



The Asia Foundation
Improving Lives, Expanding Opportunities

Toward a Resilient Care Ecosystem in Asia and the Pacific

Promising Practices, Lessons Learned, and Pathways for Action on Decent Care Work



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Term	Definition
Care economy	The care economy represents diverse paid and unpaid work activities that provide direct and unpaid care for people needing support. This includes children, people with disabilities, and those who are elderly or sick. Provision of care includes self-care to support people to function capably, comfortably, and safely. ¹
Care work	“A form of social reproduction”, including productive activities “involved in looking after and providing for various physical, social and emotional needs of others” in both domestic and non-domestic settings. ²
Direct Care work	Direct Care Work is person to person provisioning of services. ³
Indirect Care work	Indirect care work are the production activities that support direct care provisioning without necessarily person-to-person contact, such as cleaning, washing, cooking, shopping or managing house. In a less-developed rural context, activities that support indirect care also entail unpaid productive activities such as fetching water or firewood, food production and processing for self-consumption. ⁴
Care worker	Someone who provides support to and for the physical, psychological, emotional and developmental needs of one or more than one person. Care work can be either paid or unpaid. Care work spans both public and private spheres and is found in a variety of settings and across formal and informal economies. ⁵
Care infrastructure	Refers to the policies, systems, resources, and services which are needed to enable families and households to meet their caregiving responsibilities. ⁶
Decent work	Includes opportunities for work that is productive and that delivers a fair income on equal basis with others; security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns and to organize and participate in the decisions that affect their lives, and equality of opportunity and treatment for all women and men. ⁷
Paid care work	Care for persons performed within a household or institution for pay or profit. Paid care work spans both public and private spheres and is provided in a variety of settings, in both formal and informal economies. Care work is a significant source of work for women globally. ⁸
Paid direct care	It entails the activities of care workers employed in care sectors such as teachers, doctors, nurses or babysitters. ⁹
Paid indirect care	This encompasses the non-care workers employed in care sectors such as administrators, cleaners, transport/security workers or domestic workers.
Paid care worker	A worker who looks after the physical, psychological, emotional, and developmental needs of others within an employment relationship. Care workers include a wide range of workers across education, health, social work, personal care service, and domestic work. Many care occupations are inaccurately viewed as unskilled or an extension of women’s perceived “natural” or “traditional” role as caregivers, a stereotype that contributes to their low status, low pay, and lack of representation. ¹⁰
Unpaid care work	All unpaid services provided by individuals within a household for the benefit of its members, including care of persons and domestic work. Common examples include cooking, cleaning, and looking after children, older persons, persons with disabilities, and those who may be ill. ¹¹
Unpaid care provider	A person who provides unpaid care or support to individuals within their household or family members living in other households. Women provide most of the unpaid care work in terms of number of hours and they also represent most unpaid carers around the world, performing over 75 percent of the total amount of unpaid care work. ¹²

Domestic work	The International Labour Organization (ILO) Domestic Workers Convention, 2011 (No. 189) defines domestic work as work performed in or for a household or households. ¹³
Paid domestic worker	The ILO Domestic Workers Convention, 2011 (No. 189) defines a domestic worker as any person engaged in domestic work within an employment relationship. A paid domestic worker receives a wage for this work and is often afforded some social protections, though this may be inconsistent across countries. ¹⁴
Formalization	The process of transforming informal jobs and firms to formal ones. This process can differ by country. ¹⁵
Formal work	Work that is covered by statutory labor law, for which all relevant taxes and contributions are paid and that confers entitlement to social security. Formal employment ensures greater protection, safer working conditions and the offer of social benefits. ¹⁶
Informal economy	It covers all economic activities by workers and economic units that are- in law or in practice- not covered or insufficiently covered by formal arrangements. ¹⁷
Informal employment	A job-based concept, it is defined in terms of the employment relationship and protections associated with the job of the worker. This concept includes certain categories of employees (wage workers) and the self-employed. ¹⁸
Collective bargaining	All negotiations which take place between an employer, a group of employers or one or more employers' organizations for determining working conditions and terms of employment; and/or regulating relations between employers and workers; and/or regulating relations between employers or their organizations and a workers' organization or workers' organizations. ¹⁹
Social Dialogue	All types of negotiation, consultation or simply exchange of information between representatives of governments, employers and workers on issues of common interest. ²⁰

Authorship and Acknowledgements

Disclaimer

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Executive Summary

The Covid-19 pandemic has elevated care to the top of the policy agenda for many policymakers and practitioners at the national, regional, and global levels. Persistent gaps, challenges, and inequities in the care ecosystem continue to threaten inclusive economic recovery and further exacerbate pre-existing intersectional inequalities. The pandemic experience has underscored the need to look at the relationship between gender inequalities and macroeconomic and



The pandemic has made it clear that care workers are indispensable. It is time to reverse the decades of underinvestment in health and care. Investment and decent work in care will not only save lives but will also start to tackle structural inequalities across gender, class and, in many cases, racial and ethnic lines.”

Sharan Burrow, General Secretary of the International Trade Union Confederation (source: [ITUC](#))

sectoral policies focusing on the participation of women in the labor force, structural transformation and impacts of investment in care services. While the care economy remains underinvested and understudied globally, this is particularly true for Asia and the Pacific, which is home to a diverse range of countries that vary considerably in terms of their economic development, cultural norms, and capacity and commitment to implement reform. These differences have led to wide variations in government investment and prioritization of care policies and services in the region.

* According to a [report](#) by Pivotal Ventures, paid care is a \$648 billion sector—larger than the \$510 billion domestic pharmaceutical industry and the U.S. hotel, car manufacturing, and social networking industries combined.

** According to an [ILO report](#), approximately 19.3% of female labor force participation is in the paid care workforce.

Economists who have studied the care economy have found that it is socially important and economically large, yet unequally distributed in terms of gender, economic circumstances, and social vulnerabilities. Care work is socially important because the act of caring for people who cannot care for themselves (such as children, older persons, or people living with disability) is critical for the health, welfare, and protection of all people, including future generations. Creating a continuum of care would help to alleviate poverty and inequalities, encourage gender equality, and increase support for children, people with disabilities and those who are elderly or sick and needing care.²¹ Care is also economically significant. Paid care is one of the fastest growing economic sectors* and represents a substantial source of employment worldwide. Addressing existing gaps in care services could generate almost 300 million jobs.** Despite its social and economic importance to society, the distribution of care work remains grossly imbalanced. Most paid and unpaid care providers are women, many of whom are from structurally disadvantaged backgrounds. Migrants comprise an increasing share of domestic workers who serve outside of formal labor protections and often under poor conditions.

In July 2022, The Asia Foundation launched a research study that aimed to examine and yield key insights and practical recommendations on the care economy in Asia and the Pacific, particularly focusing on promoting decent work for care providers. This included understanding the issues, opportunities, and imperatives with respect to paid versus unpaid care, formally- versus informally-employed

care workers, care-related financing and infrastructure, and the implications of climate change, migration, conflict, and gender-based violence (GBV) for the care workforce. The analysis further explored a range of care needs, including childcare, disability care, eldercare, and care-related migration. It also evaluated different care-related policy interventions across the Asia and the Pacific region, highlighting the role of technology, decent work principles, women's associations,

community-based models, flexible work policies, and dignity of care in addressing common challenges to building a resilient care economy. Finally, the study sought to better understand how governments should finance, invest in, coordinate, and collaborate with families and households, civil society, and the private sector to meet society's care needs and ensure decent work for care providers and the dignity of those who need care.

Insights

A comprehensive literature review and conversations with care economy experts conducted between July and September 2022, and the regional convening of nearly 80 diverse actors on the care economy in Bali in November 2022, yielded several key findings:



Care workers are not a monolith: Care workers experience unique challenges and require targeted solutions based on a variety of distinctions, such as whether they are paid versus unpaid, formally or informally employed, provide direct or indirect care work, considered “high-skilled” or “low-skilled,” or nationals versus migrants in their countries.



Significant policy change, advocacy, and agenda-setting are needed at the regional, national, and global levels to build political will, identify contextually relevant policies and programs, and enact durable reforms and sustainable financing mechanisms. There is a need for strong support for social dialogue, collective bargaining and the role of trade unions in shaping policies, programs, financial decisions and budgets around care.



Coordination and cooperation between actors across local, national, regional, and global bodies is critical to promote knowledge sharing and joint learning, particularly regarding promising care practices and models worth adapting across contexts. Communities of practice—which can operate effectively in the digital space— are one vehicle to drive this change.



Dominant cultural norms, social pressures, and demographic shifts complicate care provision in Asia and the Pacific. The pervasive impact of gendered norms on caregiving and the outsized influence of filial piety in the region have led many governments to eschew a leadership role in shaping the care economy. This includes by explicitly or implicitly delegating care responsibilities to households and families, where most care work is carried out on an unpaid basis by women and girls.



Poor governance and unclear coordination are common impediments to reform. Poor governance, inadequate coordination, lack of political will, and a dearth of innovative financing models within governments and between governments and other actors remain critical bottlenecks to driving reform. This is further

complicated by the fact that care policies and programs are typically spread across different agencies of government and often operate in silos with little to no interaction or coordinating mechanisms.



Most policies focus on legal reforms for formal paid workers, neglecting informally-employed workers, workers on digital platforms, and domestic migrant care workers. Common legal and regulatory reforms (e.g., flexible work arrangements, adequate leave, income security/benefits and universal childcare laws) that have improved working conditions for workers in the formal sector rarely extend to care workers in the informal sector, especially from the most marginal and disadvantaged groups. Enforcement and compliance with existing policies remains a concern in many countries. Even where promising policies exist, poor enforcement and lack of accountability lead to compliance challenges, particularly in the informal sector. Unions and worker organizations and their leaders working to address these concerns face significant resistance, especially in countries where democratic space is tightening and often coupled with a re-traditionalization of roles where men are perceived as the primary breadwinners and women as the unpaid primary caregivers within the household.



Paid care workers are undervalued and underpaid, consistent with other highly feminized sectors. Despite being in high demand, paid care workers receive persistently low wages and fewer employment benefits and safeguards than other workers, which has detrimental effects on their health and well-being. Most have little bargaining power to advocate for their rights, nor are they included in social dialogue to address these inequities.



Rising care demands during Covid-19 have deepened already existing gender inequalities. Unless policymakers take immediate action, existing inequalities will continue to grow, further limiting gender, economic, health, and human rights outcomes and eroding progress on the sustainable development goals (SDGs). While the demand for long term care is rising steeply, legal frameworks and paid workforce supply (with sufficient education and training) remain insufficient and inadequate.²⁴



Asia and the Pacific are two separate regions and, in many ways, each region requires targeted research and policy attention. While data on the care economy and analyses for Asia are limited, they exist. This is not the case for the Pacific Islands, for which very little care data exists, but for which available data suggests care concerns are growing, particularly in the context of rising climate-related and GBV in the region.



Existing data suggests a greater prioritization of childcare. This reflects a large and growing youth population relative to elder or disability care. It is especially true for the Pacific Islands, where data on eldercare and disability care is particularly scarce.



Across Asia and the Pacific, there is a dearth of care data to guide the development of effective transformative care policies and programs that are informed with a care lens, are rights-based, gender-responsive, integrated, and inclusive. Integrating care into standard time-use surveys and other national data collection mechanisms is critical, but qualitative and participatory data are also important ways to connect statistics with the lived experience of care workers, families, and communities to build the case for more robust investments in care.

Recommendations

A central theme that emerged from the research findings is that Asia and the Pacific is diverse, with unique challenges and concerns with regard to the care economy. For example, the research found that while women experience a disproportionate responsibility for providing unpaid care to dependents, this disparity is particularly pronounced in Asia and the Pacific where women perform 80% of the total amount of unpaid care work.

Moreover, the region encompasses diverse care needs, policies, and practices. As previously noted, countries vary considerably in terms of their wealth, economic development, culture, geography, and political will to pursue reform measures. Further, their specific priorities are shaped by the nature of the care-related challenges with which they grapple. High-income countries like Japan, South Korea, and Singapore have aging populations and care worker shortages, meaning they are likely to invest in eldercare relative to low- and middle-income countries like India and Bangladesh, which have larger youth populations and are more likely to invest in childcare. In the Pacific, there is little data to understand current trends, although the limited data which exists suggests a disproportionate focus on childcare relative to elder and disability care.

Even amongst countries at similar income levels, variations exist due to governance structures, domestic politics, and other factors. Accordingly, the recommendations below have been disaggregated by income level, in recognition of the region's enormous complexity and diversity and the need to tailor strategies to different contexts.

Recommendations for Governments

FOR ALL GOVERNMENTS



Improve coordination and collaboration by creating internal and external taskforces or similar structures to focus efforts on care policy and implementation.



Transform patriarchal norms and mindsets through leading and funding campaigns around the redistribution of care work across genders and gender mainstreaming initiatives.



Improve data collection to incorporate measures of paid and unpaid work in national statistics. This could include conducting more cost-benefit analyses of investments and impact assessments of care policies and programs.



Expand and incorporate care services in existing social benefits and protections, particularly those available to informally-employed domestic and migrant care workers.



Improve the reputation of care work and retain care workers through funding and creating employer incentives for upskilling career advancement opportunities for paid and unpaid care providers.



Promote long-term return on investment (ROI) in care through investments in childcare, eldercare, care for individuals with disabilities, education, health, and social work through investment in social work, and investments in health and education systems, and skill-building to better support and serve childcare, eldercare, and disability care needs. Commit to gender budgeting processes that can inform inclusive approaches to the design and delivery of care policies and investments.



Ensure social dialogue and collective bargaining through participation of trade unions, employers' associations/private sector, and other relevant stakeholders in designing and developing transformative care policies and programs based on 5R Framework for Decent Care Work.*



Ensure that trade unions and workers have the right to freedom of association and collective bargaining, among other fundamental rights.



Commit to international labor standards and ratify the International Labour Organization (ILO) conventions related to decent work, social protection, informal economy, maternity protection, reconciliation of work and family, domestic workers, violence and harassment, occupational safety and health.



Improve national, regional and international coordination by joining the Global Alliance for Care, a global network launched by UN Women and the Government of Mexico in 2021, which includes governments, the civil society, the private sector, and others, to promote joint-learning, innovation, and collective problem-solving on issues related to multilateral financing mechanisms and other care policy issues.²⁵

* Developed by the International Labour Organization (ILO), the 5R Framework for Decent Care Work states that policy recommendations and measures needed to promote effective care work should recognize, reduce, and redistribute unpaid care work; reward paid care work, by promoting more and decent work for care workers; and guarantee care workers' representation, social dialogue, and collective bargaining.

FOR GOVERNMENTS ACROSS DIFFERENT INCOME LEVELS

HIGH-INCOME COUNTRIES

Subsidize care provision through:

- Subsidies to private sector to promote technology innovation
- Non-contributory pension care credits to unpaid care providers.

Professionalize care work through:

- Investing and developing more robust care infrastructure
- Providing vocational training and skills upgradation for women on parental leave

Enforce care regulations through:

- Developing monitoring tools and creating compliance and accountability bodies

LOW- TO MIDDLE-INCOME COUNTRIES

Leverage and strengthen existing resources to improve care provision through:

- Creating and/or invest in community-based care programs
- Ensuring that basic care infrastructure exists

Professionalize care work through:

- Providing public works programs to improve the participation of time-poor care providers in labor markets

Transform patriarchal mindsets and behavior change through:

- Including all types of care providers in ad campaigns highlighting care work

Recommendations for Civil Society, the Private Sector, and International Organizations

While government leadership on care delivery and provision is the foundation of robust care systems, collaboration and engagement with other actors is crucial. All actors have a unique role to play in contributing to strengthening the care economy.

Regional and international bodies like the Association of Southeast Asian Nations (ASEAN), the Asia-Pacific Economic Cooperation (APEC), and the G20, among others, as well as multilateral institutions, regional organizations, bilateral development agencies, and other diplomatic actors are positioned to make significant changes to policy agendas and the financing and resource allocation of care policy. They can also critically influence norm-setting for countries around more equitable care redistribution between genders.

Civil society organizations (CSO) can further mobilize workers' associations and care groups, and negotiate and collectively bargain for better care worker rights. They can also foster social norms change through advocacy and behavior change campaigns, particularly campaigns and programs that engage men and boys to challenge patriarchal gender and caregiving norms. Finally, they can conduct additional research to bridge key data gaps in the care economy (particularly in terms of intersectional and/or contextual issues of concern) and make or facilitate the development of evidence-based care policy recommendations and innovative models of care that can be adapted or scaled.

The **private sector** can play complementary and leveraging

roles. For example, companies can implement policies that offer care support services to employees with care responsibilities. They can also promote and encourage male champions of care to serve as models for male workers with care needs. They can invest in technological innovations that expand care access and collaborate with governments through public-private partnerships to finance high value-added innovations, research, and programs that are responsive to the intersection of care and other sectors, such as climate change. They can engage meaningfully with workers organizations and trade unions in social dialogue to formulate and design care policies and programs. They can also work with unions to affirm freedom of association and collective bargaining, and they can work together to determine standards for decent work, occupational safety and health, including violence and harassment in the workplace, and improving the quality-of-care services.* Finally, they can explore and support the expansion and adaptation

* The [Investor Initiative for Responsible Care](#) is a good case for how this is undertaken in the context of long-term care intended to raise the standards in the sector.

of childcare facilities that meet eldercare and disability care needs—for which fewer facilities exist.

The **philanthropic sector** can play a catalytic role in supporting collaboration and coalition building across sectors, particularly focusing on providing core funding and staff support to enable CSO and worker collectives to effectively elevate their priorities and perspectives at regional and global forums. It can also contribute to standards setting on workers' rights in the context of social impact investing, for example in developing Environmental, Social, and Governance (ESG) indicators. Additionally, the philanthropic sector can support financing initiatives that strengthen the capacity of workers' unions and cooperatives to negotiate and bargain for better social protections, as well as funding initiatives like the World Bank's Invest in Childcare Initiative or the Global Alliance for Care. Philanthropic organizations can also invest in promising care models developed by civil society organizations or the private sector.



The Way Forward

Building a resilient care ecosystem requires significant commitment and collaboration from all stakeholders. This paper highlights promising practices, lessons learned, and recommended pathways for action, together with key gaps for which further action is warranted. Specifically, more research and data are needed on topics such as government investments in disability and long-term care, public care financing models, and care

By working together with care providers and recipients, governments, private sector, and civil society, practitioners and policymakers can build well-resourced and resilient care ecosystem as the foundation of inclusive and sustainable economic development in the region.

investments in the Pacific Islands. Data and dialogue on the intersection of care with other sectors is scarce, with more insights needed on how the care economy relates to GBV, climate change, and disaster and conflict. Finally, greater clarity is needed on the following issues: mechanisms and platforms for governments and organizations to engage care workers and those being cared for to develop gender-transformative care provider-centered policy interventions that are responsive to the needs of care providers and those being cared for, and promote worker's rights; the role of different actors within the care

ecosystem (e.g., the private sector) in responding to care; how to guarantee social protections for informally-employed care workers beyond formalization; and the impact of the care economy on care providers and receivers in the Pacific Islands.

Despite the gaps highlighted in this report, The Asia Foundation's research and its recent convening of care practitioners, policymakers, and experts at The Bali Care Economy Dialogue in November 2022 affirms that there is growing commitment and momentum amongst governments, civil society, philanthropy, and the private sector in Asia and the Pacific to promote decent work for all care providers and build the larger care movement. There are many opportunities for significant investment, including more robust care infrastructure, public policy, and technological innovation.

This report aims to catalyze collective action, starting with greater dialogue on care needs in the region. By working together with care providers and recipients, governments, private sector, and civil society, practitioners and policymakers can build a well-resourced and resilient care ecosystem as the foundation of inclusive and sustainable economic development in the region. In this way, we can move governments, policy makers, and other stakeholders toward decent work and dignity of care for all care providers and care receivers across the globe.

Introduction

Economists concerned with gender equality have studied the care economy for decades, producing rich analyses and nuanced recommendations that highlight the pivotal—yet undervalued and under-prioritized—economic role that care providers and care services play in the broader economy.

In recent years, ongoing conflicts and crises have spurred new interest in the care economy among policymakers, practitioners, and other actors around the world. The Covid-19 pandemic led to a rising demand for care, which subsequently exposed the essential nature of care work. Climate change threats and the concomitant risk of exacerbating certain diseases (like malaria) are further intensifying the work involved in caring for people, animals, plants, and places. Ongoing conflicts, such as the Russian invasion of Ukraine, have disrupted access to critical care-specific (e.g., childcare centers, care workers) and care-adjacent services (healthcare facilities, schools) for those who need to be cared for.

Despite these ongoing challenges, the care economy remains underinvested and understudied, particularly among resource-constrained Asia-Pacific economies. For example, only 21 out of 58 countries in the Asia-Pacific have one data point to measure unpaid care.²⁷ The Asia-Pacific region is composed of diverse societies with different levels of income, social norms and values, and governance systems, necessitating contextually driven approaches to understanding

and solving the challenges of unpaid and paid care work at the national and regional level. In the wake of the recent crises across the globe, the continued fragility, inadequacy, and injustice of the existing care infrastructure has led to an uneven economic recovery that remains highly vulnerable to future shocks. Investing in the care economy is imperative for inclusive and sustainable economic development, gender equality, broad-based social development and meeting the Sustainable Development Goals.

Who Comprises the Care Economy?

Care work is both ubiquitous and a vitally important social and economic activity. Currently there are no internationally agreed statistical standards on the care economy, its reference scope, and how to measure it. While various definitions exist, this paper defines care work as a sub-category of work that includes “activities involved in looking after and providing for the various physical, social, and emotional needs of others” in domestic and non-domestic settings.²⁸ Globally, care workers—most of whom are disproportionately women and girls—support over one billion people, including young children, the elderly, and people with disabilities.²⁹ While some are paid for this work, most care providers are unpaid and lack adequate support from their families to redistribute care responsibilities. While this is true across most regions of the world, this is particularly the case for Asia and the Pacific, where pervasive gendered norms on caregiving view

care provision as a family—and largely female—responsibility, as the white paper will elaborate on later.

Most care workers also lack support from their governments in accessing the social protections and care infrastructure required to deliver the

volume and quality of care necessary to meet high and rising demands.³⁰ This underscores the fact that the activities of individual care workers in Asia and the Pacific are large, gendered, essential, and constitute their own “care economy.”

A Note on Key Terminology

While various definitions of the care economy exist, this paper refers to the ILO and UN Women’s definition of the care economy.

The care economy represents diverse paid and unpaid work activities that provide direct and unpaid care for people needing support. This includes children, people with disabilities, and those who are elderly or sick. Provision of care includes self-care to support people to function capably, comfortably, and safely.³¹

In this paper, the term ‘care providers’ refers to both paid care workers and unpaid care providers.

Paid care workers are individuals who work in the formal or informal care sector and are paid for the care services they provide. They include workers across education (particularly those teachers who support early childhood development), health, social work, personal care service, and domestic work. Many care occupations are perceived as unskilled or an extension of women’s perceived “natural” or “traditional” role as caregivers, a stereotype that contributes to their low status, low pay, and lack of representation.³² As they are employed in the formal or informal care sectors, we refer to them as care *workers*.

Unpaid care providers are individuals who provide unpaid care or support to individuals within their household or community. This includes cooking, cleaning, collecting water and fuel, and looking after children, older persons, persons with disabilities, and also those who may be ill.³³ However, as they do not work in the formal or informal care sector despite providing care services, we refer to them as care *providers*.

**Please refer to the Glossary for a comprehensive list of key terms related to the Care Economy.*

The Case for Care: Prioritizing the Care Economy



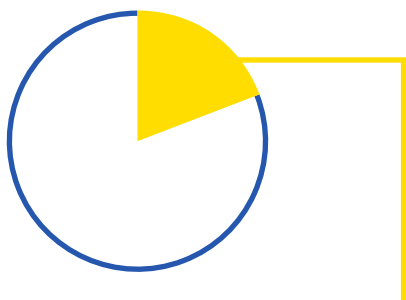
Data from the International Labor Organization (ILO) found that investing and addressing existing gaps in care services could generate almost 300 million more jobs and create a continuum of care that would help to alleviate poverty, encourage gender equality and support for children and the elderly.

The care economy is emerging as a significant concern for policy makers as it is socially important, economically large, but unequally distributed in terms of gender, economic circumstances, and societal vulnerabilities. Care work is socially important because the act of caring for people who cannot care for themselves is critical for the health, welfare, and protection of all people, including future generations. At its core, care is a basic human right and need that is vital to the health, wellbeing, and fabric of society. It is also an expression of humanity and a recognition of the interrelationship between all people within a population.

Care work is also economically significant. Paid care is one of the fastest growing economic sectors and a substantial source of employment worldwide. In the United States, a report published by Melinda Gates' Pivotal Ventures found that paid care is a \$648 billion sector—larger than the \$510 billion domestic pharmaceutical industry and the U.S. hotel, car manufacturing, and social networking industries combined.³⁴ Moreover, data from the International Labor Organization (ILO) found that investing and addressing existing gaps in care services could generate almost 300 million more jobs and create a continuum of care that would help to alleviate poverty, encourage gender equality and support for children and the elderly.³⁵

However, these statistics underestimate the contribution of care providers as a share of economic production because unpaid care provision is not counted in gross domestic product (GDP). Data from the ILO across 64 countries shows that more than 16.4 million hours go toward unpaid care every day, and that women perform 76.2% of these

hours of unpaid care work, which is more than three times as much as men.³⁷ In Asia and the Pacific, this rises to 80%. Women in Asia and the Pacific perform four times as much care work as men. This is equivalent to two billion people working every day for eight hours without remuneration. If valued based on an hourly minimum wage, this would amount to 9% of global GDP, which corresponds to approximately US \$11 trillion.³⁸ In other words, if the care work sector was valued as its own economy, then it would be the third largest economy in the world (after the U.S. and China)³⁹ and more than twice as large as global agriculture as a sector.⁴⁰



Globally, approximately 19.3% of female labor force participation is in the paid care workforce.

Despite its social and economic importance to society, the distribution of care work is grossly imbalanced across genders. Most care providers are women. Globally, approximately

19.3% of formal female labor force participation is in the paid care workforce.⁴¹ This includes more than 75 million domestic workers, over three-quarters of whom are women.⁴² In terms of the care workforce itself, men—despite being 50% of the total world population—represent only 5% of the total care workforce.⁴³

Many paid care workers come from structurally disadvantaged and marginalized backgrounds, and many are migrants who work as domestic workers or outside of the formal economy under poor conditions.⁴⁴ Unpaid care work leads to time poverty—the concept that women tend to work longer hours than men and therefore have less time for self-care, leisure, or rest—and is a leading barrier to women’s labor force participation. This situation can result in reduced or no income for many women and diminished overall enjoyment of freedom, autonomy, and overall well-being for care workers.⁴⁵ If unaddressed, such imbalances will significantly exacerbate class, gender, and other types of intersectional inequality, and perpetuate harmful gender norms, reversing hard-earned progress in gender equality and furthering extreme poverty. Aside from the human rights, economic, and social implications, this situation is eroding progress on achieving the SDGs.

45% of the population in Asia still prefers that family members, mostly women, provide care.



Care in Asia and the Pacific

In Asia and the Pacific, addressing the imbalances in care provision, quality of care, and work environments is further complicated and of greater urgency due to demographic shifts, climate-related threats, and existing gender and cultural norms that place expectations disproportionately upon women to be responsible for all care-related needs. Historically, women in Asia and the Pacific have worked the longest hours globally, with more than half the time spent on unpaid care work.⁴⁶ According to a recent study, women spend 4.1 times more time on unpaid care work than men in the Asia and the Pacific. One explanation for this is that many societies across the region view care work as being primarily “female” and reserved solely for family members. According to a 2020 study, because many Asian countries have such close intergenerational ties, about 45% of the population in Asia still prefers that family members, mostly women, perform unpaid care work.⁴⁷ In the Pacific, patriarchal mindsets combined with threats of violence against women may force many women and girls to assume all of the unpaid caregiving responsibilities within the household, thereby limiting

their ability to seek paid employment and growth opportunities—critical for establishing autonomy, agency, and self-worth. As the paper will discuss below, the Covid-19 pandemic further reinforced this tradition, with women’s unpaid work increasing and existing social inequalities exacerbated.

Moreover, a demographic shift across the region has increased pressure on the care economy. Countries like Japan, South Korea, and China are experiencing lower fertility rates combined with higher life expectancies, leading to growing eldercare demands.⁴⁸ This trend is rising in middle-income economies as well, including India and Sri Lanka, which are experiencing a growing median age.⁴⁹ Such demographic shifts have created additional demands for eldercare, including within countries that currently lack adequate and specialized eldercare services and resources. Additionally, the Pacific Island countries have amongst the highest cases of non-communicable diseases in the world, leading to heightened risks of disability and death. Such challenges have led to rising disability care needs in that region of the world⁵⁰ and with a dearth of disability infrastructure and

investment to respond despite the fact that as many one in six persons have a disability in the Asia and the Pacific.⁵¹

The Pacific Islands are also experiencing severe climate-related threats, with rising sea levels threatening to submerge entire sections of land by 2060.⁵² Although data on the intersection of care and

“

Climate change intensifies the work involved in caring for people, animals, plants, and places. For example, rising sea levels caused by climate change can drastically exacerbate the risk of mosquito-borne diseases, such as Malaria.^{53 54} This adds a greater burden on care workers. Climate disasters, like cyclones, can also reduce the availability and quality of public services in marginalized communities and directly compound the unfair distribution of unpaid care work that sustains gender inequality.”⁵⁵

climate change is scarce, a preliminary study by Oxfam suggests that: Climate change can also complicate care provision and the burden of care on marginalized populations. For example, in the aftermath of Cyclone Winston in Fiji, members of the lesbian, gay, bisexual, transgender, and other queer individuals (LGBTIQ+) community struggled to access food and shelter due to the level of discrimination they experienced. This rendered it difficult for LGBTIQ+ care providers to both meet their own needs and provide care to others.⁵⁶



Photo by Prajudeb Chaijimpia / Alamy

The Impact of Covid-19 on Care Work

The Covid-19 pandemic has amplified the complexities of and demand for care, with far-reaching consequences.⁵⁷ Globally, it has exposed and deepened inequalities, particularly for already vulnerable and structurally disadvantaged populations. When it emerged in late-2019, the pandemic put a strain on existing health and care systems, widening socio-economic divides and changing priorities, and underscoring the fundamental value and importance of care.⁵⁸ Over the past two years, Covid-related lockdowns and other disruptions have led to widespread school and daycare closures and heightened eldercare and disability care needs. These factors have combined to increase care responsibilities for both men and women. However, data continues to suggest that women shouldered a disproportionate share of rising paid and unpaid care responsibilities, leading to what many economists have referred to as a “she-cession”—larger employment declines and reduced employment hours amongst women than men.⁵⁹ As a result, women in the aftermath of the pandemic have had fewer opportunities to be promoted and gain meaningful leadership positions that contribute to core organizational decision-making.



Decent work and dignity of care as a basic human right

The pandemic increased the demand for care, elevating the issue of care work on global and regional agendas. It highlighted the importance and urgency of prioritizing and protecting care workers and mitigating the negative impact on (particularly women's) labor force participation to meet rising care needs. However, most policy conversations to date have focused almost exclusively on the economic impact of care on the global economy. While it is true that unpaid care work hampers economic growth globally—as unpaid care responsibilities often preclude care providers from participating fully or at all in the labor market—the ability to provide choice and decent care that honors the dignity of those being cared for is a basic and fundamental human right that needs to be centered in policy dialogues.

Care providers have a right to decide how to spend their time. This means having a balanced workload, for which the distribution of care work should be more equal across all genders.

Secondly, those who are being cared for (including young children, older people, and people with disabilities) have a right to receive care that affirms their dignity and is high-quality and tailored to their specific needs. Governments, including federal, state, and municipal ministries and agencies, in turn have a duty to protect these rights. This involves governments taking greater ownership and accountability to meet rising care demands and to build resilient care infrastructure and ecosystems.

It is crucial to acknowledge and emphasize that decent work and the dignity of care carry significant economic benefits and are a human right for all care workers and care receivers. Although this paper will focus more heavily on the economic benefits of investment in the care economy—as that argument is one that will more likely gain traction with investors and policymakers—the authors want to be clear that both rights-based arguments are critically important.

Scope, Methodology, and Policy Objectives

Despite increasing global attention on care, data of the kind needed to support efforts to build a resilient care ecosystem remains limited regarding what works, in what contexts, for whom, and why. From July to November 2022, The Asia Foundation conducted qualitative desk research and held conversations with experts in the care economy to better understand the existing landscape of care in Asia and the Pacific, with a focus on building a robust and resilient care ecosystem in the region.

An initial draft of this paper was presented at The Bali Care Economy Dialogue in November 2022, a regional convening that was led by The Asia Foundation and The Global Alliance for Care, among other partners, and which brought nearly 80 care practitioners and policymakers from civil society groups, the private sector, bilateral and multilateral agencies, and academia across Asia and the Pacific, other regions. The discussions were insightful, valuable, and nuanced and were later incorporated into the final draft of this paper.

This paper reports key findings as they relate to the care ecosystem in Asia and the Pacific. It explores paid versus unpaid care, formal versus informal care workers, care-related financing and infrastructure, and the intersection of the care ecosystem with climate change, migration, conflict, and gender-based-violence (GBV). The analysis addresses a range

of care needs, including childcare, eldercare, disability care, and care-related migration. The analysis also evaluates different care-related policy interventions across Asia and the Pacific. This includes highlighting the role of technology, decent work principles, women's associations, community-based models, flexible work policies, and dignity of care. These interventions are essential to addressing common challenges confronting care providers and recipients as the region endeavors to build a resilient care economy. Challenges include that care systems are often underfunded and undervalued and will be discussed in more detail below.

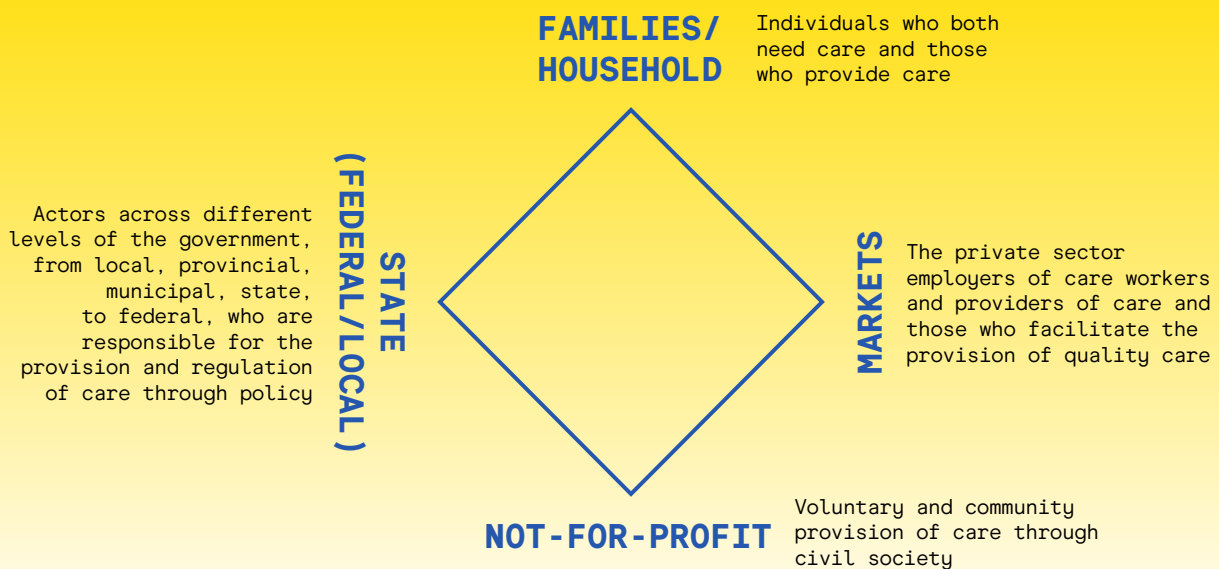
The paper further expands on the idea of the “care diamond,” a framework introduced by Shahra Razavi, Director of the Social Protection Department at the ILO, to examine the “architecture” through which care is provided: families/households, markets, the state, and the not-for-profit sector.⁶⁰ Using the care diamond as a model, the paper outlines the unique roles of families and households, the private sector, civil society, and governments in contributing to the region's care ecosystem.

Finally, the paper highlights additional research questions that warrant further exploration and discussion by the care policy and development community at-large.

The Overall Framework and Policy Objective for this Paper

Introduced in 2007, Razavi’s care diamond evaluates how care responsibilities are shared across four different welfare sectors—families, the state, the market and the sector—and how the care needs of particular groups (e.g., children and the elderly) are provided for within these four domains.⁶¹

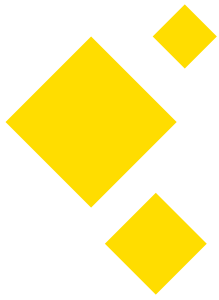
Figure 1
Razavi’s “Care Diamond”



Within this model, *families and households* refer to those individuals who both need care (particularly in the case of children, older persons, and those who have a disability) and those who provide care (such as parents, spouses, children and other guardians). The *market* refers to both the private sector employers of care workers and providers of care and those who facilitate the provision of quality care (such as private investors and infrastructure companies). *Not-for-profit* refers to the voluntary and community provision of care through civil society. And finally, the *state* refers to actors across different levels of the government (local, provincial,

municipal, state, federal) who are responsible for the provision and regulation of care through policy.

This framework guides the structure of the paper and is also fundamental to understanding the role of collaboration and coordination in advancing the care ecosystem across Asia and the Pacific. The model highlights the importance of government collaboration with other actors, including the private sector, researchers, civil society, families, and communities, in order to change policy, laws, and deep-rooted social and cultural norms on care.



Through the care diamond model, our paper explores the policy question—**How can governments catalyze these four different domains of society to meet society’s care needs and ensure justice for care providers?**

Audience and Caveats

This paper is written for a diverse audience of actors across the care ecosystem. This includes government policymakers, leaders of CSO, and private sector companies and enterprises that support and invest in care needs. Additionally, it is hoped that the paper will be of value to other actors who are involved with care work, including care workers and those being cared for, multilateral and international organizations, and researchers, among others. It is hoped that this paper will catalyze further dialogue, research, funding and investment, amongst a wide range of stakeholders who seek to contribute to a more resilient care ecosystem in Asia and the Pacific through effective collaboration and coordination.

It is important to note a few caveats. First, most of the numerical data presented in this paper focus on paid care within the formal labor force due to a paucity of data on unpaid care providers and/or those who are informally employed. Yet, unpaid care providers and informally employed care workers play a critical role in meeting care demands, and policy solutions that exclude these actors will be insufficient. It is imperative that governments protect and represent these individuals through extended social protection schemes. Policymakers also need to prioritize

data collection strategies that illuminate the unique and diverse needs of these groups.

Secondly, care providers across Asia and the Pacific are not a monolithic group. While the paper presents high-level findings related to care providers, it is crucial to recognize the diversity that exists within the region, especially amongst different care provider populations whose members face different challenges, complexities, and experiences. Effective policy solutions must be targeted and tailored to meet these specific nuances. This means acknowledging, for instance, that what may work for formally employed care workers may not work for informally employed care workers. Many care workers who are informally employed may desire legal recognition for their work but may be reluctant to formalize their working arrangements in a way that would require them to participate in the formal sector (for example they may prefer more flexible working arrangements). For these reasons, the paper does not advocate for the formalization of all informally employed care workers. These nuances are critical, to both address root causes of inequality for different populations and achieve transformative, systems-level outcomes for the care economy.



**CHAPTER
1**

The State of Care Work in Asia and the Pacific

Care Challenges Across Countries

Asia and the Pacific comprise a diverse range of countries that vary considerably in terms of economic activity and development, cultural norms, and existing capacity and resources to implement reform. These differences have led to variations in government investment and prioritization of care.

Due to the demand for eldercare exceeding the supply of care workers available, the past decade has seen a rise in investments in technology and an easing of migration policies.

* It is important to recognize that South Asian countries, including Nepal, Bangladesh, and Sri Lanka, are experiencing growing restrictions to mobility for women in domestic work on the grounds of protecting women from violence and harassment.

High-income economies like Japan, South Korea, and Singapore are experiencing low fertility rates and high life expectancies, which has led to a stronger focus on eldercare relative to low- and middle-income neighbors in the region.⁶² As demand

for eldercare exceeds the supply of care workers available, the past decade has seen a rise in investments in technology and a relative easing of migration policies in previously protectionist, high-income nations of east Asia.* Many of these countries are also simultaneously prioritizing and strengthening investments in childcare infrastructure and policy as an effort to incentivize childbirths. Thus, investing in eldercare has not led to a de-prioritization of other forms of care.

In contrast, low-and-middle income countries (LMICs) in Asia, such as India, Bangladesh, Thailand, and Pakistan, are grappling with large populations, including youth populations, which has placed rising demands on childcare. At the same time, ongoing demographic shifts suggest that these countries will also face aging populations and care worker shortages in coming years.

The delivery and provision of care within LMICs is complex and rife with challenges. Many countries lack the financial resources, systems, and processes to provide progressive care reforms and infrastructure informed by quality data and a strong evidence base. Moreover, while gender norms are pervasive throughout the region, gender scholar and researcher Alice Evans argues that these norms are especially pronounced in LMICs.⁶⁴ This may be due to religious, cultural, and traditional practices in these countries that perpetuate fixed gender roles. Closing civil society space, especially for women, in these countries may further reinforce such care norms through women being confined to the home while men engage in public spaces, mosques, and markets. This has led to particularly low female labor force participation rates (23.6% in

South Asia versus 59.04% in East Asia and Pacific) and unequal distribution of care between genders.⁶⁵

In contrast with the Asia-Pacific region, very little data exists on the state of the care workforce and economy in the Pacific Islands. Existing data suggests a greater prioritization of childcare (due to a large and growing youth population) relative to elder or disability care. However, even basic data such as the size of the paid and unpaid care workforce, care priorities amongst governments, existing innovations and best practices, and existing platforms for care coordination appear to be missing, highlighting a significant gap in the existing literature on the care economy. This will be discussed later in the paper.

Types of Care Providers and Key Needs and Challenges

Three types of care providers exist: (1) formally-employed paid care workers, (2) informally-employed paid care workers, and (3) unpaid care providers. In this paper, the term 'care providers' refers to both paid care workers and unpaid care providers.

Formally-employed paid care workers

are individuals who look after the physical, psychological, emotional, and developmental needs of others within an employment relationship. They belong to the formal labor market (often as employees of a company) and are compensated for the care services they provide. Formally-employed care workers, like formally-employed individuals in general, are also entitled to social protections, such as affordable healthcare and paid leave.

Informally-employed paid care workers

also provide crucial care services to promote the developmental needs of others at a cost. However, unlike formally-employed paid care workers, these individuals do not belong to the formal labor market and therefore lack access to social and labor market protections.

Unpaid care providers

are individuals who provide care services to individuals within their families and communities but are not compensated for this work and are, therefore, not part of formal or informal care economy labor force.

Key concerns and challenges faced by care providers

In Asia and the Pacific—and indeed across the globe—in addition to being majority female, care workers frequently belong to minority groups who often experience discrimination and come from low-income, structurally disadvantaged backgrounds. Due to their low-income status, many care workers are often in desperate need of employment and unable to advocate for their rights. As a result, paid care work—whether formal or informal—remains a highly feminized industry that is overrepresented by individuals from marginalized communities.⁶⁶

As with many feminized industries, paid care work is often in high demand, yet workers tend to earn persistently low wages. For example, women wage workers earn

Women wage workers earn approximately 20% less than men in the health and care sector.

approximately 20% less than men in the health and care sector.⁶⁷ One explanation for this is that “traditional gender ideologies” are often used in harmful ways to justify the low pay that care providers receive. For example, these ideologies may hold that part of the remuneration is psychological in nature and that no/low skills are involved, given that “all women and girls” are able to do these things. Data shows that many formally-employed paid care workers, especially women, also receive fewer benefits than other types of formally-employed workers.⁶⁸

Moreover, many paid care workers operate in poor working conditions, for long hours, and with limited pay—which at times leads to poor quality of care being provided. This is especially true of domestic workers and migrant care workers, who often work in unregulated conditions and are exploited, and face discrimination and heightened risks of harassment and violence. They can access few avenues to advocate for their rights due to a lack of access to networks, technology, and the opportunity to self-organize or unionize, as the case study below on the mistreatment of Pacific Island care workers in Australia illustrates. These include the hesitancy of migrant care workers to utilize the provided grievance platforms due to fear of retaliation in the form of job loss and deportation. This is particularly a concern for informally-employed care workers, representing a sizeable contingent of the care workforce in South Asia, who further lack access to social protections and have fewer avenues to advocate for their rights. Finally, care workers are often overburdened, overworked, and lack adequate and up-to-date training and soft skills. The profession also suffers from a reputation problem, with data suggesting that people generally consider direct care work and childcare as low-skilled and less important than other forms of care work, such as healthcare.^{69 70}

This section provided an overview of top-level challenges faced by formally- and informally-paid care workers. The next section will delve deeper into the challenges that are faced by unpaid care providers.

CASE STUDY →

Care-Related Migrants: Mistreatment of Pacific Island Workers in Australia

In response to widening gaps in the eldercare workforce and other industries, the Australian federal government expanded the Pacific Australian Labor Mobility Scheme (PALM) in 2022. Previously, the scheme had invited workers from Pacific Island countries to provide much-needed labor in agriculture and other low-skilled industries. The recent amendment expanded the list of industries to include eldercare.

A recent report by the Committee for Economic Development of Australia found that 65,000 care employees left the sector annually and Australia would need to recruit an extra 35,000 care workers per year to fill growing shortages. To incentivize migration, Australian Prime Minister Anthony Albanese announced that the government would seek to expand the scheme to allow workers to travel with their families, noting that a previous exclusion on families may have precluded workers from applying to PALM in the past. Others argue that more reforms are needed—particularly from the employers of

care workers—to both encourage future migration and retain existing workers.

A HISTORY OF EXPLOITATION

Welfare advocate Geoffrey Smith argues that employers need to improve work conditions for migrant workers, including care workers from the Pacific Islands. In the past, workers were forced to reside in poor conditions and work long hours for low pay, leading to burnout. Moreover, workers are oftentimes provided low-quality health insurance that does not cover the cost of childbirth. This has led to reports of employers threatening to fire or revoke the visas of women who become pregnant, despite being in breach of women's rights.

Despite growing discussions on regulating workplace conditions for Pacific Island migrants, no explicit policies have been passed. Women's rights and migrant activists argue that unless significant reforms are taken to support workers' rights, fewer care workers from the Pacific Islands will migrate to Australia to fill increasing gaps in the care workforce.

Source: [Australian Broadcasting Corporation News](#), [CEDA](#), [The Financial Review](#), and [The Guardian](#)

[Unless] significant reforms are taken, to support workers' rights, fewer care workers from the Pacific Islands will be migrate to Australia to fill rising gaps in the care workforce going forward.

The Role of Families and Households in the Provision of Unpaid Care

Photo by szefei wong / Alamy

even across genders. In Asia and the Pacific, this disparity is larger than any other region, as women perform 80% of the total amount of unpaid care work.⁷² This is due to dominant gender norms and close intergenerational ties. Scholars Marian Baird, Michele Ford, and Elizabeth Hill write that, across the region, pervasive “gendered familism reflects the belief that care is a private familial (and female) responsibility, based on two assumptions: that families are altruistic, and that care work is a natural function of women and girls. As a result, the primary responsibility of women and girls is to undertake unpaid reproductive labor even at the expense of opportunities to engage in paid work.”⁷³

The expectation that women should be the primary care providers while men should be the primary breadwinners is deeply entrenched throughout the region, irrespective of the country’s income level.⁷⁴ This is further validated by data from the region which shows that about 45% of the population of Asia prefers that family members, mostly women, provide care.⁷⁵ What varies considerably across economies, however, is the extent to which and how familial care is further supplemented through non-familial care provision (e.g., domestic workers, specialists in elder care, among other providers). As most non-familial care is provided by the state, market, and/or not-for-profit.

CHAPTER 2

Gender Norms on Caregiving

Families and households play a significant role in the care economy. This includes both those who require care, such as young children, those who are old or who have a disability, and care providers, such as mothers, fathers, siblings, grandparents, and other guardians. As familial care provision is usually not compensated, the care being provided is *unpaid care*.

Women and girls experience a disproportionate responsibility for providing unpaid care to dependents. Globally, women perform approximately 76% of the total amount of unpaid care work, which is 3.2 times as much as men and boys.⁷¹ Nowhere in the world is this distribution

Challenges with Unpaid Caregiving

Unpaid care work constitutes a critical and significant component of the care economy in Asia and the Pacific and can be extremely burdensome and challenging for care providers as well as societies. Four primary consequences of unpaid care on care providers are identified below.

CONSEQUENCE 1 →



The Motherhood Employment Penalty

Unpaid care is a key barrier to women's labor force participation.⁷⁶ The Covid-19 pandemic further exacerbated this trend. With widespread school and care facility closures, the demand for unpaid care increased, predominantly on women. According to a rapid assessment survey conducted by UN Women, women in South Korea, India, and China reported spending approximately 34.1, 33.2, and 31.9 hours

Women in South Korea, India, and China, reported spending approximately **34.1, 33.2, 31.9 hours a week, respectively, on childcare—almost equivalent to a full-time job which is 40 hours a week in many parts of the world.**

a week, respectively, on childcare—almost equivalent to a standard full-time job (which is 40 hours a week in many parts of the world).⁷⁷ To meet these responsibilities, many working mothers were forced to reduce their work hours or leave the workforce entirely, which scholars have referred to as the “Motherhood Employment Penalty.” In Nepal, the number of women not engaged in paid work increased by 337 percent in 2020 during the lockdown period. Additionally, preliminary data from the region shows that women who were employed at the start of the pandemic were 20 percentage points less likely to be employed than men a few months later.⁷⁸ This affects women's opportunities for promotion, particularly into leadership opportunities that allow them to contribute to core organizational decisions.

Declining female labor force participation impacts both care providers and the global economy. Estimates show that approximately \$3.8 trillion could be added if the unpaid care work of women was included within the GDP measurements of Asia and the Pacific.⁷⁹ For unpaid care providers, inability to participate in the labor market leads to greater financial insecurity and dependence on male family members to meet basic financial needs.



CONSEQUENCE 2 →



Adverse Health Outcomes

Unpaid care work can lead to poor physical and mental health outcomes for care providers.⁸⁰ Many unpaid care providers are responsible for physical work (e.g., household chores, cooking, cleaning, water and fuel collection, and related functions) to provide care, leading to physical exhaustion, lack of rest, and illness.⁸¹ Unpaid care work is also associated with adverse mental health outcomes.⁸² Care work can be emotionally and physically draining, and studies have found that unpaid care is linked to emotional distress, depression, and anxiety.⁸³ Many unpaid care providers lack access to critical

health services due to constraints on time or money associated with heavy unpaid care burdens.⁸⁴

Rising unpaid care demands associated with the Covid-19 pandemic further exacerbated the risk of poor health outcomes. According to preliminary rapid assessment surveys from Asia and the Pacific, unpaid care providers reported declines in both their physical and mental health. A study conducted by UN Women found that 66% of women indicated deterioration in their physical and mental health post-Covid.⁸⁵

CONSEQUENCE 3 →



Worsening educational outcomes for girls

High levels of unpaid care work can lead to adverse educational outcomes, as the more time that is spent on care provision, the less time is available for other activities. According to UNICEF data from 2016, girls aged 5–14 spent approximately 160 million more hours on unpaid care every day than did boys of the same age.⁸⁶ While statistics specific to Asia and the Pacific do not exist, data highlight three key trends from the region: (1) girls are often the first to be pulled out of school at times of crisis; (2) school closures can lead to re-traditionalization of roles beyond school closures and can lead to girls being denied the opportunity to return to school; and (3) an uptick in rates of child marriage and child pregnancy (which is correlated with higher risks of medical emergencies) occurred during the pandemic to reduce the economic burden on the family and for reasons of security and family honor. Therefore, within the context of Covid-19—a global crisis

with widespread school closures—it is safe to assume that unpaid care is a critical risk factor for girls being pulled out of schools, leading to increased school dropout rates of young girls who are care providers. This is especially true for Asia and the Pacific where young girls already comprised a sizeable percentage of the unpaid care providers.

Female education enrollment is positively correlated with good health and economic outcomes, underscoring its significance from a policy and rights perspective. For example, each additional year of education reportedly leads to a 7–9% reduction in mortality for children under 5 years of age in developing countries.^{87 88} Secondly, it undermines economic growth; limited educational opportunities for girls and barriers to completing 12 years of education cost countries between \$15 trillion and \$30 trillion in lost lifetime productivity and earnings in 2018.⁸⁹

CONSEQUENCE
4 →


Decreased agency, autonomy, and control

An overarching consequence of performing unpaid care is that it results in a loss of agency for care providers. Unpaid care providers often lack control over critical decisions in their lives, such as the ability to participate in the labor force, receive an education, access adequate healthcare, and more.^{90 91}

For those who belong to low-income and marginalized populations, this challenge is further compounded by limited access to basic amenities, infrastructure, social protection policies, non-familial care

provision, and time-saving domestic technologies (e.g. innovations or products which make washing, cooking, and other chores more efficient).⁹² Survivors and victims of GBV are further at risk due to often being kept isolated by their abusers, which further restricts their mobility and ability to seek outside resources. This, combined with strong filial piety and gendered familialism, has rendered it difficult, or even impossible, for many women to seek outside care-related support.

According to a community survey conducted by Voice for Change, a women's human rights organization in the Jiwaka Province of Papua New Guinea, the "burden of unpaid care and domestic work was having a severe impact on women and girls and was viewed by female respondents as one of the most serious forms of violence against women and girls in the Jiwaka Province."⁹³ This finding underscores the impact of unpaid care work on a woman's ability to exercise basic autonomy and freedom.

Gendered Familialism:

An ideology that reflects the belief that care is primarily a private familial responsibility reserved for women, based on two assumptions: that families are altruistic and that care work is a natural function of women & girls.

Filial Piety: A

Confucian belief that promotes respect for one's parents and ancestors. Filial piety is demonstrated, in part, through service to one's parents and has shaped family care giving in large parts of the world.

**CHAPTER
3**

The Role of Governments in Leading Paid and Unpaid Care Policy

As discussed earlier in the paper, the Asia and the Pacific region is highly diverse, with countries varying widely in terms of economic development, income status, cultures, available resources, capacities, and political priorities. These differences make the region a difficult field for comparative political analysis and for one-size-fits-all policy interventions that can be adapted.

The objective of this section, therefore, is to not prescribe a one-size-fits-all model for government-led care, but rather to highlight different models that have effectively guided government activity across different nations. These examples underscore a crucial point: that government models may differ from country to country. One model may, for example, mirror the Nordic model in which the federal and municipal governments have assumed a very active role in providing public care services, such as home care and residential care services, which can cover the need for personal and medical care, as well as assistance with household chores.⁹⁴ Or it may instead look like the Singaporean model, in which the government has “outsourced” care to non-governmental actors by developing the informal economy and encouraging care-related migration and private investments in care. In

essence, the Singaporean government has avoided providing direct care services by ensuring that citizens can access care resources through other means.

Given these nuanced differences, it is imperative that governments play a central role in ensuring a resilient care ecosystem is available in countries and communities. While the specific care policies and interventions may differ, all governments broadly have four critical and distinct responsibilities:

- to lead on the direct provision and/or facilitation of care to all those who need to be cared for;
- to create policy and regulatory environments around care to support the needs of care workers and hold providers accountable for the provision of care in ways that affirm the dignity of those receiving care;
- to support, enable, and coordinate other actors to deliver care response. Below is a brief overview of each role and a summary of key variations across the region; and
- to create and/or coordinate the collection of high-quality data on care, to inform data-driven policies and decision-making.

Provide or Facilitate Direct Care Provision

A core responsibility of the government is to provide or facilitate direct care provision to all those who need access to care. This includes building or facilitating adequate, effective, and well-structured care infrastructure (e.g., childcare centers, disability and eldercare facilities) and passing care policy that legislates and mandates decent care work and care service provision and access (e.g., parental leave, universal childcare access, decent wage and working conditions, and flexible work arrangements). However, as the researcher Marian Baird and others have observed, “when the demands of the economy clash with a gender order

limited in part by strict migration policies that restricted the entry of foreign domestic workers and other foreign migrant care workers. Japan also restricted informal care activity, in favor of a more heavily regulated welfare regime. In Papua New Guinea and Timor-Leste, a lack of financial resources, government capacity, and infrastructure limited the government’s ability to build strong and robust care ecosystems⁹⁵ and especially to women.

Historically, both high-income countries like Japan, South Korea, Singapore, and lower middle-income countries like Papua New Guinea, Fiji, and Timor-Leste offered very limited state-led care provisions to families and households, increasing the demand for unpaid care. In Japan, the provision of paid care through paid care workers was limited in part by strict migration policies that restricted the entry of foreign domestic workers and other foreign migrant care workers. Japan also restricted informal care activity, in favor of a more heavily regulated welfare regime. In Papua New Guinea and Timor-Leste, a lack of financial resources, government capacity, and infrastructure limited the government’s ability to build strong and robust care ecosystems.⁹⁵

In recent years, however, this trend has begun to change, especially in high-income countries like Japan and South Korea. Both countries have been grappling with rapidly aging populations and low fertility rates for the past decade—an issue that became more prominent during the Covid-19 pandemic, in which eldercare demands greatly increased while care worker supply greatly decreased. This has led to a greater awareness and prioritization of care. As the famous saying holds, “necessity is the mother of invention” and indeed this seems

that frames women as primary carers, the state tends to resist and truncate the development of a supportive work/care regime. For this and other reasons, the overall lack of commitment across the Asia-Pacific to the public provision of care means that the responsibility for care is primarily devolved back to families.” Historically, both high-income countries like Japan and South Korea and lower middle-income countries like Papua New Guinea and Timor-Leste offered very limited state-led care provisions to families and households, increasing the demand for unpaid care. In Japan, the provision of paid care through paid care workers was



to be the case for Japan and South Korea. Today, just 25% of all people in South Korea believe that elder care is a family's responsibility (compared to the regional average of 45%), whereas 45% think the State is responsible and should provide more adequate support to meet eldercare needs.⁹⁶

In both countries, the growing need for care support has paved the way for increasingly innovative, unique, and modern innovations. For example, Japan instituted long-term care insurance in 2000 and South Korea has gradually invested more resources in childcare and long-term care services over the past two decades. Japan

introduced and expanded its 2015 Robot Strategy to meet critical gaps in worker shortages, including in the care sector. The initiative has enabled the Government to actively engage the private sector to develop culturally- and behaviorally-competent care robots for elderly people (see the case study below).⁹⁷ In 2019, South Korea expanded its parental leave policy, which provides women up to two years of maternity leave, allows male workers to take additional time off for paternity leave, and permits working parents with children under the age of eight to work reduced hours (between 15 to 35 hours) for up to one year.⁹⁸

CASE STUDY →

Japan's Robot Revolution for the Elderly



In 2015, in response to a rapidly aging population and workforce shortages, Japan's Ministry of Economy, Trade and Industry launched the Robot Strategy, through which the government has partnered with leading technology companies like Panasonic to fund the development of robots to meet increasing eldercare needs. These robots are not designed to replace overwhelmed care workers, like elder nurses, but instead to reduce their workload and create better working conditions. Preliminary data suggests that the robots have been successful in supporting care workers meet the needs of elderly populations. For example, scientists have reported a positive impact of care robots on older people's activity and social participation, and on older adults with moderate dementia.⁹⁹

One robot is Paro, a furry seal that reacts to touch, speech, and light by

moving its head, blinking its eyes, and playing recordings of Canadian harp seal cries—imitating a “therapy animal.” As of 2016, the latest year for which data exist, about 15% of the country's nursing homes had adopted robots.

While the robots serve to reduce feelings of loneliness amongst elderly people and have improved the morale of both staff and residents, they are expensive to manufacture (approximately \$4,000 USD per robot). Most companies have relied heavily on Government subsidies to manufacture the robots. Individuals have used nursing care insurance to help cover the cost of some robots. However, additional funding is required to increase production and affordability.

Source: [Reuters](#), [Stanford's Shorenstein Asia-Pacific Research Center](#), and the [Canon Institute for Global Studies](#)



Photo by Bodong / A Lamy

While the Pacific Islands lack adequate research and data to inform care policies, activity and investment, the relative low levels of economic development and income in Pacific Island communities and the persistent societal norm that holds eldercare a family's responsibility¹⁰⁰ suggest that insufficient capacity, resources, finance and care infrastructure and other issues pose critical roadblocks to care reform in the region. According to the World Bank's 2022 Women's Business and the Law Report, the Pacific Islands have lagged behind the rest of the world on essential care provision. For example, only five countries in the world do not have any form of paid maternity leave (let alone parental leave) across all levels of government,* and all are in the Pacific Islands.**¹⁰³

Other governments have explicitly or tacitly outsourced care to the informal and private sectors. High-income and upper-middle income countries, Singapore and Malaysia, respectively, have "privileged the development of an informal, non-

familial care workforce over provision of formal care provision."¹⁰⁴ In Singapore, the government introduced the CareShield Life Long-Term Care insurance scheme, which provides a monthly cash payment to families supporting persons with disability, to meet their financial care needs.¹⁰⁵ For more comprehensive care, the government offers individual savings schemes, tax relief and subsidies for families to co-reside and to purchase care in the private market.¹⁰⁶

In middle-income countries like India, Bangladesh, Philippines, and Sri Lanka, where the care sector is less-regulated and where there has been limited government action on care, families tend to engage with informally-employed, paid care workers to meet care-related deficits. These countries, especially China and India, have relied heavily on domestic care workers from the informal economy for care provision.¹⁰⁷

In contrast, both New Zealand and Australia have adopted a hybrid approach that restricts informal, non-familial care provision and includes some efforts (albeit with limited public resources) to develop a formal care sector that offers childcare services, eldercare, disability care and more.¹⁰⁸ In Australia, the government has funded a range of aged care homes across the country that provide care and support services to those who need it. These facilities are also regulated for quality of care standards and funding under the Aged Care Act 1997.¹⁰⁹ The Australian government also legislated in 2013 for a National Disability Insurance Scheme (NDIS) that went into full operation in 2020. NDIS entitles people with a permanent and significant disability to full funding for any "reasonable and necessary" support needs related to their disability.

* Some countries (such as the United States) do not have federally-mandated paid maternity and family leave. However, some states in the U.S. do include paid leave legislation for family members.

** These countries include the Marshall Islands, the Federated States of Micronesia, Palau, Papua New Guinea, and Tonga.

Professionalize paid care work and create opportunities for advancement

Another significant state role is to professionalize paid care work through policies that guarantee and enforce safe working conditions and decent pay, and to develop opportunities for career advancement. Examples of professionalizing paid care work include legislated minimum wage requirements, collective pay agreements, employment protections, leave policies, such as maternity and sick leave, and mental health and wellness days. Professionalizing paid care protects care workers from unsafe and hazardous work conditions and simultaneously lends credibility to paid care work as a viable career path. This is essential for dispelling the stigma around care being “low-skilled” and attracting male workers to the sector. Moreover, the professionalization of care work through training and regulations leads to improved quality of care being delivered to recipients. For professionalization initiatives to succeed well, governments also have a responsibility to ensure that care workers have opportunities to advance within their career (for which explicit and equitable promotion pathways and competitive wages that pay workers commensurate with their skill and labor-intensive are critical).

Professionalization of care work through training and regulations additionally leads to improved quality of care being delivered to recipients. Countries with highly-regulated employment sectors offer formally-employed care workers better work conditions than those with less-regulated employment.

Countries with highly-regulated employment sectors are generally high-income, such as Singapore, Australia, and New Zealand, and offer formally-employed care workers better working conditions than those with less-regulated employment (generally middle-income countries like Sri Lanka and Cambodia). When enforced, the regulatory environment also tends to improve the quality of the care facilities available and care provisions as a result.

Although formally-employed care workers receive statutory employment provisions (e.g., sick leave, aged pension, and parental leave)—a significant advantage that unpaid or informally-employed paid care workers do not have—they remain undervalued by society and underpaid. This is true globally¹¹⁰ and in Asia and the Pacific, where research shows that care workers are deeply undervalued, underpaid, and receive few employment benefits.¹¹¹ In fact, although countries like Japan, South Korea, and Singapore have highly developed formal employment sectors, they continue to have minimally developed formal care infrastructure—arguably due to the underlying belief that care provision is a family’s responsibility. As a result, scholars like Baird and others argue that working women in Japan and South Korea have responded by choosing not to have children and instead working long hours in the labor force.¹¹² Although other scholars, like Emory University Professor Mark Ravina, believe that Japan’s poor work-life balance has forced many women to prioritize their career, leaving them with very little time to start families should they wish to.¹¹³ In contrast, both Australia and New Zealand have begun

to prioritize formal care provisions due to mounting pressure from families and households and changing demographics, including disability care needs and a sizeable and growing aging population.¹¹⁴

It is important to note that these policies are only applicable to care

workers employed in the formal workforce. For those who are informally-employed or unpaid, no such policies exist. This suggests that most employed persons in the region are neither protected nor represented in existing care-focused public policy.

Create opportunities and avenues for improved coordination and collaboration

Thirdly, governments have a responsibility to create opportunities for joint learning, collaboration, and coordination amongst internal agencies and actors across the care ecosystem, and to facilitate partnerships between different

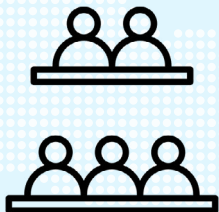
Governments can step in by bringing organizations together to leverage their respective strengths and expertise in care policy.

actors. Facilitating partnerships between governments and other actors (such as CSOs) is important because very few organizations work on care in Asia and the Pacific, and many operate under shoestring budgets that do not allow for this facilitation role. Governments can bring these organizations together to leverage their respective strengths and expertise in care policy and, mobilize funding for the delivery of care through more generous and targeted grantmaking and finance incentives. This may include, for

example, governments financing CSO efforts (e.g., blended finance model or financing the delivery of care through increased grantmaking or pursuing a combination of both approaches). Convening opportunities for cross-learning can play a crucial role in reform within the government and across the care ecosystem. Given governance challenges and a lack of coordination and collaboration, such opportunities—whether via official platforms and communities of practice or an increase in knowledge sessions, among possible avenues—enable different policymakers and actors outside of the government to better articulate and understand their respective priorities. These avenues can help identify opportunities for collaboration, promote transparency, and avoid a duplication of effort. Crucially, CSO leaders can speak directly to the impact of ill-conceived policies and the potential of well-developed policies to transform the current care ecosystem. Through convening power, advocacy and effective networking CSOs can play a valuable role in policy influencing and holding governments to account.

CASE
STUDY →

A New Inter-Ministerial Steering Committee to Promote Care



In its 15th Five Year Plan (2020-2024), the Government of Nepal declared a commitment to “Valuing women’s household labor and family care activities for counting its contribution to the National Income.” In collaboration with the UN Women – ILO Joint Programme (JP), the Government established an inter-ministerial National Steering Committee on Decent Employment and Care Economy (NSC) to focus on promoting inclusive growth policies and investments in the care economy. Housed under the National Planning Commission (NPC), the NSC consists of representatives from the National Women Commission, Ministry of Women, Children and Senior Citizens, Ministry of Labor, Employment and Social Security, Ministry of Education, Science and Technology, Ministry of Health and Population, Central Bureau of Statistics, Federation of Nepalese Chambers of Commerce and Industry and Joint Trade Union Coordination

Center. The NSC may expand to include representatives from the Ministry of Finance and Ministry of Industry, Commerce and Supplies within NSC.

The NSC has announced a strong commitment to advance care outcomes through: (1) Building political consensus across the national government to prioritize care investments, and (2) Identifying investments in the care economy that are aligned with the NPC. Although still nascent, a representative from the ILO has reported improved coordination and communication across ministries on care-related priorities, more diverse representation across government agencies, and a stronger appetite amongst policymakers to collaborate on care..

Source: Representative from ILO – Nepal



Lead or facilitate data collection efforts for evidence-based policy

Finally, data is critical for governments to make informed care policy decisions. Credible data—qualitative, quantitative, and participatory—can help governments make critical decisions on what to prioritize, where to invest, whom to involve, and how to allocate resources most efficiently and effectively. The primary responsibility of ensuring that policies are evidence-based and data-driven lies with the government. Governments can facilitate the data collection process through provision of funding, by leading or collaborating with researchers, civil society, and private institutions, collaborating with efforts happening at the global level and with leading multilateral institutions (like the ILO) and creating major whole-of-government data-informed initiatives as has happened in different countries. This includes investing in data and research that can inform pipeline approaches to education, training, and skill building for care workers including

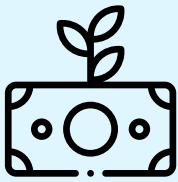
professionalization. To achieve this means working with universities, training institutions, the community and the private sector for effective coordination and planning for future care needs.

This is especially important for the care economy as research to inform this White Paper found that data on care needs, workers, financing, policy, and impacts is both scarce and fragmented. From the literature review and conversations with partners, data paucity emerged as a key impediment to informed policymaking and an urgent need for government prioritization. Specialized sources of data on the care economy, including on the prevalence and characteristics of paid care workers, are not included in official statistics, whereas data availability on unpaid care workers is limited to a few countries in the region.¹¹⁵ Time-use surveys are the main specialized household surveys to generate estimates on the amount of time women, girls, men and boys spend on the unpaid provision of care for family members and domestic work in the household. The large data gaps in Asia and the Pacific is partly due to the dearth of financial and specialized and trained personnel needed to collect these data.

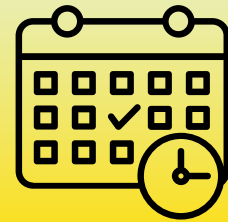
In particular, the following topics surfaced as central data gaps:

Credible data can help governments make critical decisions on what to prioritize, where to invest, whom to involve, and how to allocate resources most efficiently.

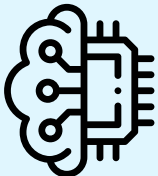
KEY DATA GAPS ON THE CARE ECONOMY IN ASIA AND THE PACIFIC



Government investments in the care economy, disaggregated by **gender, rural, remote and urban settings**



Data on investments in care types **beyond childcare** (e.g., long-term care)

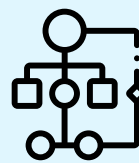


The role and impact of **technology and automation** in promoting decent work for care workers

Care infrastructure in **rural vs. urban** settings



Wage and compensation models for care providers



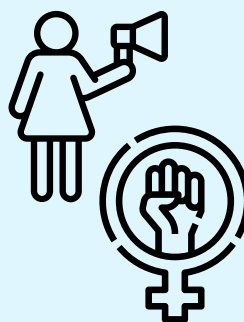
Public care **financing models** for the broader care economy

Compensation schemes for care workers that effectively compensate care workers **based upon the value of the care work they deliver to others** (e.g., equal pay for equal work)

Models for dignity of care (human-centered care) as a central tenet of caregiving rather than compliance-led care

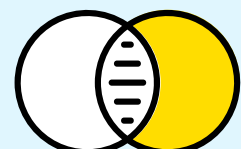


Changing care norms, particularly with regard to perceived **positive vs. negative** perceptions around investing in childcare vs. disability and eldercare, respectively.



The impact of investing in care on **women's economic empowerment outcomes**, with a focus on how better care affects women's incomes, labor force participation, nutrition outcomes, and early childhood development

The intersection of the care economy and mental health





CHAPTER 4

The Role of the Market and Private Sector in Paid Care

As previously noted, recent years have seen a rise in the demand for—and a shortage in the supply of—care workers in the Asia-Pacific region. Moreover, the dearth of government-led care provision in some countries has led more families and households to rely on market-led solutions to meet care-related needs. In the care economy, the market is where individuals can both receive care services from those who provide it and provide care services to those who demand it. The demanders of care work include those who pay for such services (e.g., parents, guardians, adults) often to meet care responsibilities for their children, older parents, and persons with disability. Providers of care work are the employers of care workers. The private sector refers to private, for-profit companies who work either in collaboration with the

government or alone, to provide care and/or employ care workers.

While data on the role and contribution of the private sector is limited, existing data highlights that the private sector has a significant role to play in supporting the development and delivery of effective care models and solutions. In market-oriented care contexts, the government's role in creating a framework for private sector engagement, appropriately regulated and with incentives for equity, is important. This is vital to regulate against surge pricing during times of high demand that preclude access for low-income families and individuals. In this way, government can provide a regulatory framework for private sector opportunities, investment, and innovation that factors in incentives for equitable care provision.

Employ Care Workers

To meet rising household demands for care, a growing number of private employers offer paid care services to families through the employment of care workers, including domestic care workers, eldercare workers, and childcare providers. Many employers of care workers recruit individuals from abroad to meet domestic care workforce supply deficits, particularly domestic care workers. Data indicate that the Philippines, Indonesia, and Sri Lanka are the biggest providers of migrant care workers in the region, while Singapore, and Malaysia are amongst the biggest employers of domestic care workers.¹¹⁶ Foreign recruitment is also a strategy in Australia, where in 2022, the government expanded the Pacific Australian Labor Mobility Scheme to encourage care workers from the Pacific Islands to fill existing vacancies in eldercare work.¹¹⁷

Paid care workers are vital for three main reasons. First, they are often

trained to provide specialized care support to families (which is generally missing in unpaid care settings). Second, paid care work provides a steady source of employment and income to many individuals across the world. Third, the option of paid care gives more unpaid care providers, particularly women, the choice to share their care responsibilities with others, freeing up their time for paid work, livelihoods, leisure and learning.

While paid care work is a valuable contribution to the economy, it remains limited in scale in Asia and the Pacific. Notwithstanding the paucity of data around the size of the paid care workforce in the region, estimates by the ILO suggest that the Asia-Pacific region is “characterized by low levels of care employment (around 10% of total employment)” in the formal labor force.¹¹⁸ One explanation for this, once again, is the pervasiveness of gender norms which dictate that caregiving is a family’s responsibility, and especially a woman’s responsibility within the family, thereby disincentivizing employers from building an adequate paid care workforce. Another explanation is the presence of the informal economy which facilitates care provision directly between care workers and households, removing the need for third-party formal care employers.

Data indicate that the Philippines, Indonesia, and Sri Lanka are the biggest providers of migrant care workers in the region, while Singapore, and Malaysia are amongst the biggest employers of domestic care workers.

Develop and/or Provide Care Infrastructure and Services



Several mobile platforms have emerged across Asia and the Pacific to facilitate care work. Below are a few examples:

- **LoveCare (Indonesia)** enables families to browse, book, and connect with local nurses, caregivers, doctors, and babysitters. Depending on their specific needs, the platform matches users with medical and/or non-medical service providers who deliver a combination of childcare, eldercare, and long-term care services.
- **Kiddocare (Malaysia)** connects parents with trained independent babysitters to provide childcare support. All babysitters are required to have undergone rigorous mandatory training and onboarding.
- **Homage (Singapore)** “matchmakes” older persons with relevant care workers depending on the specific nature of their needs and the level of specialization required.¹¹⁹
- **SmartPeep (Singapore)** is a technology that monitors older persons in wards with cameras and sends notifications to care workers for emergency situations.¹²⁰
- **Hello Task (Bangladesh)** runs an application that allows families to book domestic workers and other household help to support childcare and other household needs.¹²¹

More companies across the region are now filling gaps in care provision through modern care practices. In East Asia, many companies are offering innovative solutions to the region’s rapidly aging populations. These include, for example, mobile applications that allow households to directly browse and book professional care providers to support their care needs.

In Singapore, the government is actively promoting a private market means to eldercare in lieu of direct care provision. For instance, the government offers individual savings schemes, tax relief, and subsidies for families to co-reside and to purchase

care in the private market.¹²²

In contrast, South Asian countries like India, which have large youth populations, have market solutions that focus predominantly on childcare. A growing number of Indian companies, including PepsiCo India and Mindtree, are offering virtual or in-person childcare facilities through expert-led online camps and pre-school classes to support hybrid or remote-working parents post Covid-19.¹²³ Companies in East Asian countries like Japan and South Korea are also beginning to invest more in childcare, to reduce the care burden on women as an incentive to further increase existing low birth rates.^{124 125}

CASE STUDY →



Blockchain technology that promotes domestic workers' rights in Vietnam

In Vietnam, a rapidly growing middle class has sparked demand for paid domestic workers in large metropolitan cities. More households and families, particularly women, are seeking paid domestic workers to relieve them of their care responsibilities, to participate more fully in the labor market.

Most domestic workers in Vietnam are women who have migrated from rural to urban areas in search of employment. Many of them lack education and skill sets relevant to formal employment, and many migrants lack the formal documentation necessary to obtain jobs. As a result, they are unable to participate in the formal economy and tend to rely on informal channels, such as friends and relatives, to secure domestic work in the informal sector.

A growing number of start-ups have emerged to provide web-based services or mobile apps to connect domestic workers with urban households. In early 2019, with funding from the U.S. State Department, HCM House Cleaning Services Development (JupVien.vn),* the Vietnam Blockchain Corporation,** and The Asia Foundation launched a joint project to use blockchain technology to address the needs and vulnerabilities of domestic workers in Vietnam.

As of 2022, the partners have collaboratively developed a blockchain-based digital identification solution for JupVien.vn's current system. The blockchain ledger maintains a record of a domestic worker's personal information, such as their name, age, place of birth, work permits, licenses and training certifications and credentials, and employment and payroll history. Domestic workers can show the ledger—which cannot be falsified—to prospective employers, government officials, banks, and other entities. This improves their chances of seeking formal employment and, more generally, integrating into the formal economy. To-date, more than 2,000 female workers have been introduced to the new system. Initial results are promising, highlighting increased transparency of domestic workers' personal records, a reduction in human error in document checks, and improved access to social services.

*JupVien.vn is an online service that matches domestic workers with employers

**Vietnam Blockchain Corporation is a technology company that develops innovative blockchain applications

Source: The Asia Foundation, 2022
(link).ource: [The Asia Foundation, 2022](#)

Challenges with market involvement

Government policies that shape the care economy often require enforcement or incentive mechanisms to achieve desired impact. For example, despite promising results from companies like Mindtree, compliance with creche provision in India remains a challenge. According to data journalism company IndiaSpend, mostly large, multinational companies have complied with the Government's mandatory creche clause. However, even when creche facilities are available, they are rarely advertised to employees and therefore infrequently used.¹²⁶ For companies that fail to comply, very few enforcement mechanisms exist. This is because while the central government amended the legislation, it is the responsibility of the states to make, enforce, and monitor the

relevant rules. This has not happened. Moreover, as there are no penalties for companies that fail to comply, many have avoided compliance. Only one state in India, Karnataka, has notified companies to adhere to the new policy; however, notification without consequences is not regulation in and of itself.¹²⁷

Another challenge relates to a lack of clarity in terms of how and where private sector companies can contribute to the care economy. For example, should the private sector more actively search for business opportunities to invest in the care economy, recognizing it as a growth market? Should governments set clear parameters for private sector engagement and investment, including incentivizing for equity and ensuring an effective regulatory framework? Is the challenge instead that the business case for private sector investment is unclear? Or is it a combination of the above and more?

The private sector has and will continue to play a dominant or supporting role in care provision across the region.

Although very little data has centered on the role of the market and private sector in contributing to the care economy, especially in Asia and the Pacific, disparate findings highlight two pertinent insights—first, that the private sector has and will continue to play a role in care provision across the region, and second, that many private sector companies are interested and eager to become more involved, yet lack a clear understanding of what the care economy entails, which pathways exist for them to engage, and how. This includes blended finance models, use of technology, and infrastructure innovation.





**CHAPTER
5**

The Role of Civil Society in Paid and Unpaid Care

While data on civil society activity in the care sector is especially limited—a key gap—existing data is sufficient to highlight that CSOs can play a crucial role, particularly in the absence of government-led care provision or care facilitation. Even when there is government-led care provision or care facilitation, the role of CSOs will continue to be vital in providing additional, complementary, and collaborative care. There are currently three types of civil society organizations in the care economy—those that advocate for transformative care policy and behavior change; those that provide direct care services; and those that mobilize and organize care workers to advocate for change. Before considering each role, it is important to note that across the region, the role and priorities of CSOs vary and many CSOs perform a combination of the three roles.

These variations may be due in part to a country’s political regime, which plays a significant role in enabling (or prohibiting) CSO activity. Full democracies* like South Korea and Japan are more likely to allow CSOs to operate, monitor existing conditions, raise awareness of certain issues, challenge and hold governments accountable for their social obligations, and rally domestic and international support in cases of government inaction. In contrast, non-democratic and authoritarian regimes may have higher costs of dissidence. These are nations where protests, social mobilization, and advocacy are often punishable by imprisonment, violent suppression, disappearance or even death.

* Please refer to the [Democracy Index](#), compiled by the Economist Intelligence Unit (EIU), for a full overview, methodology and breakdown of political regime classifications.

Photo by AMM Anisuzzaman / A Lamy

Advocacy and Norms Change

The first type of CSOs include those that place pressure on governments to enforce existing care policies or introduce new ones. Exerting pressure is effective where welfare states already exist, i.e., the government has already introduced and committed to providing social protection to its citizens but may not be delivering on this commitment.¹³⁰ One example of this is South Korea, where the government already has a fully developed welfare scheme that provides social protection to its citizens. In South Korea, very few organizations provide direct services, including childcare or eldercare services; but instead are largely advocacy-focused.¹³¹ For example, a group of women's associations, including the Korean Women Workers Association and the Korean Women's Development Institute, collaborated

to advocate for a strong parental leave policy. This ultimately led to the creation of South Korea's maternity protection scheme.¹³² This speaks to the power of women's and feminist networks to influence policy change.

Other CSOs actively engage in norms and behavior change as part of their programming. One example of this is The Gender Lab, which conducts workshops for adolescent girls and boys to help them question the predominant gender narratives around them, push boundaries, create community projects, and emerge as powerful change-makers. Reflecting on a recent workshop with boys around caregiving, The Gender Lab Co-Founder Akshat Singhal said: *"Within our context of our programs, boys' understanding of care is gendered and it still remains invisible for many of them... [they think] 'My father is managing a business, but my mother isn't doing anything.' And so, we need to start early with boys to build a community of peers. We need to build strong feminist, youth led and intergenerational movements for care justice."* Singhal explained that boys often associate care differently with respect to their mothers versus their fathers. For example, they associate their mothers with providing emotional care (and associate emotional care with care work) and their fathers with providing financial care. To shift these norms, The Gender Lab hopes to further engage with boys in childhood and at schools through ongoing trainings and build a community of peers who normalize boys and men doing care work and engage with fathers and educators to be enablers for boys to build these mindsets and life skills around care work.¹³³



Direct Care Provision

The second type of CSOs provide direct care services to citizens. These organizations often operate in environments where the state provision of care services is either scarce or absent altogether. One example of this is India, where a large youth population has led to innovative CSO programs in childcare. Not-for-profits such as Mumbai Mobile Creches operate free daycare centers for the children of construction workers who belong to low-income migrant communities.

Investing in CSOs with flexible funding to sustain their core operations and build their capacity and outreach is important to gain traction and make progress.

Another example is Indonesia, where the government became a democracy in 1998 after decades of dictatorship. The welfare state remains less developed (vis-à-vis South Korea or Japan) and many social protection services like childcare and eldercare are provided directly by families and households. Even where government-led social protection services do exist, they often do not reach the lowest strata of society or informally employed workers, who often lack the documentation that is needed to access such services. In response, a growing number of CSOs, including socio-religious institutions, research centers, business associations, and others, have begun to fill critical welfare gaps for underserved populations. For example, Migrant Care works to protect women

migrant workers from exploitation and discrimination by advocating for improved protection and services provided by the government. The Indonesia Street Children Organization (ISCO) runs daycare centers and educational programs for the children of domestic workers and informal sector workers who cannot access government-led social protection schemes.

Unfortunately, while the work of these organizations has centered on challenging and changing existing gender norms and mindsets, the Covid-19 pandemic has also contributed to a re-traditionalization of gender roles.¹³⁴ As the pandemic placed increased unpaid care demands on women, reducing female labor force participation rates, some of the progress achieved by organizations like ISCO and Migrant Care has been eroded. Investing in CSOs with flexible funding to sustain their core operations and build their capacity and outreach is important to gain traction and make progress. Lastly, as discussed earlier, a country's political regime can play a determining role in CSO activity. In Indonesia some argue that the country's relatively young democracy, combined with predominant religious values, have often preserved, reinforced and strengthened existing gender norms during times of crisis. As a result, CSOs have lacked the platform (and arguably even the freedom) to exert pressure on governments and therefore provide direct services that help meet existing gaps in the care ecosystem.^{135 136}

Worker Organizing and Collectives

Finally, the third type of CSOs mobilize and organize care workers to advocate for change. These include workers' unions, which intercede and push for better regulated working conditions as well as decent work and care policies. The Asia-Pacific region is home to two major regional trade union bodies, the International Trade Union Confederation (ITUC) - Asia Pacific and the World Federation of Trade Unions (WFTU) - Asia Pacific Region.¹³⁷ While most unions across the region push for improved labor conditions for workers, very few have applied a gender lens to issues, including the care economy, instead prioritizing minimum wages and conditions for workers, the majority of whom are generally male.¹³⁸ Moreover, their ability to advocate for women workers is constrained by their focus on the formal sector, whereas most female workers, including care workers, in the region belong to the informal economy, which comprises 68% of the

total employed workforce in Asia and the Pacific.^{139 140}

Some organizations do advocate for the rights of care workers in the informal sector. These include: (1) the Self-Employed Women's Association (SEWA) in India, which is the largest union of informal workers in the world; and (2) Women in Informal Employment: Globalizing and Organizing (WIEGO), a global research and policy network that advocates for improved conditions for workers in the informal economy, including care workers. In 1986, SEWA launched a child-care cooperative, Sangini, which provides full-time care to women informal workers in Ahmedabad, India (see the case study below for more details).¹⁴¹

CASE STUDY →



Care cooperatives that support childcare needs for informal sector workers

The **Self-Employed Women's Association (SEWA)** was founded in 1972 in Ahmedabad, India. Today, it represents more than 2.1 million women workers in the informal economy across 16 states in India. SEWA's workers include agricultural workers, home-based workers, street vendors, domestic workers, and waste-pickers. Because its members are not protected by government social protections, a central tenet of SEWA's work is to ensure livelihoods security and improve working conditions for all its members. To do this, SEWA encourages women to form cooperatives and trains them to advocate for improved social protections and rights from the government through collective bargaining and negotiation.

In the 1980s, a group of workers asked SEWA for additional childcare support, citing childcare responsibilities as a barrier to work. In response, SEWA launched the Sangini Child Care Workers' Cooperative in 1986, in Ahmedabad. Today, the cooperative—which includes childcare teachers, helpers, and children's parents—runs 11 childcare centers for 350-400 children aged 0 - 6 years of age. SEWA charges members a small fee of Rs. 300 (or approx. \$3.60 USD) to enroll their children each month, receiving an integrated approach to childcare including basic education and social skills, adequate nutrition,

and basic healthcare. In contrast with government-run childcare facilities which operate with erratic or abbreviated hours, the Sangini childcare centers are open daily from 9 a.m. to 5 p.m. In 2018, mothers reported they could work longer hours and received an increase in their monthly incomes, from Rs. 500 to Rs. 1000 (\$8 to \$17 USD).

The cooperative also recruits childcare workers directly from the community, offering women from low-income backgrounds critical employment and livelihood opportunities. Childcare providers receive training upon recruitment and can upgrade their skills every three months through refresher training and capacity building opportunities that build upon existing skills. This has enabled childcare workers to improve their status within communities and gain respect, as they are viewed as valuable resources for promoting children's social development and well-being.

The Sangini Childcare Cooperative and SEWA are part of a broader workers' movement that advocates for improved quality and access to childcare for workers in the informal economy.

Source: Cooperatives Meeting Informal Economy Workers' Child Care Needs (ILO and WIEGO), 2018.

A Summary of Key Insights

Razavi's care diamond model analyzes how care responsibilities are distributed across four different welfare sectors: (a) families and households; (b) civil society and not-for-profits; (c) the market and private sector; and finally (d) the government. This model underscores the unique role that each actor plays in contributing to care. It also validates a key finding that emerged during the literature review, which is that greater collaboration and coordination are needed for advancing care policy.

Further, analysis of each welfare state has also raised or reiterated additional insights and challenges that add further nuance and complexity to this issue. These include the following:



Care workers are not a monolith. Different types of care workers experience unique challenges and require targeted solutions based on whether they are paid vs. unpaid, or formally- vs. informally employed, considered “high-skilled” vs. “low-skilled”, nationals vs. migrants in the countries in which they reside, and other distinctions.



Coordination and cooperation between actors across local, national, regional, and global bodies is critical. This will promote knowledge-sharing and joint learning, particularly in terms of promising practices and models in care worth adapting across contexts.



Significant policy change, advocacy, and agenda-setting are needed at the national, regional, and global levels: These will build political will, identify contextually-relevant policies and programs, and enact durable reforms and sustainable financing mechanisms. Donors need to fund robust social dialogue around collective bargaining and the role of trade unions in shaping policies, programs, financial decisions and budgets around care.



Dominant cultural norms, social pressures, and demographic shifts complicate care provision in Asia and the Pacific. The pervasiveness of gendered familism and filial piety have led many governments to eschew their leadership role in shaping the care economy by focusing the burden of care on households and families, where most of the care work is carried out by unpaid women.



Poor governance and unclear coordination are common impediments to reform.

Governance, weak coordination, lack of political will, and a dearth of innovative financing models within governments and between governments and other actors remain critical bottlenecks to driving reform. This is further complicated by the fact that care responsibilities are spread across different agencies of the government, which often operate in siloes with little to no interaction.



Enforcement and compliance of existing policies remains a concern in many countries.

Even where promising policies do exist, they face compliance problems due to poor enforcement and accountability mechanisms.

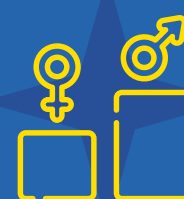


Rising care demands during Covid-19 have deepened already existing gender inequalities. Unless policymakers act now, these inequalities will continue to grow, further exacerbating gender, economic, health, and human rights outcomes in the future and eroding progress on the SDGs.



Most policies focus on legal reforms for formal paid workers, neglecting informal workers.

Legal and regulatory reforms include parental leave policies, flexible work arrangements, universal childcare laws, among others. While these policies are often universally accepted in theory by policymakers, very few apply to care workers in the informal workforce.



Paid care workers are undervalued and underpaid, consistent with other highly feminized sectors.

Despite being in high demand, paid care workers are paid persistently low wages and receive fewer employer benefits than other workers. Most are also women from structurally disadvantaged backgrounds who have little bargaining power due to lack of access to networks. Finally, there is a paucity of data on effective wage and compensation schemes for paid care workers, though scholars do agree that minimum wage standards and collective pay agreements are needed.

Recommendations for Governments



Governments have a central role to play in transforming the care economy by leading and coordinating care infrastructure that supports and maintains the rights of paid care workers and unpaid care providers and meets the needs of its populations. This is vital because care needs are persistently going unmet and, as discussed earlier, most care policies to-date have focused mainly on paid care workers, neglecting care workers in the informal sector and unpaid care providers completely.

In addition to designing and delivering effective care regulation, providing incentives for equity in care provision by CSOs and the private sector, governments must also commit to ensure that adequate resources are available to build a resilient care ecosystem. They must ensure that paid care workers receive decent remuneration and can work in safe and healthy environments. Governments must also promote greater redistribution of care work across genders, including by incentivizing more men to undertake care responsibilities. Finally, governments must ensure that significant populations are represented in care protections, including care workers in the informal sector and unpaid care providers.

Below are a set of thematic priorities and recommendations for

governments for supporting both paid and unpaid care providers. These priorities and recommendations are offered in recognition of the enormous complexity and diversity that exists within Asia and the Pacific and not as a one-size-fits-all solution. Countries vary considerably in terms of their wealth, economic development, capabilities, political will, and ability to introduce progressive care reforms. Moreover, their specific priorities will be shaped by the nature of the care-related challenges with which they are grappling. What does seem consistent, however, is that disability care is currently deprioritized across all countries irrespective of income levels. It is seen as problematic and a deficit investment by many governments and other actors given the critical importance of addressing disability needs as part of a care ecosystem.

It is hoped that by presenting these recommendations—disaggregated by income level—care policy can be elevated to the top of the policy agenda, foster greater discussion and dialogue amongst policymakers on advancing care policy going forward, and encourage more targeted policymaking.

These recommendations apply to countries across all income levels in Asia and the Pacific.

To improve coordination and collaboration on care policy:

Create a national internal taskforce or steering committee focused on care comprising individuals/agencies across the whole of government who are tasked with care policy. The taskforce should serve as a forum for policy makers and practitioners across government agencies to share common care challenges and best practices, discuss reflections and experiences, and co-design effective policy toolkits and solutions. This would include an investment in data to build the evidence base to inform policies and budgets for programs and services.

Create an external taskforce or steering committee focused on care comprising individuals/government agencies, as well as civil society, the private sector, international organizations, researchers, and others who work on care, to share common care challenges and best practices, discuss reflections and experiences, and co-design effective policy toolkits and other innovative resources and solutions. This external body can also be a sounding board for proposed government policies and initiatives.

Join the Global Alliance for Care, a global network launched by UN Women and the Government of Mexico in 2021, which includes governments, civil society actors, the private sector, and others, to promote joint-learning, innovation, and collective problem-solving on issues related to multilateral financing mechanisms and other care policy issues.¹⁴²

To transform patriarchal norms and redistribute care across genders:

Offer a wide range of socio-cultural gender mainstreaming initiatives, which could include school curricula and TV programs (as in Pakistan and the Philippines), and/or programs that change gender norms and incentivize men to engage in care work (as Promundo and Rutgers did in Indonesia and other countries and such as the Gender Lab model for schools in India).

To improve data collection for evidence-based decision-making:

Generate official statistics on paid and unpaid work to promote evidence-based, gender-responsive care policies and systems.¹⁴³ This would enable governments to fill existing gaps in data on care and better understand key metrics needed for designing effective, data-backed legislation. Please refer to the [sub-section on key data gaps](#) for a list of potential topics for data collection and prioritization.

To improve care provision and access through greater investments in care:

Expand and incorporate a care lens in social protections: Covid-19 has prompted a global focus on expanding or reevaluating the efficacy of existing social safety nets. The average regional investment is around 5% of GDP, which is less than half the global average of 11%. In Asia and the Pacific, however, most countries spend less than 2% on social protection. Therefore, governments should both expand their social safety nets and integrate care

into such processes.¹⁴⁴ The Economic and Social Commission for Asia and the Pacific (ESCAP) data demonstrate that even modest social protection packages (approximately 2-6% of GDP investments per country) would improve care outcomes for significant populations.¹⁴⁵ This is especially true for middle-income nations like Indonesia, the Maldives, the Philippines, and Sri Lanka, where data shows that such investments (like universal child benefits, cash transfers for unpaid women child providers) could lead to a 50% increase in purchasing power.¹⁴⁶

To improve the reputation of care work and care workers as being low-skilled and equip them with marketable skills to support future job prospects:

Provide upskilling opportunities to paid care workers and unpaid care providers, allowing them to gain marketable skills and seek safer, more lucrative employment opportunities that would update their standard of living.¹⁴⁷ This could include introducing upskilling programs directly or funding organizations which provide such services.

To promote the rights and agency of care workers and to feature their voices in policymaking:

Actively engage and create a space for unions and informal worker collectives to negotiate and advocate for improved care policy, and work with these groups to ensure that the needs of both formally- and informally-employed care workers are being met.

To promote long-term ROI on care through investments in related sectors:

Invest in quality care services in education and in health and social work. Multiple studies point to how investing in early childhood education and health and social work can yield significant short- and long-term returns on investment to the economy.¹⁴⁸ Early childhood education frees up mothers to participate in the labor force, in the absence of normative change.¹⁴⁹ In addition, stronger health systems and social work and upskilling investments improve life expectancies, as well as mental and physical health outcomes—reducing or delaying the need for eldercare in the future. This enables more care providers to work and extends one's ability to participate in the labor force for longer, both of which yield substantial economic benefits.

Recommendations for High-Income Countries

Many high-income countries in Asia and the Pacific, such as Japan, South Korea, and Singapore, are grappling with rapidly aging populations and low fertility rates, which have led to rising eldercare demands and a supply shortage of care providers. Therefore, thematic priorities for these countries should focus on the following: (a) financing and subsidizing care provision because care services, particularly in eldercare and disability care, are expensive,

long term care is complex and the demand for these services is growing; (b) professionalizing care work so that it is considered to be equivalent to other forms of paid professional occupations and employs all genders; and (c) ensuring that care policies are effectively enforced and comply with standards of high quality.

Below are examples of policy practices that could address these needs.

Financing and subsidizing care provision:

Create fiscal space to invest in care policies. This includes providing direct financing toward care investments and/or establishing more progressive, transparent, and redistributive tax structures to provide increased tax revenue. Closing large care gaps requires a progressive and sustainable annual investment of US\$4.4 trillion (or 4 percent of total annual GDP) by 2030 or annual investment of US\$5.4 trillion (4.2 percent of GDP before taxes) by 2035. Some of this could be offset by an increase in tax revenue from the additional earnings and employment.¹⁵⁰

Examples include taxing wealth more highly than consumption or work, or by setting up an environmental tax or other taxation on negative externalities, which could offer new sources of tax revenue to invest in the care sector. This could also include eliminating and substantially reducing labor taxation on care occupations, especially domestic work, and by offering tax reductions, subsidies, or incentives to employers to comply and offer positive care facilities and infrastructure to employees (Japan does the latter).

Create subsidies for the private sector to promote gender responsive technological innovation. This could include financing artificial intelligence companies and other firms to develop gender transformative blockchain technology (Vietnam), eldercare robots (Japan), telecare platforms,¹⁵¹ and other types of technological innovations for expanding care provision. However, it is important to ensure that such investments have a gender and social inclusion lens without which they risk increasing existing gender, wealth, and other inequities.

Institute universal long-term care insurance. Currently only Japan, Singapore, and a few countries in Europe with large aging populations offer long-term care services. Globally, most countries do not provide long-term social care protection. Given growing elder populations across east Asia and ongoing demographic shifts, combined with a paucity of services available for people with disabilities, this model is worth consideration.

Offer pension care credits to unpaid care providers. This would allow those who are unable to participate in the labor force due to existing care responsibilities with the opportunity to save for retirement. This is common in the United Kingdom, Chile, France, and Finland, where such credits have enabled unpaid care providers to escape poverty, especially in old age.

Offer portable care vouchers and cash transfers to families and households with care responsibilities. These vouchers could be used to fund specialized paid care support (valuable especially for those who are elderly or have a disability). Families should be given the option of choosing whether to use the vouchers and cash transfers for paid care or to support unpaid care providers (as an informal form of remuneration). This is a prominent element of the Australian health system,¹⁵² with similar models found in New Zealand, the UK, and Canada.

Contribute to the World Bank's Childcare Incentive Fund. Launched this year, the Fund will catalyze at least \$180 million in new funding in the next 5 years to support childcare, providing wide returns for families, businesses, and economies.¹⁵³ The Fund aims to match country investments in childcare on a \$1:\$1 basis (up to \$10 million per country) and will be used alongside funding from the World Bank, other development partners, private sector resources, and countries' own commitments.

Professionalizing care work

Create or facilitate the creation of more robust care infrastructure. For eldercare and disability care (which are what most high-income countries in the region are grappling with), this could include a hybrid range of care options for people who are elderly or who have a disability, ranging from quality homecare to institutional care.

Mandate higher remuneration and provide certification opportunities to paid care workers (through certified vocational trainings) to eliminate stigma around care work being “low-skilled,” and increase the recruitment of more male paid care workers and improve gender equality in the paid care sector. This is especially relevant for countries that have a large paid care workforce (like Singapore) which relies heavily on migrants from Southeast Asia to support childcare, disability care and eldercare needs.

Provide vocational training, retraining and skills upgrading for women on parental leave with children under three years old. This is a model that has grown in popularity across Europe. It can potentially raise fertility rates in East Asia, where long work hours, combined with the lack of childcare support, have disincentivized many women from having children.¹⁵⁴ The Government of France offers childcare services to jobseekers with family responsibilities seeking employment. In Austria, the government offers certified qualifications through partnerships with vocational schools and applied sciences universities that enable mothers to more easily enter traditionally male-dominated industries.

Enforcement of care regulations

Develop or leverage existing resources, such as monitoring tools, and/or allocate additional resources toward creating and/or strengthening existing compliance and accountability bodies that monitor the effectiveness of existing care policies and compliance rates, in order to improve the enforcement and compliance of care policies.

Recommendations for Low- to Middle-Income Countries

As discussed earlier, the delivery and provision of care within LMICs in the region is complex due to a dearth of available financial and non-financial resources, pervasive unequal gender norms, and the widespread presence of unregulated or informal care work.

First, many of these countries lack the financial resources, systems, and processes needed to provide progressive care reforms and infrastructure informed by quality data and a strong evidence base. Even where resources may exist, however, countries may not prioritize the care economy vis-a-vis other policy issues (either due to a lack of awareness of what the care economy entails or the belief that it lacks urgency). Second, while unequal gender norms are pervasive throughout the region, gender scholar Alice Evans argues that these norms are especially pronounced in LMICs.¹⁵⁵ This has led to particularly low female labor force participation rates (23.6% in South

Asia versus 59.04% in East Asia and Pacific)¹⁵⁶ and unequal distribution of care between genders. Third, even where paid care work does exist, it is often unregulated or informal. Many paid care workers are forced to operate in poor working conditions, for long hours, and with limited pay—which has led to poor quality of care being provided at times. This is particularly a concern for informally-employed care workers, who represent a sizeable share of the care workforce in South Asia, and who further lack access to social protections and have fewer avenues to advocate for their rights.

Accordingly, thematic priorities for these countries should focus on the following: (a) Leveraging and strengthening existing resources to improve care provision; (b) Transforming gender norms to redistribute the burden of care across genders; and (c) Professionalizing paid care work.

Leveraging and strengthening existing resources to improve care provision:

Ensure that basic care infrastructure exists, to reduce the inefficiencies related to unpaid care work. This includes developing and/or maintaining basic water and sanitation infrastructure, in consultation with local communities, investing in labor-saving devices they've identified as useful. This may include cookstoves and water pumps, and building accessible and affordable transportation to aid travel for both paid (formal and informal) and unpaid care providers.

Create and invest in community-based child/disability/eldercare programs. In many low-income countries (as well as some middle-income countries) where access to paid care is expensive or inaccessible due to restricted mobility, community-based interventions can be valuable. While such models are prevalent in the healthcare sector, the government should develop and/or finance the development of such models to support care provision. Potential interventions include creating a network of unpaid care providers within the community who take turns in providing childcare or offering tablets to facilitate children's remote learning needs.

Professionalizing care work:

Actively engage and create a space for unions and informal worker collectives

to negotiate and advocate for improved care policy, and work with these groups to ensure that the needs of care workers across both the formal and informal sectors are being met.

Provide public works programs to improve the participation of time poor unpaid care providers in labor markets.

As many LMICs do not offer unemployment insurance schemes and opportunities to participate in the labor market are slim for subsets of the population (low-income rural women, for instance), governments can offer temporary employment through public works programs.

Gender transformative campaigns:

Include both care workers and unpaid care providers, including men, in ad campaigns that highlight care work. In India and other countries, several filmmakers have featured the voices of informal workers and other marginalized populations in documentaries and advertising campaigns. By featuring the voices of diverse care workers—both paid and unpaid—governments can conduct awareness-raising amongst the public and dispel widely-held beliefs around care work being an exclusively female responsibility.



Recommendations for Other Actors

While the recommendations mentioned in the previous section are geared towards governments, policymakers need not embark on action measures alone. As Razavi's model highlights, the private sector, civil society, and households and families can and should play valuable roles in contributing to the care economy, particularly alongside international organizations, and bilateral and multilateral development agencies.

One recommendation for all actors is to **join the Global Alliance for Care**. To promote joint-learning, knowledge sharing, and collaborative action on issues related to the care economy. The GAC is one avenue in which actors outside of the government can play a critical role in driving change.¹⁵⁷ However, various other roles exist for specific types of actors, which have been outlined below.

Recommendations for International Organizations, Bilateral and Multilateral Agencies

Regional and international bodies like the Association of Southeast Asian Nations (ASEAN) and the Asia-Pacific Economic Cooperation (APEC), as well as multilateral institutions, regional organizations, bilateral development agencies, and other diplomatic actors can influence norm-setting for countries around more equitable care re-distribution between genders. These institutions have the resources, influence, and broader leverage to elevate care on the global agenda, set clear expectations for countries on the need for more equitable care re-distribution between genders, and further invest in care through significant financial and resource investments. They can further invest in more robust care data collection and research, to address critical gaps in data around the care economy.

Recommendations for Civil Society Organizations

Civil society organizations can continue to strengthen and build their capacity to mobilize workers' associations and care groups, including strengthening their ability to network, skillfully negotiate and collectively bargain for better care worker rights, as the example of SEWA illustrates. They can also foster social norm change around redistributing care from women to men by conducting advocacy campaigns and different behavior change interventions. As the example of The Gender Lab highlights, it is imperative that organizations engage men and boys as early on as possible in their programming, in order to shift traditional and patriarchal mindsets around caregiving and to engage girls and young women to challenge these assumptions. In addition, they can conduct more research on investing in care and the economic spillovers and multipliers it secures, including the costs of investing in care and their anticipated economic and social impacts.¹⁵⁸

Recommendations for the Private Sector

Private sector organizations can play complementary and leveraging roles. For example, companies can introduce and implement policies that offer care services and support to all employees who have care responsibilities. This could be through better care infrastructure (like in-house daycare facilities) and better care policies (like flexible work arrangements and parental leave policies). Like The Gender Lab, the private sector can also engage men and boys to shift norms on caregiving, particularly to promote care distribution to men within the workplace. One recommendation is for companies to appoint male workplace champions/ambassadors of care who both acknowledge the critical role of care work and provide care work within their households—these individuals can serve as examples to other male colleagues. Companies should also create environments and cultures that incentivize men to take paternity leave without fear of stigma and discrimination, and that highlight the benefits of men building early relationships with their children and expanding their sense of identity.

The private sector can further develop unique technological innovations to expand care access and improve conditions for care workers. Examples include Vietnam's blockchain case, Japan's robot strategy, mobile app-based platforms like Indonesia's LoveCare and Malaysia's Kiddocare, and China's cloud-based home care service platform for seniors, which connects seniors virtually to care workers and facilitates easier home care provision to the elderly and persons with a disability.¹⁵⁹

Investors and donors, such as philanthropic foundations and high net worth individuals, can play a vital role in financing inclusive and equitable care models. For example, they can support capacity building initiatives that strengthen the capacity of workers' unions and cooperatives to negotiate and bargain for better social protections. They can also work with governments to finance resource-heavy, but high value-add technological innovations. In addition, they can fund programs that have traditionally been neglected but need to be further explored, such as research exploring the intersectionality of care. Relatedly, investors and funders can also explore and support the expansion of childcare facilities to meet eldercare and disability care needs as well—for which fewer facilities exist.

Finally, wherever possible, it is important for all non-state actors to actively engage and work with governments, including attending and regularly participating in government-led care task forces, and reporting back key reflections and action points to their respective organizations.



The Way Forward

Building a resilient care ecosystem will require significant commitment and collaboration from all stakeholders. This report has highlighted promising practices, lessons learned, and pathways for action, with the supporting research identifying several gaps that warrant further discussion and exploration.

First, data paucity and/or insufficient policy attention are key gaps across various dimensions of care economy challenges, constraints, and potential policy and other responses. More research and data are needed, particularly as they relate to Asia and the Pacific, on topics such as disability care or caregiving specific to the Pacific Islands context. Research should also go beyond traditional data collection and include qualitative practices (such as listening sessions and participatory research with communities, which captures voices from care workers and those being

cared for—as powerful vehicles for informing and driving policy change. To date, very little qualitative and participatory research on care has been conducted.

Second, data and dialogue on the intersection of care with other sectors is scarce, with more insights needed on causal relationships. For example, while data suggests that GBV against care workers affects the quality of care provided, it is unclear whether care work has an impact on the prevalence of GBV. Similarly, while data suggests that climate change and the care economy are interconnected issues, the specific nature of their relationship is unclear. Additional questions include: Would positioning care work as a “green economy” job lead to more prioritization and investment in the care economy? How do transportation systems and public spaces affect the delivery, accessibility, and feasibility of care work? Conversely, how does

care work impact what is needed of transportation infrastructure? Also, how is care sustained during times of climate-induced disaster and when supply chains are also affected? Finally, more clarity is needed on the following issues: (a) mechanisms and platforms for governments and organizations to engage care workers and those being cared for to develop provider-centered policy interventions; (b) the role of different actors within the care ecosystem (e.g., the private sector) in responding to care; (c) how to guarantee social protections for informal care workers beyond formalization, where the introduction of legal or regulatory provisions alone may be insufficient; (d) the impact of the care economy on care providers in the Pacific Islands—a region for which insights and data are, again, severely limited.

Despite the gaps laid out in this report, The Asia Foundation's research and the November 2022 Bali Care Economy Dialogue in Indonesia affirm that there is a growing commitment in Asia and the Pacific to promote decent work for all care providers. There are many opportunities for significant investment, including more robust care infrastructure, public policy, and technological innovation.

To promote the levels of investment in care that are needed to transform the care ecosystem, significant organizing, advocacy, and collaboration are needed, particularly to elevate care policy to the top of government

agendas across the region. Dialogue participants were unequivocally clear that there is an urgent need for action and commitments on care. A key priority going forward should be to collectively mount and drive a strong advocacy and communications agenda that engages key policymakers on care. This is especially crucial for the upcoming G20, which will be led by India, which—as the paper highlights—is a country with significant opportunity and potential to transform the care ecosystem, particularly as it relates to regulating care in the informal sector.

For governments to prioritize care policy and for care to become a focal point of discussion in future world fora, such as the G20, G7, ASEAN and APEC, robust data, innovative pilot interventions and demonstration projects, significant financial investments, and collective action are urgently needed.

It is hoped that this report can help provide a focal point for collective action, starting with greater dialogue on care in the region and sharing promising models and practices that can be adapted across contexts and care types. By working together with care providers and recipients, government, private sector, and civil society, policymakers and practitioners can build a well-resourced and resilient care ecosystem in Asia and the Pacific. In this way, we can ensure decent work and dignity of care for all who need it.

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