel 2011.
- ¹²⁴ ECOSOC 2016.
- ¹²⁵ In Latin America, where there has been greater progress in transformative care agendas, 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 means a strong public sector to guarantee that not all care responsibilities fall onto families, and especially on women. However, it places a stronger emphasis on the private sector, seen as co-responsible for care provision, and positions interaction in the labour market at the centre of the debates (Martínez-Franzoni 2015).
- ¹²⁶ See, for example, UNRISD 2010; World Bank 2012; UN Women 2015a; UNDP 2015; ILO 2016.
- ¹²⁷ Chopra 2013.
- ¹²⁸ Esquivel and Kaufmann 2016.
- ¹²⁹ CEPAL 2015:25.
- ¹³⁰ Paraphrasing Eyben’s (2012) “hegemony cracked”.
- ¹³¹ Post-2015 Women’s Coalition 2015; see also Gabizon 2016.
- ¹³² Women’s Major Group 2014; see also Gabizon 2016. For an analysis of the SDGs from a feminist perspective, see Esquivel and Sweetman 2016.
- ¹³³ APWLD 2014.
- ¹³⁴ Rao 2016.
- ¹³⁵ Chigateri et al. 2016.
- ¹³⁶ Chopra et al. 2014.
- ¹³⁷ Rodríguez Gustá and Madera 2015.
- ¹³⁸ ActionAid 2013a:27.
- ¹³⁹ Evans and Atim 2015.
- ¹⁴⁰ Williams 2012.
- ¹⁴¹ Kabeer 2016; Mather 2014; WIEGO n.d., 2016.
- ¹⁴² Budlender 2015.
- ¹⁴³ Samman et al. 2016.
- ¹⁴⁴ Aguirre and Ferrari 2014:37.
- ¹⁴⁵ These factors bear some resemblance with those proposed by Eyben (2012:18) “naming, framing, claiming and programming” to get care onto development agendas.
- ¹⁴⁶ African Shadow Report on Beijing +20 national reviews cited in Esquivel and Kaufmann 2016.
- ¹⁴⁷ Cecchini et al. 2015.
- ¹⁴⁸ Sepúlveda Carmona and Donald 2014.
- ¹⁴⁹ Chopra et al. 2014.
- ¹⁵⁰ Recognition in national economic policy seems more ambitious, but also vaguer and harder to articulate than recognition in social protection and infrastructure policies.
- ¹⁵¹ Republic of Nigeria 2014:22.
- ¹⁵² ActionAid 2013b.
- ¹⁵³ A factor that has proved positive in other contexts, like Indonesia and Bangladesh (Nesbitt-Ahmed and Chopra 2015).
- ¹⁵⁴ Fassler 2009.
- ¹⁵⁵ Aguirre and Ferrari 2014.
- ¹⁵⁶ Kabeer 2016; WIEGO n.d.; Goldsmith 2013.
- ¹⁵⁷ Alfes 2016.
- ¹⁵⁸ Budlender 2010.
- ¹⁵⁹ Hirway 2016.
- ¹⁶⁰ UNDP 2015; Samman et al. 2016; Charmes 2015.
- ¹⁶¹ Rao 2016.
- ¹⁶² Aguirre 2013.
- ¹⁶³ Kytölä 2009 cited in Fontana and Elson 2014.
- ¹⁶⁴ ActionAid 2013a:5; Kidder and Pionetti 2013; Chopra et al. 2014. The need to produce sound (representative) evidence made Oxfam conduct a time-use survey in rural communities in five countries to establish a “base line” for its future work (Rost et al. 2015).
- ¹⁶⁵ ILO 2013b.
- ¹⁶⁶ ECOSOC 2016.
- ¹⁶⁷ The agreed monitoring indicator is “Percentage of time spent on unpaid domestic and care work, by sex, age group and location” (ECOSOC 2016) which in practice measures reductions in women’s unpaid care and domestic work or redistribution relative to men only.
- ¹⁶⁸ See, for example, Antonopoulos et al. (2012) for a definition of time poverty that takes as a starting point the unpaid care and domestic work required to live with incomes at poverty level; Bardasi and Wodon (2009), who combine paid and unpaid work hours for the income poor; Goodin et al. (2008) who base their calculations on the “socially required work time”.
- ¹⁶⁹ Data for circa the mid-2000s. See Antonopoulos et al. 2012.
- ¹⁷⁰ Zacharias et al. 2014.
- ¹⁷¹ Daly 2015:23; Chopra 2013.

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