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‘Care is not a burden’: a 7-4-7 framework of action for operationalising the Triple R

Deepta Chopra and Meenakshi Krishnan

ABSTRACT

Our research on government policy responses to address the increase in women’s unpaid care and domestic work during COVID-19, across 59 countries of Asia and the Pacific, shows that less than 30 per cent of measures are care-sensitive and of these only 12 per cent are gender-differentiated. From this analysis, this paper proposes a care-integral approach to ensure gender-transformative outcomes. This approach comprises a unique three-tier framework for policy action constituting: (1) seven foundational care normative principles, (2) typology of four care-sensitive policy categories, and (3) seven levers of change to guide implementation. Together this 7-4-7 framework presents comprehensive strategies for policymakers to operationalise the Triple R agenda of ‘Recognise’, ‘Reduce’, and ‘Redistribute’ unpaid work. Further, this paper makes a unique contribution by redirecting attention of the Triple R approach on quantity of care, to make a case for improving the overall quality of care.

D’après nos recherches sur les réponses en matière de politiques données par les gouvernements pour faire face à la hausse du travail non rémunéré de soins et domestique effectué par les femmes pendant la pandémie de Covid-19 – recherches menées dans 59 pays de la région Asie et Pacifique – moins de 30 pour cent des mesures tiennent compte des soins et, sur ces mesures, seulement 12 pour cent sont différenciées en fonction du genre. Sur la base de cette analyse, cet article propose une approche intégrant les soins pour garantir des résultats transformateurs sur le plan du genre. Cette approche englobe un cadre unique à trois niveaux pour l’élaboration d’actions en matière de politiques : (i) sept principes normatifs fondamentaux en matière de soins, (ii) une typologie de quatre catégories de politiques tenant compte des soins, et (iii) sept leviers du changement pour orienter la mise en œuvre. Ce cadre 7-4-7 présente des stratégies complètes permettant aux décideurs d’opérationnaliser le programme Triple R consistant à « reconnaître », « réduire » et « redistribuer » le travail non rémunéré. De plus, cet article apporte une contribution sans pareille en réorientant l’attention de l’approche Triple R sur la quantité des soins, afin de présenter des arguments pour améliorer la qualité globale des soins.

Nuestra investigación sobre las políticas públicas impulsadas por los gobiernos en 59 países de Asia y el Pacífico para abordar el aumento

KEYWORDS

Care-integral; Triple R; unpaid care work; ethics of care; gender-transformative policy

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de los cuidados y del trabajo doméstico no remunerado realizados por mujeres durante la COVID-19. La misma da cuenta de que menos del 30% de las medidas tiene que ver con los cuidados y, de éstas, sólo el 12% están diferenciadas por género. A partir de este análisis, el presente artículo propone un enfoque integral de los cuidados, encaminado a garantizar resultados que transformen las nociones relativas al género. Este enfoque comprende un marco único de tres niveles para la acción política, que consiste en (i) siete principios normativos fundacionales del cuidado; (ii) una tipología de cuatro categorías de políticas basadas en el cuidado; y (iii) siete palancas de cambio para guiar su aplicación. En conjunto, este marco 7-4-7 presenta estrategias integrales dirigidas a que los formuladores de políticas hagan operativa la agenda de la Triple R de reconocer, reducir y redistribuir el trabajo no remunerado. Además, este documento hace un aporte único, pues redirige la atención generada por el enfoque de la Triple R hacia la cantidad de cuidados, para defender la mejora de la calidad general de los mismos.

1. Introduction

This paper draws up a blueprint to operationalise the Triple R agenda in policies for addressing women's unpaid care and domestic work. The increasing importance of care in policy agendas (Esquivel and Kaufmann 2017; Eyben 2012), the formulation of Sustainable Development Goal (SDG) 5.4 and the recent post-pandemic spotlight on care indicate that 'Recognition' of care as a policy issue has come a long way. However, the lack of progress on actualising its intent – especially 'Reduce' and 'Redistribute' – reflects the political and conceptual challenges in operationalising and achieving these aims. This necessitates thinking through concrete policy recommendations in order to recognise women's unpaid care work, reduce the drudgery of this care work and the amount shouldered by women; and redistribute this unpaid care work beyond men and other family members, to other institutional actors in the Care Diamond, i.e. the state, the market, and the community (Razavi 2007). In this paper, we argue that these concrete policy recommendations (that we divide into four care-sensitive policy categories) sit on top of seven normative care principles, which are operationalised through seven levers of change. This allows us to build a 7-4-7 framework for operationalising the Triple R agenda.[1]

Research evidence across the world has thrown up evidence of the negative impact the pandemic has had on women (ESCAP 2020; Kabeer *et al.* 2021). One of the most prominent of these impacts has been an increase in the number of unpaid care work tasks and the time spent on these tasks – cooking, cleaning, taking care of the children, the sick, the elderly – that women have had to perform, alongside their paid work (Staab *et al.* 2020; UN Women 2020b). The policy discourse has largely surrounded the need to build back better (Nazneen and Araujo 2020; ESCAP 2021) through addressing the 'unpaid care work burden' on women.

At the outset, therefore, it is important to outline our approach towards unpaid care work. While the care economy is the sum of all forms of paid and unpaid care work (ILO

2018), our focus is on the hidden care economy that largely comprises the unpaid care and domestic work performed by women and girls the world over. We include here not only household tasks of cooking, cleaning, household management, and care of dependants, but also water, fuelwood, and fodder collection as these, too, take up an inordinate amount of women's time despite officially being recognised as part of economic activity by labour statisticians (Charmes 2019).

We consider care as a foundational element of our society – something that has a 'widespread, long-term, positive impact on wellbeing and development' (Chopra and Sweetman 2014, 409). We therefore question the framing of care as a 'burden' (Cook and Dong 2011; Kabeer 2007). Instead, we align with research that has shown that the real problem is not care itself, but the fact that care (both paid and unpaid) is disproportionately performed by women, leading to their physical and emotional depletion (Chopra and Zambelli 2017; Rai *et al.* 2014). Research has also shown how this disproportionate shouldering of unpaid care has been exacerbated by the pandemic, leading to adverse outcomes such as women withdrawing from the labour force (Care and IRC 2020; UN Women 2020a). This has been particularly true for young women, who were twice as likely to lose their jobs as men (ILO 2021). Therefore, to understand the impact of COVID-19 on societies and find ways to build back better, it is critical to identify solutions that increase the amount and quality of care, without increasing women's mental and physical depletion.

We draw from data across 59 countries in the Asia and Pacific region, in order to understand the types of gendered policy responses that this region has had to the COVID-19 pandemic. This analysis has helped us assess the extent to which the aims of these policy responses have been gender-differentiated and/or care-sensitive. Having care-sensitive aims implies policies that directly or indirectly tackle the issue of the unequal distribution of unpaid care and domestic work on women's shoulders. In addition to being care-sensitive, when policies explicitly target women (because of recognising their gendered vulnerabilities), they can be defined as having gender-differentiated aims.

Our proposed framework will allow assessment of the extent of gender-transformative outcomes that policies can achieve. Policies can fall on a spectrum from creating (1) *gender-blind outcomes* (arising from policies that fail to account for women's needs by not recognising women's differentiated needs, and instead embody gendered and patriarchal assumptions); (2) *gender-sensitive outcomes* (arising from policies that acknowledge women's care work but naturalise these roles – thereby addressing their practical gender needs without addressing the underlying power dynamics, e.g. domestic violence policies or acknowledging but reinforcing women's care roles, like maternity entitlements); and (3) *gender-transformative outcomes* (arising from policies that aim to address the strategic needs of women – including the sexual division of labour; such policies take care as integral, and therefore not only recognise, reduce, and redistribute care work across all stakeholders in the Care Diamond, but also focus attention on increasing the quality of care).

In this paper, we go beyond the need for policies to be care-sensitive, and contend that a care-integral approach is essential for policy outcomes to be gender-transformative. This implies that care is integrated into policies as a foundational component. This would address the needs of both care providers and care receivers, with a view to improving the quality of care and transforming gender relations. In this way, we aim to redirect current attention of the Triple R framework on recognition, reduction, and redistribution of the *quantity* of care, towards also improving the *quality* of care.

In order to ensure that policies can have gender-transformative outcomes, our blueprint sets out seven normative principles that need to govern and guide all policymaking and implementation (Section 3.1). These normative care principles are essential for both designing policy measures that are care-integral, as well as in setting the intent and direction of their implementation. The policy measures themselves are broken down into four care-sensitive policy categories, under which policymakers can tailor their policies as per their national context (Section 3.2). Finally, in order to move the needle in the direction of gender equality and women's economic participation, it is important to consider critical levers of change. Our research and analysis of the policy responses to COVID-19 has thrown up seven key mechanisms and implementation success factors that must be deployed in order to move the care agenda from discourse to ground reality. These are elaborated in detail in Section 3.3.

Taken together, this three-pronged approach of normative principles, care policies, and levers of change, we contend, will present a comprehensive and practical strategy for policymakers to operationalise the Triple R framework – i.e. recognise the value of care; reduce the drudgery of care tasks; and redistribute care tasks to other actors in the Care Diamond, with a focus on the state as being one of the prime actors in terms of care provisioning.

1.1. Methodology

This paper draws on empirical work commissioned by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), as part of understanding the gendered dimensions of the care economy under the COVID-19 pandemic in the Asia and Pacific region, and mapping policy measures responding directly or indirectly to the increase in women's unpaid care work as a result of the pandemic. A database of care-sensitive policy measures was developed from a wide desk-based survey of sources, primarily including the UNDP–UN Women COVID-19 Global Gender Response Tracker, review of country measures on social protection policies by the World Bank Open Knowledge Repository, COVID-19 policy responses trackers by the International Monetary Fund, the Blavatnik School of Government, the University of Oxford, the International Labour Organization (ILO), KPMG, and Asia Pacific Foundation of Canada.[2] We also considered grey literature and media reports related to any specific country-level measures.

In order to identify care-sensitive policy measures, we worked out an inclusion criterion that encompassed any policy that directly addressed women's care work. This

included policies such as assistance for children, for older persons, and for health issues, as well as food assistance, utility bill waivers/deferrals, and parental leave and flexible working policies. We excluded policies such as social insurance, utility bill exemptions or waivers to enterprises, unemployment benefits, social assistance like cash transfers or house rent waivers, as they were considered as not directly having an impact on the distribution of care responsibilities. As a subset of these care-sensitive policies, we identified policies that specifically targeted women beneficiaries, rather than the whole population group, as gender-differentiated. We finally analysed these trends in the Asia and Pacific region against the Triple R agenda, in order to come up with a three-tier framework, which outlines normative principles, concrete recommendations within four policy categories, and levers of change in order to implement these policies.

This paper presents these empirical findings alongside these three aspects, focusing specifically on good examples drawn from the Asia and Pacific region. To lay the conceptual foundations of our three-pronged approach, the next section provides a discussion of the literature around the underlying principles and ethics of care – which forms the bedrock of our framework.

2. A 7-4-7 framework: incorporating a feminist ethics of care

There is a growing recognition that an imbalance in the division of care work is detrimental to the wellbeing of women and girls. Alongside, an increase in numbers of population groups that need care, including the elderly, the ill, etc., combined with a rollback of the state from providing basic services, has led to a care deficit. Advanced, industrialised countries have sought to fill this care deficit with the help of migrant caregivers from the global South, in what has been termed the emergence of global care chains (Yeates 2004). This, however, has left a gap in care within the households of these migrant workers (Arat-Koc 2006). In the absence of state provisioning or men stepping in to fill the deficit within households, developing countries are experiencing an absolute care deficit where certain care requirements go completely unmet (Esquivel 2008). Furthermore, these care deficits often go hand in hand with other dimensions of deprivation (employment, income, infrastructure, opportunities), reinforcing inequality (Esquivel 2008, 5). The effects of this crisis of care have been spotlighted by the COVID-19 pandemic (Care Collective 2020).

It is clear, therefore, that we need to increase the amount and quality of care in society. However, this implies a normative shift to adopt care-ethical principles. Feminists have long written about the need for this. Carol Gilligan's landmark work, *In a Different Voice* (1982), showed how care was socially engendered. She proposed a feminist 'ethic of care' as an alternative to traditional Kantian, justice-based ethics, arguing for a more feminine moral orientation in opposition to the male-centred, rational, individualistic moral reasoning. Early research on ethics of care, however, was critiqued for being pro-feminine and further entrenching the association between women and care as natural (Tronto 1993).

Tronto argues for a more political feminist approach to care, making a passionate case for 'moving care from its current peripheral location to a place near the centre of human life' (1993, 101). This calls for a recognition of the essential nature of human interdependence and relationality. Tronto shows how the actual business of caregiving and care-receiving has been left to less powerful across gender, race, and class categories, resulting in a vicious circle of devaluing care and, by corollary, devaluing the people who provide care, largely women and girls. A reconfiguration of social and political institutions in the public and private spheres are needed for reallocating women's roles and work (Tronto 2011), building on principles of relationality, mutual interdependence, context sensitivity, responsibility, and experiential grounding in everyday practices.

Studies have demonstrated the interdependent nature of care and paid labour, especially for women in the global South (Carswell 2016; Chopra and Zambelli 2017) confirming that for them 'care and work are not separate; care, while often motivated by love and personal responsibility, is work, and work, traditionally understood, must continually be balanced with responsibilities of care' (Robinson 2006, 334). These findings challenge the dichotomous thinking of work and care that current neo-liberal orthodoxies promote, and require an upending of capitalist, patriarchal structures and power relations, by centring care concerns (Folbre 2021; Fraser 2016; Tronto 2017). However, despite growing momentum in scholarship (Hankivsky 2004; Robinson 2011; Sevenhuijsen and Švab 2004; Williams 2010), care-ethical reasoning is yet to find its way into public policymaking and development discourses continue to reflect either the language of rights or economic efficiency (Mahon 2011).

Recognising a feminist political ethics of care as a source of normative judgements can allow for care concerns to inform social policies at local, national, and global levels. It is important to note that adopting a feminist ethics of care means that care is not merely an add-on to existing 'business as usual' policies, neither is care meant to override all other concerns. Rather, the emphasis on a care-integral perspective is to move away from an add-care-and-stir approach, to ensure that care-related concerns will 'always be part of the equation' (Stensöta 2015, 189). Despite the recognition of the importance of unpaid care work, most countries were found in our research to be lacking in incorporating this care lens to policy design or in implementing care-sensitive policies. We were asked for specific policy actions that governments could take against each aspect of the Triple R. Yet, in conversations with policymakers and donors, it was clear that policy actions without normative shifts to centre care concerns, and without essential socio-political levers to support execution, would again fall short of the mandate of reducing drudgery and redistributing care.

With this orientation in mind, we now turn to operationalising the Triple R agenda, which has served as an important normative guideline for bringing care into the conversation in development policy. Figure 1 delineates our three-pronged approach.

The next section explains each of these three levels of our 7-4-7 framework – the seven normative care principles, the four care policy actions, and the seven levers of change, providing examples from our research for some of these. While the four policy actions are similar to other work in this area (Daly 2002; Esquivel 2014), the unique contribution

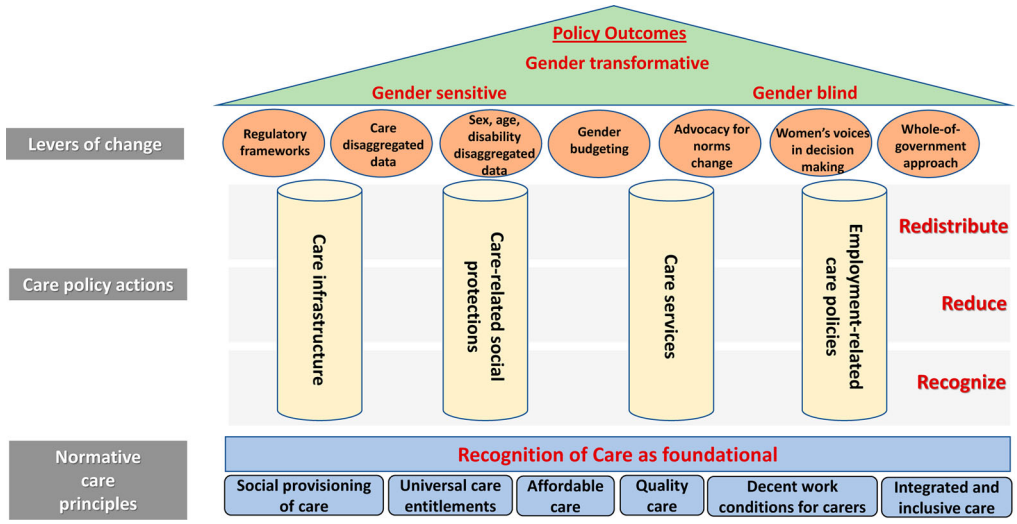

Figure 1. The 7-4-7 framework for realising the Triple R for unpaid care.

of our work lies in drawing out the seven normative principles underlying these policy actions, and the seven levers of change that help these four policy actions to be true to the intent of recognise, reduce, and redistribute unpaid care, and attention to increasing the quality of care.

3. Operationalising the Triple R agenda

This paper posits that to succeed in identifying specific care policy solutions that can be effective in the macro policy context, we need to begin with a normative commitment to care.

3.1. Seven normative care principles

We reiterate that care is not a burden in and of itself, rather it is the lopsided distribution of care on the shoulders of women and girls that threatens their continued well-being and empowerment. We, therefore, propose a set of seven core care principles, drawing from our commitment to a feminist political ethics of care as discussed in Section 2, that must become the point of departure for policymakers.

Social media memes in the early days of the pandemic highlighted how the world could continue to function without hedge fund managers but not without essential care workers. This is emblematic of the skewed value our society has given to financial wealth as opposed to quality of life and well-being. Studies, pre and post the pandemic, have shown how investments in care sectors like health care or education or long-term care can create more jobs as compared to investment in traditional sectors like construction (de Henau and Himmelweit 2021; Elson 2017; ILO 2018). These simulations clearly point to the need to pivot economies around care instead of treating it as an externality.

This would require a normative shift such that care is placed at the core of economic and societal actions, where care is considered as foundational to human life and well-being. In this formulation, we challenge the normative public–private divide and notion of an autonomous individual that has informed neo-classical economics, and emphasise the need for a care ethical perspective: of care as relational, situated, interdependent. We argue for the recognition of a relational right to give and receive care (Kittay 2009) premised on a feminist political ethics of care moral orientation as a necessary base for rights premised on an ethics of justice. This is our first and most foundational principle that cuts across all the other normative principles. Care must be treated as central to human life and development, with policies and programmes expressing *an explicit intention to care*. An explicit intent enhances the visibility of care work and its importance, especially in policy design. This intention needs to be twofold: to care for dependents and the vulnerable, as well as to ensure an equitable distribution of care across stakeholders of the Care Diamond (Razavi 2007).

Building on this underlying commitment to care, our second normative principle is to guarantee the relational right to care providing and receiving, with the state stepping in as the guarantor of rights for all. The extent to which unpaid *care is provided through social provisioning by states* has been at the heart of debates around 'social investment' especially in child-care policies across Organisation for Economic Co-operation and Development (OECD) and Latin American countries (Mahon 2011; Razavi 2012). However, cash transfers and a push towards market-based services are seen to be emerging as a preferred social protection policy tool. These may prove to be counter-productive, as unpaid care cannot be provided by the market without compromising the quality of care provided and received (Folbre 1994). As Lavinas (2018) shows, a financialised neo-liberal turn in recent decades, with features of greater privatisation of services and emphasis on fiscal austerity, have resulted in a 'just give money to the poor' orientation among social policy design in countries of the global South. Such policies increase household credit and debt in the name of financial inclusion. Because of reduced spending on public infrastructure and services, households are instead forced to buy private services and insurance (*ibid.*). The pandemic further has shown the devastating consequences of absence of adequate health-care infrastructure in many developing countries. Given that care is 'heavily intertwined with *the economic … the social … and the public*', with consequences for the well-being of societies as a whole (Esquivel 2013, 10), we argue for an emphasis on social provisioning of care infrastructure and care services, as opposed to over-reliance on the market.

Universal care entitlements are the third normative principle we propose. Policy actions must aim to leave no one behind, and this requires that care-sensitive policies are accessible to everyone, irrespective of identity markers such as caste/class/religion/indigeneity/sexual orientation, and geographic location (e.g. rural/urban). In addition, policies need to cater specifically to under-served and vulnerable groups, such as single mothers, certain indigenous groups, etc., who are often further marginalised in a crisis. Universality as a principle minimises targeting errors and the need to invest in expensive

ways of targeting (Devereux 2021), without leaving out the most marginalised groups from policy coverage.

Along with the universality principle, access to policies is determined by the *affordability of care*. This is our fourth normative principle. Women sit at intersecting locations of inequalities, which marks their ability to pay for care (either through the market or through user fees). The ILO has tracked data on the extent of out-of-pocket (OOP) expenses that poor households spend as a percentage of total health expenditure, noting variations in rural/urban and among younger/older persons (ILO 2017). The OOP is found to be much higher in rural areas in many countries on account of underfunding and lack of financial resources. Similarly, research in OECD countries finds high OOP in the case of child care, often up to a third of the salary, which can act as a deterrent to families opting for day care use. This then results in lower women's labour force participation and earnings (OECD 2020). Affordable care may not always be available from the market; this thus reiterates the role of the state in regulating prices/user fees as well as provisioning for care.

In addition to affordability, it is not enough to just provide care policies unless this is backed up by a commitment to *the quality of care* in designing care-sensitive programmes and policies. This is our fifth normative principle. What quality care entails may be highly debatable depending on the needs and preferences of individual users, however, the absence of quality is most easily noticed and erodes the effectiveness of usage. Hence, quality of care as a normative principle is less about setting a gold standard and more about recognising the context, and the person-dependent nature of care. Care work does not lend itself easily to commodification or productivity enhancements. Care is an affective, labour-intensive, and relational process where the care recipient is not just a vulnerable dependent but also exercises agency and dignity. Bearing this in mind, attention to quality of care is a necessary component, which must be negotiated between caregivers and care receivers.

The ILO 5R high road to care approach (ILO 2018) expands on the Triple R by adding elements of Reward and Representation for care workers. These become imperative with redistribution of care out of the home and moving to the paid care sector. The ILO has put forth a Decent Work agenda for carers, which will ensure quality care being provided in the paid care sectors. The decent work criteria encompass four main concerns – employment (including opportunities and working conditions), social protection, workers' rights in terms of freedom of association and non-discrimination, and social dialogue in terms of negotiation with employers (Ghai 2003). These concerns apply towards a broader notion of work adopted by the ILO, i.e. to encapsulate both paid work and unpaid work (International Labour Conference 2009). A focus on *decent work conditions for carers* as our sixth normative principle encompasses reduction of drudgery that is often associated with unpaid care work. Here, therefore, the underlying principle is one of ensuring decent work conditions to unpaid workers and caregivers in the family and community, which would contribute to increasing the quality of unpaid care. In addition, this would provide opportunities for unpaid carers (mostly women) to be able to get decent jobs, as the drudgery of unpaid care is reduced, freeing up

essential time and energy of women. This normative principle ensures that the focus on increased quality of care is reinforced, by incorporating the needs of both the care recipients and the caregivers in policy and programming.

The seventh and last normative care principle is to take an *integrated and inclusive view of care*. There is a need to consider intersectional identities and social locations of caregivers and care recipients by making policy responses differentiated as per the care needs of different groups. Sectoral overlaps between child care and early childhood education, between health care and caring for older persons or persons with disabilities, between workplace conditions and flexible caring arrangements for workers with care responsibilities, and differences between rural and urban areas, low- and high-income households, women with disabilities, and women as carers of persons with disabilities, are some illustrations of the challenges that can be overcome by taking an integrated and inclusive view of care needs.

Our empirical work on COVID-19 policy responses to the unpaid care economy in Asia and the Pacific found that out of the total 746 socio-economic policy measures announced by governments across the region, only 208 measures were care-sensitive. This means that only 28 per cent of the policy measures adopted by governments in the immediate aftermath of the pandemic were aimed at ameliorating the care needs of individuals and households, especially vulnerable groups. Of these care policies, only 90 were found to be gender-differentiated measures. These measures specifically addressed women's roles as carers and accounted for their gender-differentiated care needs. While these amounted to 43 per cent of all care-sensitive policies, they represent only 12 per cent of aggregate socio-economic policy measures adopted by countries in Asia and the Pacific region. Additionally, we found that many of these measures were either one-off, one-time relief measures or, at best, short duration and temporary for two to four months. It is important here to clarify that our research classified measures in terms of being care-sensitive or gender-differentiated in their aims, rather than focusing on the outcomes of these measures – which could be either gender-blind, gender-sensitive, or gender-transformative. This research has not mapped the outcomes of these measures, instead, using these data to come up with the 7-4-7 framework that can be used to assess these outcomes in the future.

The example of the Republic of Korea exemplifies how care could be recognised as integral, and as a public good guaranteed by the state. The country is one of the few in the region with the highest number of care-sensitive policy measures (ESCAP 2021a). Given its prior experience with SARS and MERS epidemics,[3] its overall preparedness was high enough to flatten the curve of COVID-19 cases early in the outbreak. Alongside the public health response, the Republic of Korea had the highest percentage of gender-differentiated policy responses as per our data. It put in place funding as well as services to support the child-care needs of working families, raised social assistance to households with young children, and mandated employers to offer flexible working hours and leave policies for workers with young children. Such support exemplifies a care-sensitive and gender-differentiated response that can alleviate the disproportionate care load on women.

3.2. Four policy categories

Feminist economics literature has proposed a number of ways to incorporate a care agenda into social policies and make them transformative (Daly 2012; Esquivel and Kaufmann 2017; Jenson 1997; Razavi 2007). Building on this work, our framework has four categorisations of policies to address unpaid care work to cater comprehensively to differentiated care needs of women, while at the same time take into account unique individual, household, local, and national contexts (ESCAP 2021a). Box 1 summarises the four care-sensitive policy categories, namely care infrastructure, care-related social protection transfers and benefits, care services, and employment-related care policies.

The point of emphasis in this framework is the distribution of care across all four institutional actors of the stylised Care Diamond – state, markets, households, and community. While our normative standpoint is to hold states accountable as the basic guarantor of rights and public provisioning for care, we also propose that these redistributive aims can be addressed by making markets (especially employers), men within households, and broader communities responsible for care provisioning. These four care-sensitive policy categories put our seven normative principles in practice, especially by taking an integrated view of paid work and unpaid care work in women's lives, comprehensively meeting women's requirements arising from their care responsibilities, and upholding decent work conditions for carers.

Drawing on our empirical analysis, Figure 2 shows the spread of the 208 care policy measures across our proposed four care policy categories. These 208 measures were

Care infrastructure – water, sanitation, energy, transport, food services, health care for the sick (HIV patients, COVID-19 patients), persons with disabilities and/or pregnant women.

Care-related social protection transfers and benefits – cash transfers, cash-for-care, vouchers, tax benefits and non-contributory pension schemes.

Care services – child care, elderly care, care for the differently abled or those who are ill, through the state or markets.

Employment-related care policies – leave policies, family-friendly working arrangements, flexitime, career breaks, sabbaticals, severance pay, employer-funded or contributory social protection schemes like maternity benefits.

Box 1. Care-sensitive policy categories. Source: ESCAP (2021a).

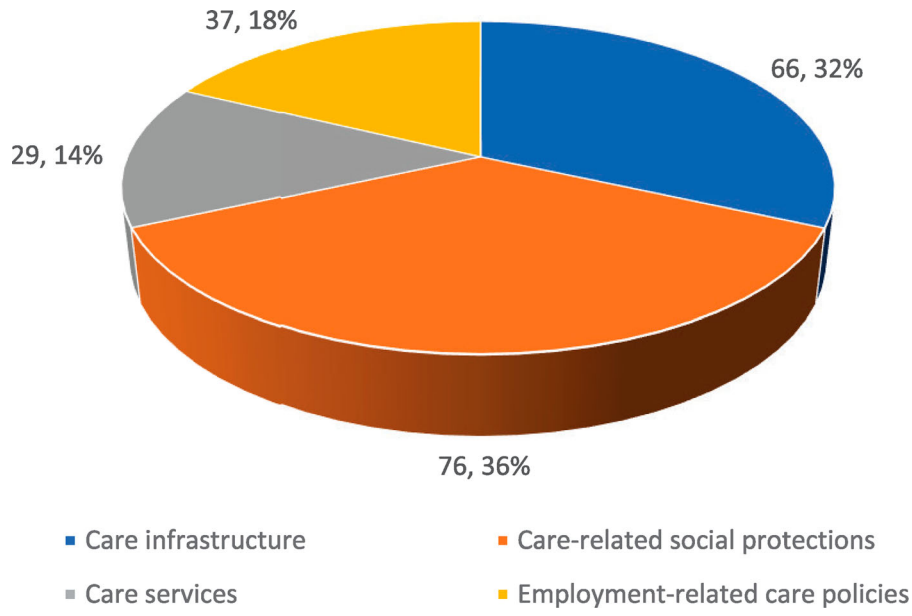

Figure 2. Policy measures across four care policy categories. Source: Authors' own calculations.

identified from a universe of 746 socio-economic policy measures adopted by governments in Asia and the Pacific region, as stated previously. The largest number of measures were taken in the care-related social protections category (36 per cent), followed by care infrastructure (32 per cent). This accords with data from around the world where, 55 per cent of social protection programmes were new and 75 per cent were found to be non-contributory (ILO 2020).

The fewest measures were adopted in the care services category (14 per cent), which reflects both the difficulty of providing market or institutional services in lockdown conditions as well as a lack of attention to these critical services. Finally, employment-related care policies were found to be widely employed in some highly developed and formalised economies, like the Republic of Korea.

Figure 3 analyses the gender focus of the 208 care policy measures identified across the four care policy categories. We found that care infrastructure (which addressed the immediate food and survival concerns of vulnerable population groups) had no specific gender-sensitive dimension, except where it catered to food provisioning for children, for which women are largely responsible. The policy category with the maximum number of gender-sensitive measures was care-related social protection, with more than half of care-related transfers found to be gender-differentiated, as Figure 3 indicates. These addressed mostly women's role as mothers. The other policy category where a gender focus was pronounced was the employment-related care policies, with measures such as expanded child-care leave and support for pregnant women. These were half of the overall policies in this category. Care services, given lockdown conditions, had the fewest total or gender-differentiated measures among pandemic responses across all four categories.

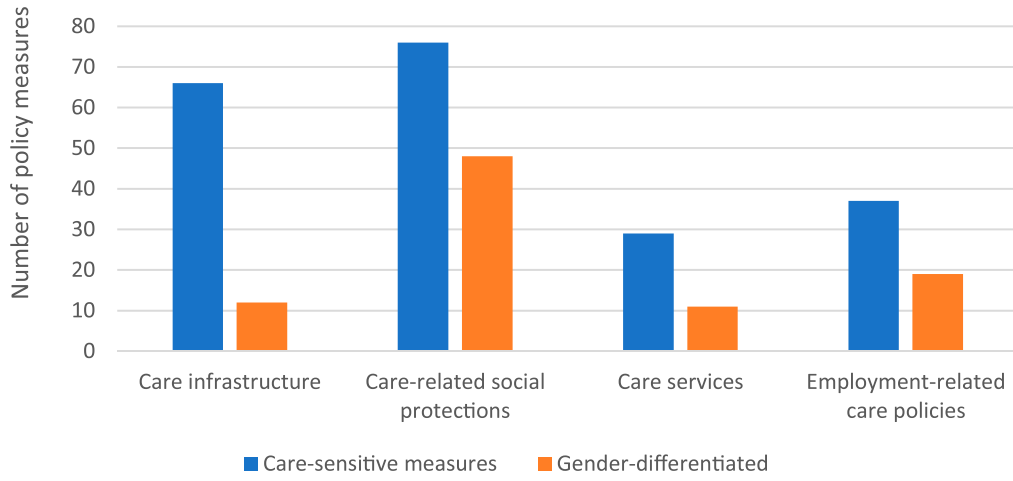

Figure 3. Care-sensitive and gender-differentiated policy measures in Asia and the Pacific. Source: Authors' own calculations.

From the above discussion, we can see that it is not enough to merely address care-differentiated needs for women through any one policy category. The normative principle of taking an integrated and inclusive perspective of care that can lead to gender-transformative outcomes requires that all four policy categories are instigated, rather than merely one or two. A further case for operationalising all four policy categories comes from the realisation that more than one policy area will be needed to address women's differentiated care concerns, thereby recognising care, reducing its drudgery, and redistributing it among the different institutional actors of the Care Diamond.

It is not by mere chance that the design of care-sensitive and gender-differentiated measures will ensure the application of the normative principles set out in Section 3.1 above. Further, the mere existence of these policy measures, however well designed, does not imply that these are implemented adequately. In order to ensure that care-integral policies are designed and implemented to ensure universality of access, affordability, and inclusivity, as well as ensure decent work for all carers, we propose levers of change – these will be essential to ensuring gender-transformative outcomes.

3.3. Levers of change

Levers of change are pivotal in generating traction towards the design, adoption, and implementation of care-sensitive and gender-equitable policies and programmes – similar to how resting on a pivot can move a heavy load easily when sufficient pressure is applied. These levers are essential for the normative principles to be put into action through design and implementation of policies, irrespective of which policy category these interventions fall within.

The following examples highlight the importance of these levers of change in the design of policy. Time-use survey data have been used to demonstrate effectively the

disproportionate distribution of care tasks and the invisibility of women's productive contributions. An absence of these data results in policies assuming a male as the universal worker, thereby implicitly privileging the male breadwinner. This can lead to policies that are not designed with women's needs or differential requirements in mind, similar to those highlighted by Boserup (1970). For example, a public works programme that assumes that men would be the primary workers would not have flexible timings, and their rates of pay may be based on performance standards set for male workers – so when women's outputs are assessed against these standards, this would lead to low returns for them. In her work on India's largest public works programme, the Mahatma Gandhi National Rural Employment Guarantee Act (the MGNREGA), Chopra (2019) shows how despite some of the design of the MGNREGA specifically addressing women's differential roles as both carers and workers, the policy fails to address social norms around women's participation in collective/public spaces. She shows how the policy suffers from lack of women's voices in decisions regarding type and location of these works – making these harder to access for women (*ibid.*). Further, the lack of childcare services and supporting infrastructure has led to women dropping out of working under this programme, and together with drudgery in the nature of work and low payment (because of the PWP payments being set as per a male worker norm), this programme has led to emotional and physical depletion amongst women, i.e. severe tiredness, exhaustion, illnesses like chest or eye infections; as well as constant worrying about their children and their family (Zaidi and Chigateri 2017), and reduced its emancipatory potential (Chopra 2019).

We contend that the absence of these levers means normative commitments to care have remained paper tigers, and not translated into either adequate design or implementation of appropriate policies and programmes. We conducted a gendered political economy analysis among countries of the ASEAN (Association of Southeast Asian Nations) bloc to distil out these levers of change, identifying strengths and weaknesses in structural and institutional contexts across countries, and matching these against actual policy and programmes (ESCAP 2021b). This analysis, alongside our reading of a huge amount of literature pertaining to gender-sensitive policy design and implementation successes and failures, yielded the following seven levers of change.

1. *Regulatory frameworks*: With the state as the guarantor of rights, legislations form the first step in codifying the recognition of care work. Without adequate laws that make the right to care justiciable, it is not possible for care policies or programmatic interventions to succeed. The Philippines is a good example of a country that ranks high in the gender gap index and has a plethora of enabling laws and policies that aim to acknowledge and address women's role in care. For example, the Women in Nation Building Act, 1995, makes provision for social security coverage for married persons, who devote full-time to managing the household and family affairs upon the working spouse's consent. The Philippines has also recently expanded the Solo Parents' Welfare Act, the Early Childhood Care and Development Act, Expanded Exclusive Breastfeeding in the Workplace Law, The Responsible Parenthood and Reproductive Health

(RPRH) Act, the *Batas Kasambahay* (Domestic Workers Act), and the most comprehensive 'The Magna Carta of Women'.

2. *Care disaggregated data*: Time-use surveys have been a widely used source of data on how men and women use their time, especially in unpaid activities and production of good and services for own final use. These data are crucial for the design of care policies targeted towards specific activities or locations, promoting a more equitable allocation of public funds that prioritise unpaid care (Fontana 2014). While the International Conference of Labour Statisticians (ICLS) has widened the definitions of the System of National Accounts (SNA) and non-SNA activities, most labour force surveys are yet to incorporate the broadened definitions of productive work or collect data on the gender differentials in care work. A National Household Care Survey carried out by Oxfam in the Philippines showed that while women's time in care tasks like cooking, cleaning, and washing did not reduce in the last four years, men had begun to spend more time on care activities (Oxfam 2021). Data on time spent on water or firewood collection argues emphatically for investments in piped water, especially for rural areas.
3. *Sex, age, and disability disaggregated data*: Care intersects with various other identity markers of women to accentuate their vulnerability. Women's location across geographies, age, class, race, ethnicity, disability, informality, marital status, and number of children are just a few key factors that determine the nature and extent of unpaid care work they need to carry out and the consequences of it. Therefore, care-sensitive policy design must factor in these intersecting inequalities. This in turn requires adequate data on target populations and their spread, so the policies can be designed with these complexities in mind.
4. *Gender budgeting*: Gender budgeting remains a central act of feminist policy change, through which processes of raising and allocating resources can achieve more gender-equitable outcomes. A key objective in gender budgeting, therefore, is to 'make women and the gendered norms [especially in relation to care] that shape our lives visible in economic and public policy decisions' (O'Hagan and Klatzer 2018, 21), and to understand the differential experiences of men and women (Frey 2008). The use of gender budgeting is key to not considering social and welfare expenditure as a cost, which ignores women's care roles, and negates the contribution of care as supporting the productive economy (Frey 2008). Therefore, it is critical to understand how public policies – especially reduction of spending on social welfare and concomitant withdrawal of public services – affect women adversely by pushing up their unpaid care work. Operationally, the adequate financing of care policies is a crucial criterion to ensure the accessibility and affordability of care infrastructure or care services and to widen the net for social protection programmes. Our research found a link between the income level of a country and the extent of care-sensitive measures they adopted. Upper-middle-income countries announced more care-related social protection transfers and benefits as well as instituted efforts to provide care services to children and older or ill people. More-advanced industrialised countries with larger formal economies undertook a larger number of employment-related measures. This

indicates that availability of fiscal resources can have a significant impact on addressing the care needs of the population.

5. *Advocacy for norms change*: Persistent gender norms can obfuscate progress towards a redistribution of care or a reduction in time taken for care tasks. For example, OXFAM We-Care programmes in the Philippines and Zimbabwe found that despite the use of time- and labour-saving devices such as electric cooking stoves, women's time in unpaid care work increased instead of going down, unless there were strong social norms interventions to increase the participation of men in these care tasks (Oxfam International 2020). Norm change is likely to be the most difficult lever to move, but it is also the one with maximum immediate benefit to redistribute women's care concerns within the household. Media campaigns breaking gender stereotypes and visibilising the role of men in care are one example of what can be done to shift attitudes within families towards care work. Institutional arenas can be avenues for perpetuating gendered attitudes and patriarchal assumptions. These need to be challenged by feminist values and ethics for care not only by women leaders, but by male colleagues championing and amplifying the voices for change (Barker *et al.* 2021). All actors of the Care Diamond need to advocate concertedly for a shift in norms against naturalisation of women as carers in a gendered division of labour. Yet, it is also important to note that 'subtle adjustments' with certain tasks becoming more acceptable for men to do, rather than radical changes may bring about more permanent changes to social norms (Rost 2021). Rost posits that equipment may also be a driver of norm change (*ibid.*). Young people's progressive views also indicate an intergenerational shift in norms towards gender equality. A social norms, attitudes, and practices survey conducted across Indonesia, Philippines, and Viet Nam reported each new generation of couples sharing child care and breadwinning more equally than the previous one (Investing in Women 2020).
6. *Women's voices in decision-making*: This is akin to the idea of ensuring Representation of women carers within the ILO's 5R framework, with the objective of ensuring that women's voices regarding their needs and constraints remain central to decision-making. Feminist institutionalists have established the gendered nature of all institutions, and especially thrown light on how gender norms, usually unwritten, characterise political institutions and policymaking processes (Krook and Mackay 2010; Lovenduski 1998; Nazneen 2017). It is therefore important to consider who is involved in decision-making, how women's interests are represented by these critical actors, both inside and outside formal institutional spaces, and how gender norms operate in resource allocation and implementation. Women's mobilisation and advocacy efforts have brought the invisible issue of care on to the policy agenda, but it has taken decades of work and mobilisation across various fora in order for this to gain traction. Given the centrality of care in post-COVID recovery plans, it becomes essential that women's voices are incorporated into decision-making at all levels – through policy design to its implementation. Further, adequate representation should be given to intersecting identities of women's groups who have been traditionally marginalised in decision-making.

7. *Whole of government approach*: Our final lever of change rests on ensuring inter-ministerial co-operation and co-ordination on making care a central policy concern. Women's issues have often been siloed within women's state machineries and championed by women's rights movements. However, care is an issue that cuts across narrow and specific remits that any particular ministries or departments may have. In order to operationalise the idea of care as a foundational public good, inter-ministerial collaborations and joint memoranda across various ministries and departments will be required. Specifically, in order to move the needle forward across the four care policy categories without overburdening any one policy category or specific policy with the responsibility of addressing care, it would be important that a whole of government approach is followed in the assessment of needs and in design and implementation of policies. For example, in Cambodia, the National Healthcare Policy and Strategy for Older People, 2016, was launched by the Ministry of Health (MoH), while the Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) anchors community-based and family-based older people development programmes in collaboration with the Cambodian National Committee for the Elderly and other line ministries (Ministry of Women's Affairs, Cambodia 2019).

4. Conclusion

While the normative case for including care as central to all policy has been argued by feminists across the disciplinary divides (Chopra and Sweetman 2014; Folbre 2008; Hochschild and Machung 2012; Oakley 1985), the Triple R agenda has really focused our attention on the most critical objectives of Recognising, Reducing, and Redistributing unpaid care work (Elson 2008). The ILO has further extended this agenda to the 5Rs, including the Reward and Representation of care workers within this overarching framing (ILO 2018). As findings from across a range of research projects, including our own, have shown, the COVID-19 pandemic has shed light on to the critical importance of care – especially highlighting how women across the world and across class, caste, religious, and other divides are impacted negatively because of the unequal distribution of care. At the same time, we have also recognised the importance of care in itself – given the care crisis across the world, it is even more imperative that policy efforts are geared towards increasing the quality of care – for care providers and for care recipients. However, our empirical analysis shows that this awareness does not translate into action when designing policy responses. The challenge, therefore, is – how do we bring the Triple R agenda into practice?

This is a first attempt to operationalise the Triple R agenda with a focus on developing a care-integral approach, thereby making a practical case for how policy responses can lead to gender-transformative outcomes when unpaid care is incorporated as a central issue. Our empirical data show that of the 746 socioeconomic policy measures adopted by governments across countries of Asia and the Pacific region, only 208 (less than 30 per cent) had care-sensitive aims while only 12 per cent had gender-differentiated

aims. For these aims to translate into gender-transformative outcomes, we have presented in this paper a three-pronged approach to the operationalisation of the Triple R – consisting of seven foundational principles, four care-sensitive policy categories, and seven levers of change. This 7-4-7 framework has been based on our search for and analysis of care-sensitive and gender-differentiated policies in the Asia and Pacific region. We show how the seven normative care principles are essential to create a conducive environment for care-sensitive policies in a way that care is not considered to be a burden, but as foundational to our societies. In this way, we are redirecting attention to the Triple R agenda, towards also improving the quality of care, instead of the current focus on recognising, reducing, and redistributing the existing quantity of care.

These principles have been drawn from our reading of the feminist ethics of care literature against the normative stance set out by the Triple R agenda. We have built on past research and recommendations regarding how to address care, to classify policies across four specific categories, which help think through how these principles can be brought alive in concrete ways. Our overall findings from research in the Asia and Pacific region on identifying policies as care-sensitive and gender-differentiated, have been presented across these four policy categories as examples. Finally, we have shown that seven levers of change are required in order to both design and implement these policies – again drawing on examples as and where relevant, in order to explicate the workings of these levers.

This framework can be used to assess the extent to which policies have either (1) gender-blind, (2) gender-sensitive, or (3) gender-transformative outcomes. Policies are seen to be gender-blind when, under the guise of gender neutrality, they actually embody gendered and patriarchal assumptions that do not account for women's differentiated needs at all. Policies that adopt a care-sensitive approach by acknowledging women's care work but end up naturalising these and aid women in reconciling 'their' care responsibilities may appear gender-sensitive but belie the true potential of the Triple R. Policies that are care-integral in perspective, i.e. recognise the centrality of care and explicitly aim to focus attention on the quality of care through their commitment to all seven normative principles outlined by us and designing policies under all four policy categories collectively, can be said to create gender-transformative outcomes. The strength of this framework lies not only in its use as an assessment tool to map out the extent of care-sensitivity in policy responses of different countries; but more importantly, as a planning tool in order to ensure that countries put in a normative care framework and has the levers of change in order to design and implement care-integral policies. The framework also highlights the centrality of the role of the state, even as other actors of the Care Diamond (the market, the community, and family) remain critical, in ensuring gender-transformative outcomes. This is through the state's role in putting in place normative principles that support the development of care-sensitive policies, as well as operationalising these through the levers of change.

As next steps, it would be important to figure out how and why certain countries have managed to incorporate more of the seven normative principles and/or the levers of change, and how these have been used across the four policy categories in order to design

and implement policies and programmes, and thereby generate more care-sensitive and gender-transformative outcomes. A political economy analysis that sets out the key actors in each context, alongside their interests and motivations and how these play out in different institutional contexts, would be essential to learn lessons regarding this. It would especially delineate the role that the state, the market, the community, and the family can play, in ensuring that women's needs due to their care responsibilities are recognised, the drudgery of unpaid care is reduced, and the unequal burden of unpaid care is redistributed to other institutional actors – at the same time as ensuring that care recipients receive good quality and quantity of care. Like its namesake (the Boeing 747), this 7-4-7 framework is being proposed at a time of major societal change – in this case generated by the COVID-19 pandemic. This moment presents great opportunities, but also great challenges, to ensure that care is put front and centre of all policy decisions. This paper has presented a comprehensive three-tiered framework comprising seven normative principles, four policy categories, and seven levers of change, which seek to address those challenges and operationalise the Triple R agenda of recognising, reducing, and redistributing unpaid care work.

Notes

1. While we acknowledge ILO's 5R framework (ILO 2018) that extends the Triple R agenda by adding the Representation and Reward for paid care workers, our paper focuses on the hidden parts of the care economy, i.e. unpaid care and domestic work. Hence, our aim in this paper is to help execute the Triple R agenda for unpaid care work in policy practice. In retaining the focus on unpaid care, we also align ourselves with target 4 under the SDG 5 on gender equality on unpaid care.
2. See links for source databases: https://data.undp.org/gendertracker/; https://openknowledge.worldbank.org/handle/10986/33635; https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19; https://covidtracker.bsg.ox.ac.uk/; https://www.ilo.org/global/topics/coronavirus/regional-country/country-responses/lang—en/index.htm; https://home.kpmg/xx/en/home/insights/2020/04/government-response-global-landscape.html; https://www.tmf-group.com/en/news-insights/coronavirus/government-support-schemes/; https://www.asiapacific.ca/covid-asia-tracker
3. Severe Acute Respiratory Syndrome and Middle East Respiratory Syndrome.

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