EVALUATION OF THE *TRANSFORMATIVE APPROACHES FOR RECOGNIZING, REDUCING AND REDISTRIBUTING UNPAID CARE WORK IN WOMEN'S ECONOMIC EMPOWERMENT PROGRAMMING* IN RWANDA AND SENEGAL

UN WOMEN

FOR ALL WOMEN AND GIRLS

Produced by UN Women Independent Evaluation, Audit and Investigation Services (IEAIS), June 2026.

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UN Women Independent Evaluation,
Audit and Investigation Services
Independent Evaluation Service
June 2026

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We extend our thanks to Inga Kaplan, Chief of the Independent Evaluation Service; Lisa Sutton, Director of the Independent Evaluation, Audit and Investigation Services; and our peer reviewer, Ross Tanner, Evaluation Specialist.

EVALUATION TEAM:

Kay Lau, Regional Evaluation Specialist and Team Lead

Asna Fall, Senegal Evaluator

Innocent Iyakaremye, Rwanda Evaluator

Heba Hesham, Care Expert

Juliet Mwaura, Evaluation Analyst

EVALUATION MANAGEMENT:

UN Women Independent Evaluation, Audit and Investigation Services (IEAIS)

Inga Kaplan, Chief, UN Women Independent Evaluation Service (IES)

Lisa Sutton, Director, UN Women Independent Evaluation, Audit and Investigation Services (IEAIS)

Copy-editing: **Catherine Simes**

Design and layout: **Yamrote A. Haileselassie**

Cover Photo: UN Women

ACRONYMS

3R	Recognize, Reduce and Redistribute
5R+	Recognize, Reduce, Redistribute, Reward and Represent, and the resourcing of resilient
CSO	Civil Society Organization
CSW	Commission on the Status of Women
ECD	Early Childhood Development
ECOWAS	Economic Community of West African States
GDP	Gross Domestic Product
IEAIS	Independent Evaluation, Audit and Investigation Services
IES	Independent Evaluation Service
ILO	International Labour Organization
OECD-DAC	Organisation for Economic Co-operation and Development Assistance Committee
OHCHR	Office of the United Nations High Commissioner for Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women

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EXECUTIVE SUMMARY

PURPOSE AND OBJECTIVES

The UN Women Independent Evaluation Service (IES) conducted an evaluation of the "Transformative Approaches to Recognize, Reduce and Redistribute Unpaid Care work in Women's Economic Empowerment Programming in Rwanda and Senegal" (3R) Programme. The evaluation's purpose was to (a) provide accountability for delivery of the programme to development partners, government stakeholders, rights holders, and other partners; and (b) generate learning on what has and has not worked, and pathways to scaling to inform implementation of UN Women's future programming in this area.

THE EVALUATION OBJECTIVES WERE TO:

Assess the **coherence** of the programme's global, regional, and country-level components, and synergies with other UN Women programming.

Verify progress towards the three target outcomes**,** identify **lessons learned** and promising innovations, and assess the programme's **effectiveness**.

Examine the **efficiency** of the programme, in terms of the delivery model and leveraging of other UN Women initiatives and resources.

Identify factors and pathways to **sustainability and scalability**, including adaptations required.

INTENDED USERS

The primary users of this evaluation are expected to be UN Women Global, Regional and Country Offices delivering the TransformCare programme (the successor to all UN Women care programming), who will use the evaluation findings to inform the direction of future work. Secondary users are expected to be UN agencies, partners, government, civil society representatives and donors delivering similar interventions in-country, to derive learning on effective and promising practices.

THE 3R PROGRAMME

The 3R Programme in Rwanda and Senegal is a key initiative within UN Women's emerging programming on transforming care systems. Phase 2 of the programme was funded by the Government of Germany, Federal Ministry for Economic Cooperation and Development (EUR 2.9 million) and ran from March 2023 until April 2026. It aimed to translate UN Women's Strategic Plan commitments on unpaid care work into practical policy, service, infrastructure, and financing pathways, while contributing to the broader 5R framework[1] by improving evidence, strengthening services and social protection, and advancing policy and investment commitments on care.

METHOD

The evaluation employed a theory-based, gender-responsive approach. Evaluation questions were developed using the theory of change and assessed against Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) criteria. Contribution analysis was used to assess UN Women's contribution, supported by document review, interviews, focus group discussions, surveys, and field visits. The team reviewed 108 documents and consulted 253 stakeholders through interviews, focus group discussions and surveys. The evaluation was conducted in line with the UN Women Evaluation Policy and Evaluation Handbook. All deliverables were subject to quality assurance by IES management and peer review.

[1] It consists of Recognize, Reduce, Redistribute unpaid care work, and Reward and Represent paid care workers,

KEY FINDINGS

EFFECTIVENESS AND GENDER EQUALITY

To what extent has the programme achieved progress towards the three target outcomes?

The evaluation found strong evidence that the programme increased understanding and capacity among government and local actors to address the undervaluing and gendered division of unpaid care work, and moderate evidence that this translated into strengthened laws, policies, planning processes and services. Verified results were strongest in local planning and budgeting uptake in Senegal and in local and national policy and legal uptake in Rwanda, reflecting strengthened recognition of the value of unpaid care work. Unpaid care work has been reduced through the introduction of energy- and labour- saving technologies in Rwanda and Senegal, and unpaid care work responsibilities been reduced through the programme's support to early childhood development centres and health insurance. There was also moderate evidence of shifts in awareness and recognition of unpaid care work, through norms programming.

The programme also made an important contribution to positioning care as a public good and investment issue able to deliver immediate and long-term dividends for gender equality, economic transformation, social justice, and environmental sustainability; as well as strengthening UN Women and wider UN capacity to support governments on care financing and policy reform. Its contribution was strongest in agenda-setting, training, tools, and technical support, helping advance global commitments, regional traction and some national and subnational planning and budget responses (although translation into sustained public investment depended on wider fiscal and political conditions and on country-level ownership).

To what extent were gender equality principles effectively integrated in the programme?

The programme was gender-transformative in design and sought to address structural constraints on women's time, agency, and full participation in the labour market. There was evidence of changes in attitudes and practices around care roles; improved access to services and resources; and stronger reach to vulnerable populations, including rural women and persons with disabilities. However, more systematic targeting and disaggregated monitoring would have strengthened evidence on how consistently these principles were operationalized across all components.

EFFICIENCY AND COHERENCE

To what extent did the global, regional, and country components work together coherently to deliver results?

The programme showed strong coherence across its global, regional, and country components. Phase 2's multilevel architecture allowed global normative work, tools and curriculum, regional technical support and convening, and country implementation to reinforce one another. The strengthened regional technical support model was widely valued for contextualizing global tools, sustaining follow-up, and supporting multi-country uptake.

To what extent did the programme efficiently leverage UN Women's initiatives, personnel, core resources and regional technical support model to deliver quality and timely results?

The programme efficiently leveraged broader UN Women personnel, platforms, and complementary funding. This allowed the programme to extend its reach beyond grant-funded activities and to draw on wider technical capacity across global, regional, and country levels. The regional technical support model was an important part of this efficient approach, providing continuity, contextualized support and follow-up that would have been difficult to sustain through country-level implementation alone.

SCALABILITY AND SUSTAINABILITY

To what extent are core 3R components likely to be sustained beyond the programme, and how can UN Women best use them to shape TransformCare and future programming?

Sustainability prospects were strongest where interventions were embedded in public systems, local planning processes, policy frameworks or institutional processes, such as policy and legal reforms, local planning uptake, and training materials and guidance that can continue to be used after the programme. They were weaker where continuation still depended on project funding, or where financing, ownership, delivery, or maintenance arrangements were not yet fully in place. For future programming, the strongest 3R assets for TransformCare are its multilevel delivery model, training curriculum, policy and financing tools, and country experiences that show how care is linked to public systems, planning and wider scale-up pathways.

CONCLUSIONS

CONCLUSION 1

The programme was efficient and broadly coherent in using resources catalytically to generate influence beyond its direct footprint. However, this model also meant that results depended not only on what the programme delivered directly, but on whether other actors took up and sustained what it had helped to put in place.

CONCLUSION 2

The programme was effective in building enabling conditions for stronger care systems and in generating tangible benefits for women. Fuller conversion of these gains into deeper and more sustained change at scale depends on wider political commitment, fiscal space, institutional ownership, and follow-through beyond the programme.

CONCLUSION 3

The programme was gender-transformative in design and generated tangible benefits for women, but transformational depth was uneven across the portfolio. Evidence was stronger on reduction and recognition of unpaid care than on sustained redistribution across the care diamond, on systematic inclusion across all groups facing compounded disadvantage, and on a more developed paid care and labour-rights agenda.

CONCLUSION 4

The programme's sustainability prospects are mixed. Sustainability prospects were strongest where interventions had an institutional home, financing pathway and clear ownership arrangements; they were weaker where continuation still depended on programme support or unresolved operating models.

CONCLUSION 5

The main strategic value of 3R for TransformCare lies in showing which assets and pathways are ready for institutionalization and scale, which would benefit from further refinement, and which offer promising areas for continued exploration - not in replicating the portfolio wholesale, but in guiding more focused and effective next steps.

RECOMMENDATIONS

The following strategic recommendations were validated with the Care Global and Regional Teams. They are framed to inform the ongoing work on TransformCare. As a systemic initiative operating across global, regional, and country levels, implementation will be led by UN Women's Policy Adviser, Macroeconomics and Global Lead on Care, with the support of the Global and Regional Care team and the Data, Monitoring, and Reporting Specialist.

RECOMMENDATION 1

Continue strengthening tracking of contributions from Global, Regional and Country Offices to target outcomes, as well as the uptake of knowledge products and time-use changes resulting from piloted interventions.

RECOMMENDATION 2

More deliberately plan for sustainability, institutionalization and supporting others to scale.

RECOMMENDATION 3

Institutionalize and further build on the strong approach to integrated programming (between global, regional and national efforts) within TransformCare.

RECOMMENDATION 4

As TransformCare scales as UN Women's core vehicle for care, the Entity must establish clear operational boundaries within the wider UN system. UN Women must deliberately map where it should lead, partner, or play a supporting role to better-placed agencies. Concurrently, internal links to related UN Women programming must be consolidated to ensure a coherent,

1. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

PURPOSE AND OBJECTIVES

The purpose of this evaluation was to:

1. provide accountability for delivery of the 3R Programme[2] in Rwanda and Senegal to development partners, government stakeholders, rights holders and other partners; and
2. generate learning on what has and has not worked, and pathways to scaling, to inform implementation of UN Women's future programming in this area, namely through the TransformCare programme.

THE EVALUATION OBJECTIVES WERE TO:

Assess the **coherence** of the programme's global, regional, and country-level components, and synergies with other UN Women programming.

Verify progress towards the three target outcomes, identify **lessons learned** and promising innovations, and assess the programme's **effectiveness**.

Examine the **efficiency** of the programme, in terms of the delivery model and leveraging of other UN Women initiatives and resources.

Identify factors and pathways to **sustainability and scalability**, including adaptations required.

USE

The intended use of this evaluation is to demonstrate accountability for UN Women's contribution to gender equality and women's empowerment; and support learning and identify effective and promising strategies to inform future programming in this area. UN Women is accountable to national partners, rights holders and development partners for its developmental effectiveness.

The primary users of the evaluation are expected to be UN Women Global, Regional and Country Offices delivering the TransformCare programme, who will use the evaluation findings to inform the direction of future work. Secondary users are UN agencies, partners, government, civil society representatives and donors delivering similar interventions in-country to derive learning on effective and promising practices.

SCOPE

The evaluation scope was guided by the 3R Programme document, covering country-level components (Outcomes 1 and 2) and the global component (Outcome 3).

While focused on the 3R Programme, the evaluation also explores synergies with broader UN Women care systems work funded through other sources across the East and Southern Africa Region, the West and Central Africa Region, and globally.

The programme ran from March 2023 to March 2026. Data collection was undertaken in January–February 2026, covering progress delivered to date. The evaluation sampled programme implementation locations in Rwanda and Senegal (Outcome 1 and 2) and regional and global stakeholders (Outcome 3).

[2] Within UN Women, individual interventions are referred to as a 'project'. However, as the official abbreviated title is "The 3R Programme', the evaluation also refers to it as a programme.

2. CONTEXT

DEFINITIONS FROM THE UN SYSTEM POLICY PAPER

The 2024 UN System Policy Paper on Transforming Care systems defines care as sustaining all forms of life and as central to the well-being of people and the planet. It describes care as a species activity that includes everything we do to maintain, continue and repair our world. It defines care systems as encompassing legal and policy frameworks, services, financing, social and physical infrastructure, programmes, standards and training, governance and administration, and social norms. It also defines care work as including both direct care for people and indirect care, such as household tasks, including collecting water and firewood, travelling and transport.[3]

BROADER UN WOMEN CARE SYSTEMS CONTEXT

UN Women has developed a wider body of work on care systems across its triple mandate, combining global normative and policy leadership, UN coordination and country-level research, advisory and programme support. UN Women now frames this work increasingly through a care systems approach that connects services and infrastructure with labour, social protection, macroeconomic policy and financing, among others. The 3R Programme sits within this broader institutional agenda as an early flagship effort to translate that approach into country-level policy, financing and programmatic action in Rwanda and Senegal.[4] In turn, it has also provided important learning to the wider policy framework, drawing on insights from Phase I and the early implementation of Phase II of the 3R Programme.

GENDER EQUALITY AND HUMAN RIGHTS CONTEXT

Unpaid and paid care work are central to gender equality because women undertake most unpaid care work and are overrepresented in paid care work that is often undervalued and poorly protected. Restrictive social norms and gender stereotypes continue to position women as primary caregivers and men as primary income earners. This constrains women and girls' time and opportunities for education, decent paid work, public life, rest and leisure. Care is also a human rights issue because inadequate, unequal or poor-quality care arrangements affect both those who provide care and those who need care and support. Recent UN system framing places stronger emphasis on state accountability, universality, transformation and leaving no one behind in the design of care systems.[5]

ECONOMIC AND DEMOGRAPHIC CONTEXT

Care work is essential to societies and economies, but remains undervalued in economic and policy systems. Limited access to affordable childcare, water, energy, transport, health and social protection can translate directly into higher time poverty for women and girls, especially in lower-resource and rural settings, limiting their ability to participate in the labour market. Demographic pressures, including large child populations and rising care needs, increase pressure on households to absorb care needs privately where public services and infrastructure remain weak. These factors are directly relevant to Rwanda and Senegal, where agriculture remains important, informality is widespread and care needs are closely shaped by service and infrastructure gaps.[6]

[3] United Nations (2024), Transforming care systems in the context of the Sustainable Development Goals and Our Common Agenda: UN System Policy Paper.

[4] United Nations (2024), Transforming care systems in the context of the Sustainable Development Goals and Our Common Agenda: UN System Policy Paper.

[5] United Nations (2024), Transforming care systems; ILO (2018), Care Work and Care Jobs for the Future of Decent Work; World Bank (2023), Breadwinners and Caregivers.

[6] ILO (2018), Care Work and Care Jobs for the Future of Decent Work; UN DESA (2024), World Population Prospects 2024; United Nations (2024), Transforming care systems.

POLITICAL AND INSTITUTIONAL CONTEXT

Recent UN system and UN Women framing treats care as a public policy and financing issue, not only a household matter. This is directly relevant to the evaluation because the programme operated in settings where policy attention to care had grown but institutional arrangements remained partial, especially regarding childcare, labour protections, family-friendly employment measures, parental leave, long-term care and integration of care into planning and budgeting.[7]

SOCIAL ROLES, ATTITUDES AND RELATIONS

In both countries, social norms continue to allocate primary responsibility for childcare, domestic work, water and fuel collection, and care of sick or dependent family members to women and girls. Care is often treated as a private or family obligation rather than a public good and shared responsibility. These roles and attitudes help explain why legal and policy advances do not automatically translate into more equal care arrangements in practice, and why sustained progress usually depends on combined action on norms, services, infrastructure and public policy.[8]

Photo: UN Women

RWANDA

Economic and demographic factors

In Rwanda, unpaid care and domestic work has significant macroeconomic relevance, with estimates placing its value at 10–39 per cent of GDP. Women are overrepresented in lower-productivity agricultural and informal work; face higher unemployment than men; and have lower employment-to-population ratios. The 2024 Labour Force Survey shows that women undertake substantially more unpaid care work per week than men. Rwanda's young and predominantly rural population, with many households dependent on agriculture, makes care systems, basic infrastructure and labour-saving services especially important for women's economic participation and for inter-generational poverty reduction.[9]

Political and institutional factors

Rwanda has expanded care-relevant policy and legal frameworks, including a National Early Childhood Development Policy and standards for centre-based and community-based services, as well as reforms strengthening women's rights to marital property, land and inheritance through the Family Law. At the same time, most women work in informal and smallholder settings where labour protections, childcare benefits and family-friendly workplace measures remain limited in practice. Evidence also points to incomplete adoption of international labour standards relevant to maternity protection and workers with family responsibilities.[10]

Gender equality, social roles and relations

Despite progress in formal gender equality frameworks, many women still face everyday constraints in combining unpaid care responsibilities with decent paid work. National gender assessments indicate that women's leadership and economic opportunities continue to be shaped by expectations around domestic and care responsibilities; limited support from men within the household; and persistent gender stereotypes. In practice, unpaid care remains a direct constraint on women's time and economic opportunities.[11]

[7] United Nations (2024), Transforming care systems; UN Women (2022), A Toolkit on Paid and Unpaid Care Work: From 3Rs to 5Rs.

[8] World Bank (2023), Breadwinners and Caregivers; Uganda Bureau of Statistics (2019), Time Use Survey 2017/2018 Report.

[9] Kamashazi (2023), Assessment of gaps in laws and policies related to unpaid care work in Rwanda; NISR (2024), Labour Force Survey 2024; FAO, Rwanda at a glance.

[10] MIGEPROF (2016), Early Childhood Development Policy; Ministry of Justice Rwanda (2024), Law No. 027/2024; Rwanda Civil Society Platform (2023), Policy brief on gender-responsive workplaces.

[11] Rwanda Civil Society Platform (2023), The state of gender equality in Rwanda.

SENEGAL

Economic and demographic factors

In Senegal, unpaid care and domestic work also represents a major economic contribution, estimated at 23.6 per cent of GDP. Time-use data show very wide gender gaps: women undertake far more housework and childcare than men, with particularly large disparities in rural areas. A 2023 survey of women farmers in northern Senegal found high unpaid work demands, including domestic work, caregiving and community responsibilities, and many respondents were also caring for a family member with a disability or chronic illness. A young population, high fertility and a high dependency ratio create strong and growing demand for childcare and household support. Climate shocks further intensify care-related vulnerabilities, especially in female-headed households.[12]

Political and institutional factors

Senegal has begun to address care within broader social and economic policy. Relevant measures include the national development vision; expanded health and social spending; a 2024 decree on childcare structures for children aged 0–3; and provisions on maternity leave. However, the institutional framework remains partial: there is still no statutory parental leave, limited ratification of key ILO care-related conventions; and limited access to affordable childcare, especially for younger children. Additionally, while initiatives for the care of older people do exist, they remain fragmented and weakly institutionalized.[13]

Gender equality, social roles and relations

Social expectations continue to assign responsibility for childcare, water and fuel collection, and household production primarily to women, while girls are socialized early into care roles. These norms contribute to high levels of women's time poverty and constrain their ability to engage in paid work. Labour-market participation is highly gendered, with lower participation and higher unemployment among women and a strong concentration of women in informal and low-paid work. In this context, economic growth alone is unlikely to reduce gender inequalities in care without deliberate investment in services, infrastructure and supportive public policy.[14]

Further detail is set out in Annex 10.

Photo: UN Women

[12] APHRC (2024), Structure of the Unpaid and Paid Care Sector in Senegal's Economy; UN Women (2023), Innovative solutions to recognize, reduce and redistribute the unpaid care work of rural women in Senegal; UN Women (2024), Care snapshot: Senegal.

[13] UN Women (2024), Care snapshot: Senegal.

[14] ANSD (2024), Enquete nationale sur l'emploi au Senegal, 4e trimestre 2023; Diallo et al. (2024), Addressing context-specific barriers to female labor market participation in decent work in Senegal; UN Women (2024), Care snapshot: Senegal.

3. PROGRAMME DESCRIPTION

PROGRAMME OVERVIEW

UN Women's Transformative Approaches to Recognize, Reduce and Redistribute Unpaid Care work in Women's Economic Empowerment Programming (3R Programme) Phase 2, operates in Rwanda and Senegal with a reinforcing global component.

The programme builds on Phase 1 of the 3R Programme, funded by the Government of Canada and implemented between April 2021 and April 2023.

Phase 2 of the 3R Programme was funded by the Government of Germany through the Federal Ministry for Economic Cooperation and Development, with a total budget of EUR 2.9 million, and is being implemented from March 2023 to March 2026. As of December 2024, EUR 1.16 million had been spent. The programme also serves as a precursor to the UN Women Transforming the Care Systems Gender Equality Accelerator launched in 2024.

The programme aimed to address structural barriers arising from the unequal distribution of unpaid care and domestic work by recognizing, reducing and redistributing care responsibilities more equitably. Its goal is to contribute to the transformation of care systems and to strengthen public-sector investment in care policies and infrastructure, thereby expanding women's access to decent work, labourmarket opportunities and economic security.

THEORY OF CHANGE

The programme's theory of change is:

1. **If** national and local laws, policies and services recognize and address the disproportionate share of unpaid care work by women and girls through the provision of public services, infrastructure and social protection (Outcome 1);
2. **And if**, transformative care services in rural and urban areas reduce and redistribute unpaid care work (Outcome 2);
3. **And if** national governments and relevant ministries (e.g. sectoral and finance) scale up investments in care service provision (Outcome 3);
4. **Then** women and girls' unpaid care work is reduced, freeing up their time to equally contribute to and benefit from sustainable livelihoods because structural gender inequalities that prevent women and girls from realizing their economic rights and empowerment will be removed.

The programme had a no-cost extension of three months, extending the programme end date from December 2025 to March 2026 to allow completion of planned activities and consolidation of results across country, regional and global components. At the time of the evaluation report, the programme was in its final phase and nearing completion, with activities across all outcomes reported as largely delivered as planned. This change to the time frame had limited implications for the evaluation, as the scope already covered implementation up to December 2025.

RESULTS FRAMEWORK AND RESULTS DATA

Table 1 sets out the programme's target outcomes and outputs. Annex 3 sets out the full results frameworks, including the outcome indicators. Outcomes 1 and 2 are delivered in Rwanda and Senegal, and Outcome 3 is delivered at the global level. The programme delivers a holistic package of activities, combining policy support and technical advisory, with service delivery support and community engagement.

Annex 3 sets out more detailed activities against each outcome, with a summary of the main results from the Annual Reports. Data from these systems were validated during the evaluation.

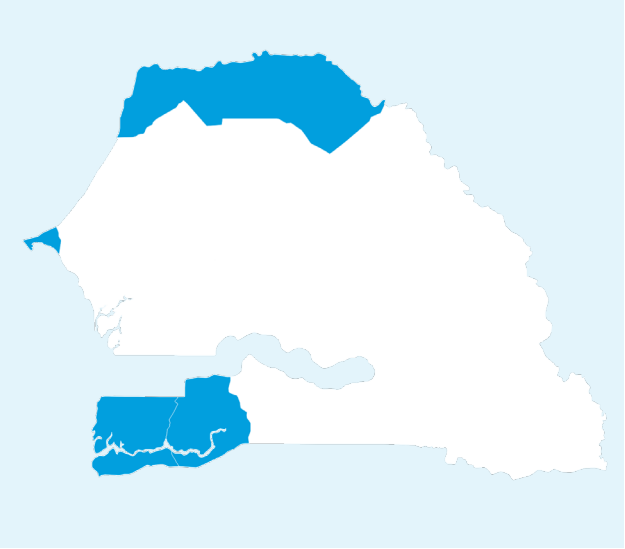
The programme is being implemented in:

- **Senegal**: Dakar and the Saint-Louis, Ziguinchor and Sédhiou regions.
- **Rwanda:** Musanze, Gasabo and Gisagara Districts, with some work also in the Nyamasheke, Nyaruguru, Ngoma and Kirehe districts, where Phase 1 was delivered.
- **Globally**: Global implementation includes normative support, development of global policy tools and methodologies, knowledge management and support of knowledge exchange, both internally within UN Women and externally, based on the learning from country implementation in Rwanda and Senegal, including training courses funded by the programme delivered in Kathmandu, Nepal and Nairobi, Kenya. Additionally, the global component ensured overall coordination of the programme.

TABLE 1.
3R Programme's target outcomes and outputs

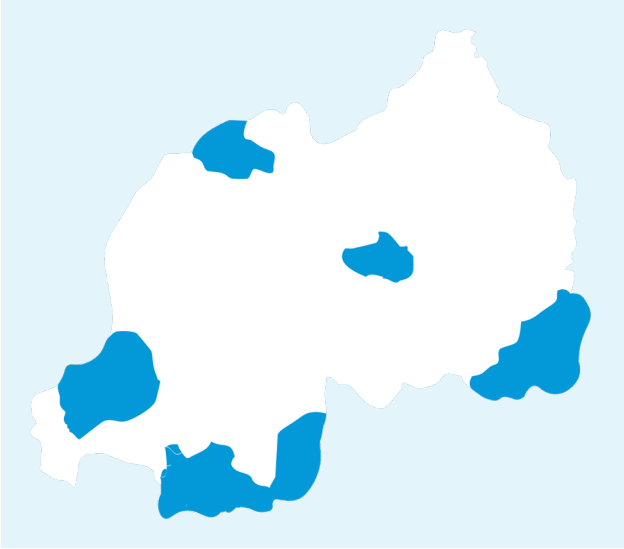
OUTCOME 1: National and local governments develop/strengthen laws, policies and services that recognize and address the disproportionate share of unpaid care work performed by women and girls	OUTCOME 2: Women's cooperatives and other organizations provide care services in rural and/or urban areas to reduce and redistribute unpaid care work	OUTCOME 3: National governments and relevant ministries (ex: sectoral and finance) scale up investments in care service provision.
The programme worked with national and local institutions to strengthen recognition of unpaid care in policy and planning. Activities included policy dialogue; technical support to laws, strategies and reform processes; training on gender-responsive planning and budgeting; and support to integrate care considerations into local development and planning instruments.	The programme supported practical interventions to expand access to care-related services, support redistribution of care responsibilities and reduce the time required for domestic work. Activities included support to community childcare and early childhood services; engagement with health insurance and other social protection actors; social norms initiatives including community dialogues; and piloting of labour and energy-saving technologies and related infrastructure.	The programme aimed to strengthen the enabling environment for greater public investment in care, globally and regionally. Activities included normative support; development of training and policy tools on care systems and care financing; technical support and capacity-building for UN Women and national stakeholders; peer learning and knowledge-sharing; and linking country-level experience to wider regional and global policy discussions on care policy and financing.
		

FIGURE 1
Senegal programme locations



Source: Prepared by the evaluation team.
The boundaries shown and the designations used on the map do not imply official endorsement or acceptance by UN Women.

FIGURE 2
Rwanda programme locations



Source: Prepared by the evaluation team.
The boundaries shown and the designations used on the map do not imply official endorsement or acceptance by UN Women.

Stakeholders

The 3R Programme is being managed by the following UN Women personnel:

- **Rwanda:** a national programme coordinator and programme associate in Rwanda, with the support of a communications analyst.
- **Senegal:** a national coordinator and 50 per cent of a programme analyst.
- **Regionally:** the programme is part-funding a care economy analyst in the East and Southern Africa region, who supported delivery in Rwanda and other initiatives on care systems across the region.
- **Globally**: a policy and knowledge management specialist and a global programme coordinator, directly funded by the programme, along with the support of core resources and other programme-funded personnel across Global, Regional and Country Office teams.[15]

UN Women has implemented the 3R Programme in partnership with:

- The **programme funder**, the German Federal Ministry of Economic Cooperation and Development.
- **Delivery partners**, including ActionAid in Rwanda and in Senegal; Enda Energie, a civil society organization; Plateforme des Femmes pour la Paix en Casamance, a women's peace platform; and Regional Development agencies in Sédhiou and Saint-Louis.
- **Feminist economists,** participating in the expert reference group and supporting the development of policy tools and materials.
- **National Steering Committees** in Rwanda and Senegal advising on implementation, including lead government ministries.[16]

[15] This includes the Policy Adviser – Macroeconomics and Global Lead on Care, the Economics Specialist, and a programme assistant and administrative assistant.

[16] Members in Rwanda comprise: Ministry of Gender and Family Promotion, National Child Development Agency, Forum des Femmes Rwandaises Parlementaires, ActionAid, Institute of Policy Analysis and Research, Rwanda Men's Resource Centre, UNICEF, Private Sector representatives, and Pro-Femmes. Members in Senegal comprise: Association des Elus locaux du Sénégal, Association des femmes travailleuses du Sénégal, Réseau National des femmes rurales du Sénégal, Fédération nationale des femmes rurales du Sénégal, Réseau des femmes agricultrices du Nord; Plateforme des femmes pour la paix en Casamance; Agence régionale de développement de saint Louis; Agence Régionale de développement de Sédhiou; ENDA Energie; ONG Dimbaya; OXFAM; FAO, PAM, PNUD, Ministère de l'agriculture et de l'équipement rural, CRES consortium pour la recherche économique et sociale and PRB Population Reference Bureau.

The programme targets:

- **National and local governments**: engaging in capacity-building; designing new technologies; developing and implementing policies, road maps and development plans on care systems.
- **Women-led organizations and cooperatives, and women participants:** receiving energy and labour-saving technologies; participating in community gatherings and awareness initiatives; and receiving support to access innovative business models and technologies to address care risks. The programme targets people with disability and vulnerable groups.
- **Early Childhood Development (ECD) centres**: receiving training to improve the quality-of-care provision, and rehabilitation and equipment support.
- **Civil society organizations (CSOs)**: delivering community engagement components and participating in capacity-building on care systems.
- **Men and boys, traditional and community leaders**: engaged in selecting participants, and participating in social norms change initiatives.
- **Private sector providers of microinsurance**: partners to strengthen access to financial products for women to manage risks related to care responsibilities.
- **Media partners,** including radio and tv stations involved in developing and broadcasting communication materials.

Key stakeholders also include **UN Women Country Offices** receiving support under the programme's global and regional components to o apply learning in national programming, use programme-developed tools and training, and strengthen engagement with the Global Accelerator on Jobs and Social Protection for Just Transitions.

UN Women also collaborates with **others working in the sector** on joint research and policy advocacy, including UN agencies, development partners, civil society and academics.

A full stakeholder mapping alongside the evaluation sampling approach is set out in Annex 1.

Photo: UN Women

4. METHODOLOGY

EVALUATION CRITERIA AND QUESTIONS

As set out in the Terms of Reference, the evaluation does not cover the DAC criteria of relevance and impact. Relevance was covered extensively in the Phase 1 evaluation. Given the timing of the evaluation, the effectiveness questions also explore evidence of early signs of impact.

The evaluation criteria and key evaluation questions are set out below.

Effectiveness, coherence and gender equality

- To what extent did the global, regional and country components work together coherently to deliver results?
- To what extent has the programme achieved progress towards the three target outcomes?
- To what extent were gender equality principles effectively integrated in the programme?

Efficiency

- To what extent did the programme efficiently leverage UN Women's initiatives, personnel, core resources and regional technical support model to deliver quality and timely results?

Scalability and sustainability

- To what extent are core 3R components likely to be sustained beyond the programme, and how can UN Women best use them to shape TransformCare and future programming?

The evaluation matrix is set out in Annex 4.[17]

EVALUATION APPROACH

The evaluation approach is theory-based. Contribution analysis was used to assess UN Women's contribution to target outcomes as set out in the theory of change (see Annex 2). The evaluation used mixed methods, drawing on both quantitative data (primarily financial and from the survey) and qualitative data (from document review, interviews and focus group discussions).

Gender equality and human rights formed a critical component of the evaluation in the following ways:[18]

Stakeholder analysis and methodology: Stakeholder analysis has been used to select a diverse group of stakeholders to engage in the evaluation, including women and men; those most affected by rights violations; and those who are marginalized and may be difficult to reach. Data was triangulated across different sources and stakeholders.

Evaluation criteria and questions: A specific evaluation criteria on gender equality was added. Associated evaluation questions have been developed. For sampled interventions, the evaluation team assessed outcomes against The Gender Results Effectiveness Scale[19] developed by the United Nations Development Programme (UNDP).

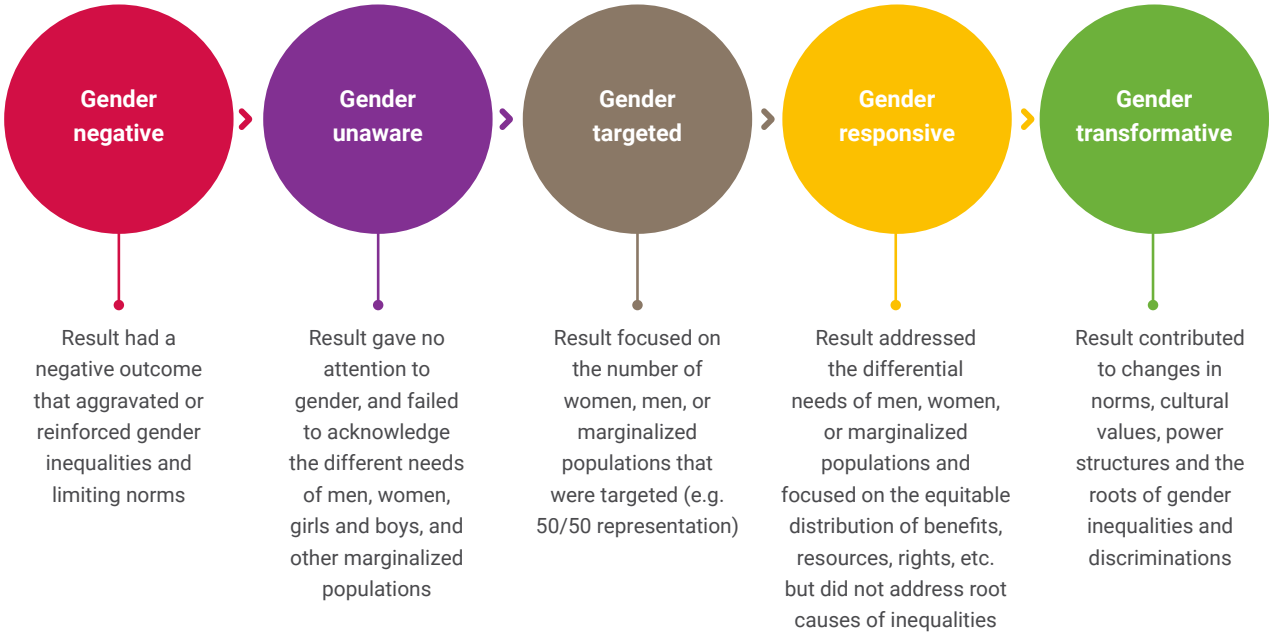
Reporting: Gender equality issues were covered in all sections of the report (findings, lessons learned, recommendations).

[17] The presentation of findings makes some small changes in terms of the presentation of evaluation questions. Firstly, responses to the evaluation question of 'How well did the programme address learning and recommendations from Phase 1?' were included in relevant sections. The Efficiency and Coherence criteria were combined, given the important linkages across these questions. Similarly, the question on 'Which innovations (including those at the care × climate/conflict nexus such as energy and labour-saving technologies) were most effective?' was answered alongside 'How best can UN Women leverage the 3R programme to contribute to TransformCare and future programming?' given the links across these two questions.

[18] Building on the Integrating Human Rights and Gender Equality in 26 Evaluation -- Towards UNEG Guidance

[19] The Gender Results Effectiveness Scale (GRES)

FIGURE 3
Gender Results Effectiveness Scale



Source: UNDP Gender Results Effectiveness Scale

DATA COLLECTION

The evaluation team reviewed 108 internal and external documents (see Annex 1 for a list of documents reviewed).

The evaluation applied a combination of purposive and random sampling (of programme participants), based on a stakeholder mapping exercise conducted with the programme team. 253 stakeholders were reached, exceeding the target sample of 239. Of these, 93 individuals participated in interviews, 138 in focus group discussions and 22 individuals responded to two surveys (some individuals were eligible to take part in both). Response rates were 18 per cent for the training survey (n=19) and 12 per cent for the community of practice survey (n=6). Annex 1 sets out the sampling strategy linked to the stakeholder mapping, the extent to which those targeted were reached and further detail on the stakeholders consulted.

The evaluation team undertook data collection between January and February 2026 across programme sites in Senegal and Rwanda, and remotely with global and regional stakeholders.

In line with the leave no one behind principle, the stakeholders consulted included women's groups in remote rural localities, youth, women-headed households, people with disabilities, parents of children with disabilities and CSOs representing vulnerable groups. See Annex 1 for additional details.

Data was disaggregated by gender and managed in accordance with the data management plan (see Annex 6). Data collection tools are set out in Annex 5.

ANALYSIS

The evaluation matrix formed the framework for analysis. Qualitative data were analysed in a tabular analysis framework, developed based on the evaluation matrix, and including tags for sex, geographies and stakeholder categories. Quantitative data were analysed in Excel.

The evaluation team presented preliminary findings to the programme team on 19 February 2026 for validation and to identify other perspectives which were incorporated in this report.

Contribution towards each target outcome was analysed using the format below.

TABLE 2

Contribution analysis rating approach

TARGET OUTCOME		
Achievement – strength of evidence		
Strong Clear and substantive progress against the target result, corroborated by multiple sources and diverse sources, with concrete examples.	**Moderate** Outcome shows some progress, but it is partial, uneven or limited in scope. Evidence is corroborated by more than one source, but examples are less detailed, come from a narrower range of stakeholders and/or remain relatively general.	**Weak** Outcome-level change is unclear, minimal or not directly observable. Evidence is based on only one source or one type of stakeholder, is mostly anecdotal, and/or no specific examples of verifiable change are provided.
UN Women's contribution – strength of evidence		
Strong Clear, specific and well-evidenced link between UN Women's interventions and the outcome. Multiple stakeholders recognize UN Women's role and explain how particular activities, partnerships or tools contributed. UN Women is seen as a catalytic, leading or clearly significant contributor.	**Moderate** UN Women is one of several contributors, with a plausible but more general link to the outcome. The role is recognized, but explanations are broad or lack detail on mechanisms and relative influence. Other actors and contextual factors appear to have played substantial roles.	**Weak** UN Women's role is unclear, marginal or largely inferred. Links between activities and the outcome are weakly articulated, not corroborated, or overshadowed by other explanations. There is little or no explanation of how UN Women's work supported change.
Contribution of other factors and testing the theory of change assumptions		

ETHICS

The evaluation complied with the relevant United Nations Evaluation Group (UNEG) and UN Women standards on ethics.[20] Specifically, the evaluation was delivered as detailed below.

Integrity

The evaluators ensured compliance with the Code of Conduct, and to deliver the evaluation with honesty, professionalism and impartiality. The evaluators are independent from programme delivery. Areas of disagreement between the evaluation team and the programme team, and changes to the evaluation findings, have been documented.

Accountability

The evaluation took a transparent sampling and analysis approach, using an analysis framework. Evaluation findings were mapped to the evaluation questions, referencing the underlying evidence.

Beneficence

The evaluation team sought informed consent, clearly explaining the purpose of the evaluation and how the information was used. Explicit oral consent was sought. The evaluators also highlighted potential benefits and harm to participating. All responses were kept confidential, so there is limited expected harm to participants. Evaluators highlighted that participants could stop the interview or focus group discussion at any point. Where interviews involved discussion of sensitive topics, a trauma-informed approach was applied. Interviewers were trained to create a safe and respectful environment and monitor participant well-being throughout the engagement.

Respect

The evaluation meaningfully engaged evaluation stakeholders, not only as subjects of data collection. The evaluation team shared the evaluation brief with all evaluation stakeholders and respondents. To ensure fair representation of different voices, the sampling approach took into consideration coverage of different categories of stakeholders, including those hard to reach.

[20] The evaluation will adhere to UNEG and UN Women Ethical Guidelines and Code of Conduct, UNEG guidance on Integrating Human Rights and Gender Equality in Evaluations, with gender-responsive and human rights approaches integrated throughout the evaluation.

LIMITATIONS AND MITIGATIONS

1. **Documentation and overlapping contribution pathways:** Some regional and global technical support was informal and not fully documented; and, in some areas, the boundaries between 3R-supported activities and wider care-related programming were not always clear. Results were also often co-produced with governments, partners and other UN Women or external initiatives. The evaluation therefore used a contribution-based approach, drawing on key informant interviews and triangulation across sources, to map the programme's specific role without over-claiming attribution.
2. **Limited outcome-level monitoring data.** Given the lack of outcome indicators, available monitoring data were stronger on activities, participation and immediate reach than on outcome-level change, institutional uptake or the programme's catalytic nature. The evaluation addressed this by drawing on qualitative evidence, document review, partner records and secondary materials to assess changes in awareness, practice, institutionalization and continuation.
3. **Qualitative design and modest survey response.** The evaluation relied primarily on qualitative methods and was not intended to be statistically representative, while survey response rates were modest. This was mitigated through triangulation across methods and sources; coverage across programme components and locations; examination of divergent cases; and careful qualification of findings where evidence was more indicative than conclusive.

DISSEMINATION AND USE

Table 3 sets out the dissemination plan for the targeted primary and secondary users.

TABLE 3
Dissemination plan approach

Dissemination approach	How this will be tracked
UN Women programme team Evaluation team to host validation meeting; share two-page brief; and host a meeting to discuss findings and next steps.	Uptake of findings and extent to which meetings result in concrete, actionable next steps
Global, Regional and Country Office colleagues, national partners and others working in the sector Evaluation team to share two-page, external-facing brief and infographic.	Number of stakeholders the brief is shared with

The programme coordinator led the follow-up process to facilitate use of evaluation findings and is responsible for issuing a management response within six weeks of the evaluation report's finalization.

EVALUATION MANAGEMENT AND QUALITY ASSURANCE

The Director of IEAIS and Chief of IES reviewed and signed off on all evaluation products, in compliance with relevant guidance[21]. Supported by the international and national evaluation consultants, the Team Lead was responsible for the evaluation, including data collection, analysis and reporting. The evaluation will also be subject to the Global Evaluation Report Assessment and Analysis System (GERAAS) process, which assesses the quality of the report, and the level of confidence readers can place in the evaluation.

The Evaluation Reference Group and Management Group (see Annex 7 for composition and terms of reference) were responsible for providing technical review, support and ensuring a high quality, transparent process.

[21] UN Women Evaluation Policy, UNEG Norms and Standards for Evaluation

FIGURE 4
Summary of methodology

GENERAL OBJECTIVE

The evaluation is a systematic analysis of UN Women's contributions to development results in gender equality and women's empowerment through the 3R Programme, with a focus on strengthening learning, decision-making and accountability.

253

people consulted through interviews, surveys and focus groups– 71% female and 29% male. Semi-structured interviews with 93 UN Women personnel and partners. Focus groups with 138 programme participants.

EVALUATION PROCESS

1. Design
2. Inception and portfolio analysis
3. Data collection
4. Data analysis and reporting
5. Monitoring and use

METHODOLOGY

Gender-responsive evaluation
Mixed methods for triangulating evidence, Theory-based
The evaluation was conducted between December 2025 and April 2026.

100+

documents reviewed – Programme documents, partner and donor reports, knowledge products and others

SCOPE

Programmatic components: All programme components, including components in Rwanda and Senegal (Outcomes 1 and 2) and global components (Outcome 3).

CONTRIBUTION ANALYSIS

Approach designed to arrive at conclusions about the contribution the programme has made to development outcomes.

2

surveys with 22 respondents –
Community of practice survey: 6
Training survey: 19

EVALUATION CRITERIA

Effectiveness
Efficiency
Coherence
Sustainability
Gender equality

5

FINDINGS

COHERENCE AND EFFICIENCY

How efficiently did the programme leverage UN Women's initiatives, personnel, core resources and regional technical support model to deliver quality and timely results? To what extent did the global, regional and country components work together coherently to deliver results?

To what extent were the activities efficiently designed and delivered to leverage other UN Women initiatives, personnel and resources (including core funding)?

FINDING 1

The 3R Programme efficiently and intentionally leveraged UN Women's wider care programming ecosystem, building on broader personnel capacity, platforms and creating synergies with complementary programme funding, to extend impact. This enabled production of global goods (such as tools, policy work and curriculum), designed for integration into broader programming for UN Women and external stakeholders.

Phase 2 of the 3R Programme was designed with core global, regional and country-level components, intended to scale impact globally. It funded a small set of catalytic roles across global, regional and country levels (global policy specialist and programme coordinator; part-funded East and Southern Africa Regional Office Care Economy Analyst; and programme coordinators in Rwanda and Senegal). Beyond the country-specific work in Rwanda and Senegal, much of the global and regional work, tools, technical support and policy engagement depended on uptake and action by country and regional teams to translate to target outcomes, making synergies integral to delivery.

The programme efficiently leveraged existing expertise, structures and platforms. It drew on complementary resourcing contributing to the same target outcomes, including core and institutional budgets,[22] leveraging co-financed and core/institutional budget-funded roles both globally[23] and regionally.[24] It also supported the implementation of and built on the experience of other care-related programming.[25] In the East and Southern Africa Regional Office, 3R support to regional care capacity also helped catalyse a wider programme of work on care, including follow-on funding under TransformCare and International Development Research Centre-supported work. Phase 2 also strengthened and utilized UN Women platforms (such as the Care, Decent Work and Macroeconomics Community of Practice) and regional care platforms to disseminate tools and facilitate learning and exchange.[26]

At country level, internal coordination with other UN Women programmes supported coherence and reduced duplication. In Rwanda, 3R was implemented in close alignment with Joint Programme on Rural Women's Economic Empowerment in the same communities and with many of the same women's groups, allowing care-focused support to leverage complementary interventions on finance, market access, transport of produce, ECD centre food provision and community vegetable gardens. This helped link care-focused support to women's wider economic needs, while reducing duplication and reinforcing results across programmes.

[22] SIDA and NORAD strategic partnership frameworks also fund transforming care systems at the global and regional level. Key activities include building internal and external capacities, producing research and tools, and convening external stakeholders. Specifically, NORAD also funds engagement with the African Union gender directorate and the United Nations Economic Commission for Africa on building a road map for continental strategy/commitment on transforming care systems.

[23] Global Lead on Care, Macro-Economics Specialist, Knowledge Management Specialist, administrative support.

[24] West and Central Africa Regional Office – the regional feminist economist supports implementation in Senegal and regional work; the East and Southern Africa Regional Office care economy analyst is part funded by other care programmes.

[25] In the East and Southern Africa region, other examples of programme funding on care systems include the Global Accelerator on Jobs and Social Protection, Global Disability fund programming, GATES Foundation and International Development Research Centre funding.

[26] For example, the pilot curriculum was delivered regionally in Asia and the Pacific through co-financing from 3R and SIDA.

The programme was critical in building TransformCare, UN Women's programming framework on transforming care systems, which enables UN Women to scale and strengthen its programming. By funding key positions focused on care systems programming, 3R enabled the piloting and consolidation of UN Women's emerging care systems approach, including development of tools, curriculum, the UN System Policy Paper on Transforming Care Systems,[27] global normative developments and a clearer global programming framework to guide programming at scale (see Finding 6).

What were the synergies across the global, regional and country components and to what extent did this help achieve scale?

FINDING 2

There were strong synergies across the global, regional and country components of the programme, which supported uptake, adaptation and wider application beyond Rwanda and Senegal.

Vertical coherence

Phase 2 strengthened coherence relative to Phase 1 through a clearer multilevel design. Greater emphasis was placed on care as public good, global public knowledge products and materials (e.g., tools, curriculum, conceptual framing) and an explicit regional role, beyond supporting country delivery; clarifying the linkages between global normative work, regional processes and country implementation; and the respective roles of the different offices, made them clear through a joint programme inception workshop and regular check-in calls. Global, Regional and Country Office personnel reported that this attention to coherence strengthened programming, enabling country realities to inform the corporate approach and demand-driven global normative work and tools to support country programming.

The global component strengthened vertical coherence and scale by providing a shared conceptual approach and practical tools that were used across regions and countries, building on the experience of the 3R Programme. Country and regional teams reported that the tools and curriculum developed under the programme improved programming quality by offering structured guidance for adaptation to different contexts. There has been strong uptake of these tools in countries beyond Rwanda and Senegal (see Finding 6).

Co-design mechanisms improved the relevance and usability of global products. Global, country and regional teams reported that the participatory, reference-group approach improved relevance and usability.[28] Some stakeholders suggested further strengthening the process through earlier visibility of planned products, longer lead-times for substantive input (beyond review) and a more flexible balance between global coherence and responsiveness to time-sensitive regional or country demand.

Vertical coherence was reinforced through coordinated global and regional technical support and a structured training roll-out that linked global products to country delivery. Regional and Country Offices valued the timely global and regional technical inputs; review of Terms of Reference and knowledge products; practical guidance; and access to expert rosters. For example, the Kenya Country Office's support to the national care policy benefitted from strong regional engagement (including some seed funding) and global technical inputs and tools (including time-use and costing-related work). Global Office support on engagement with the Global Accelerator on Jobs and Social Protection was also cited as critical for securing a role for Country Offices in the joint programme. Regional Offices played a central role in rolling out and adapting the care systems curriculum for their regions, and strengthening alignment between UN Women country programming and the global approach.

[27] United Nations. (2024). Transforming Care Systems in the Context of the Sustainable Development Goals and Our Common Agenda. UN System Policy Paper.

[28] For example, ministers across all regions shaped the engendering fiscal space tools.

Global normative developments helped elevate care systems in the policy agenda, with the regional layer critical to translating these developments into regional and national policy processes and uptake. Phase 2 contributed to key resolutions on care systems (see Finding 6), and Regional Offices played an important role in translating these resolutions into regionally relevant frameworks and entry points for national advocacy. Interviewees across global, regional and country levels reported that governments were generally more responsive to regional and national commitments and priorities than to global developments alone. In practice, regional processes functioned as the main bridge between normative progress and country-level uptake, supporting cross-country agenda-setting, political commitment and policy dialogue. Global and Country Offices appreciated the role of Regional Offices in supporting them to use global normative developments in policy dialogue, by aligning them with regional frameworks and country priorities.

For example, the East and Southern Africa Regional Office supported the translation of global normative commitments into regional policy agendas through engagement with regional bodies such as the African Union. This influenced country-level uptake, through the work of the regional care economy analyst, partly funded by the programme. For example, as a result of the G20 outcome document, the Africa Union Commission is interested in preparing a continental road map on care systems. This work is reinforced through the Regional Office's dissemination, advocacy and regional convening (see examples in Box 1 below). At the same time, external stakeholders in the East and Southern Africa region perceived UN Women's global convening as more visible than its regional convening and advocated for stronger resourcing of this area.[29]

There have also been promising regional developments in other regions. In Latin America, regional agreements and dialogue exposed ministers of women to care concepts, influencing national implementation. The UN Economic and Social Commission for Asia and the Pacific is building on the momentum of the upcoming Commission on the Status of Women (CSW) 72 on care systems to progress a regional road map.

BOX 1

Examples of East and Southern Africa Regional Office's regional convening, dissemination and advocacy

- → Knowledge sharefair (2022) supporting exchange between regional internal and external stakeholders
- → Presented at Oxfam's stakeholder consultation on "Deepening Regional Care Economic Advocacy in Africa" (2023)
- → Presentation of *Why Women Earn Less: Gender Pay Gap and Labour Market Inequalities in East and Southern Africa* at various regional convenings in 2023–24, including Aspen Institute Africa webinar, 31st International Association for Feminist Economics annual conference, WePropser Technical Group Meeting and an International Monetary Fund training session.

Horizontal coherence

Global and Regional Offices played a knowledge-broker role that enabled horizontal learning and supported uptake beyond the pilots. Country Offices emphasized that these exchanges strengthened programming both technically (e.g. how to apply the costing tool, examples that can be shared with government stakeholders) and operationally (e.g. what evidence persuaded decision makers, and practical implementation steps), see Boxes 2 and 3 below. Learning was facilitated through the Care, Decent Work and Macroeconomics Community of Practice, global monthly meetings of regional advisers, and global and regional teams matchmaking offices delivering similar programming. Externally, the programme also supported learning exchange with partners (e.g. the East and Southern Africa Regional Office's sharefair on care bringing together governments and CSOs) and delivery of regional trainings using the pilot curriculum (including in Asia and the Pacific).

[29] There is an opportunity to leverage existing strategic partnership funding (e.g. Sweden, NORAD) intended to support convening across global, regional and national levels.

BOX 2

Examples of internal exchange

- → Rwanda's experience informed Kenyan programming (integration of social norms and social protection and costing). Phase 2 of 3R in Rwanda then built on Kenya's experience of training and developing the care policy with a broad spectrum of stakeholders.
- → Tanzania adapted the 3R Programme in Rwanda and mobilized funding for its own care programming and drew on lessons about using the Time Use Survey to advocate locally and nationally for energy and labour-saving technologies.
- → Multiple offices mentioned the good practice on care costing (Morocco and Ethiopia); care blocks (Colombia) and convening (Asia–Pacific care forum).
- → Exchanges between the West and Central Africa and East and Southern Africa Regional Offices on gender bonds and financing.

BOX 3

Examples of external exchange

- → Incorporation of key elements from Uruguay's National Integrated Care System into Colombia's National Care System through UN Women global and regional support (partly funded by the programme).
- → UN Women hosted the Asia–Pacific Care Learning Week (September 2025), partly funded by the programme, and supported by the global team, which focused on country exchange across 15 countries. For example, Indonesia expressed interest in adopting Malaysia's caregiver hub model to strengthen regulation and incentivization.
- → With 3R-funded regional support, the South Africa Country Office provided the requested good practice examples to inform the G20 policy discussion, drawing on Tanzania and Rwanda's care infrastructure programming and Kenya's work on the care policy.

Source: interviews and survey responses

Country Offices noted that effective learning exchange depends on stronger linkages across learning platforms and tailoring activities to the local context. Several reported more regular Community of Practice meetings and observed that improved connectivity helped to avoid duplication and missed opportunities for exchange between offices using the same tools. Offices also emphasized the need to organize learning around thematic entry points and national priorities/focus areas,[30] as lessons do not transfer evenly across countries with different care policy agendas and institutional contexts.

Scale through integration with wider UN Women programming

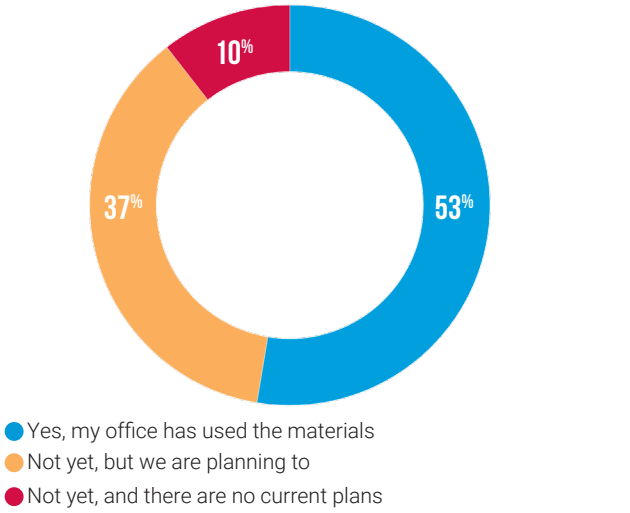
The programme contributed to scale beyond Rwanda and Senegal, acting as a catalyst and generating learning, products and approaches taken up through other UN Women programming and partnerships. This was facilitated by (a) diffusion of the care systems curriculum; (b) adaptation of piloted models; (c) use of 3R examples as evidence for policy dialogue and advocacy; and (d) application of tested tools.

First, the care systems curriculum developed under the programme was delivered in multiple regions and countries through training and workshops, extending reach beyond the pilots. Among training survey respondents, 90 per cent (17) reported adapting the materials for other training courses or that they were planning to do so, with delivery to multiple stakeholder groups, see Figures 5 and 6 below.

[30] For example, childcare, eldercare, labour-saving technologies, private sector, social protection.

FIGURE 5

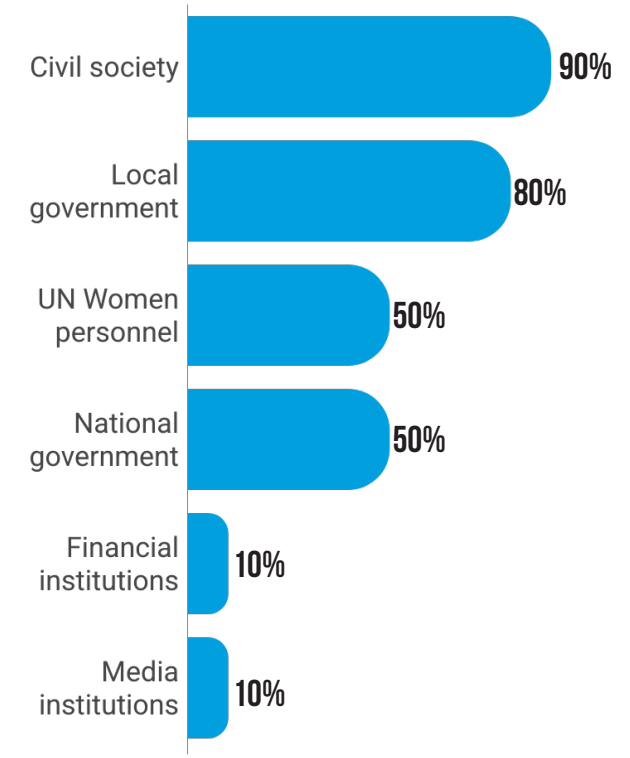
Survey responses on use of training curriculum:
Have you or your office/team used the global TransformCare training curriculum?



Source: evaluation survey of training participants, n= 19

FIGURE 6

Survey responses on stakeholders trained:
Which stakeholders have you trained using these materials?



Source: evaluation survey of training participants, n= 19

For example, the Asia–Pacific region was able to take forward the training through the TransformCare Facility Investment Initiative. Box 4 sets out further examples of the curriculum being delivered in other contexts (Finding 6 details outcomes resulting from these training courses).

Second, piloted models developed under 3R were adapted and applied to other contexts. For example, the Tanzania Country Office adapted the 3R Programme's tools and training materials through integrating a care systems outcome into its Women's Leadership and Economic Rights programme. In West and Central Africa, programme components have been replicated based on available funding. The Mali Country Office used the 3R Phase 1 tool on integrating care into local development plans to support municipalities. The Senegal 3R guidance on "How to develop a national action plan on care" has been applied in Liberia, Ivory Coast, Mali and Nigeria.[31]

Third, the 3R programme provided credible examples and evidence, used by UN Women in policy dialogue and advocacy with government and inter-governmental stakeholders. In West and Central Africa, personnel reported using 3R examples in policy dialogues (e.g. Nigeria, Mali, Côte d'Ivoire, Liberia and ECOWAS), regional briefs and webinars. 3R evidence also fed into advocacy products, including G20-related briefing notes on the care economy, which contributed to the G20 South Africa Summit: Leaders' Declaration[32] (see Finding 6 on regional outcomes).

Finally, key tools strengthened under the programme supported scale through wider application. The UN Women–International Labour Organization (ILO) costing and investment tool revised under the programme was used in over 20 countries. Country Offices reported that this informed national policy processes (see Finding 6). Globally, findings from these assessments influenced policy and programming, including the UN Global Accelerator on Jobs and Social Protection and the ILO's 2024 tripartite conclusions on the care economy.[33]

[31] Interviews with Regional and Country Office personnel.

[32] G20 South Africa. (2025). G20 South Africa Summit: Leaders' Declaration. Johannesburg: G20 South Africa Presidency, Interviews with Global and Regional Office personnel.

[33] Interviews with Global, Regional and Country Office personnel, and UN agencies

BOX 4

Examples of training delivery

- → Regional care learning week in Nepal with 57 attendees from 15 countries.
- → Building Care Delivery Models workshop in Kathmandu.
- → The Investment Case for Care in Viet Nam.
- → Financing Care Training India.
- → National consultation on care in Thailand, August 2026.
- → First national dialogue on care in Pakistan September 2026.
- → Government, implementing partners, women's rights organizations and women's businesses were trained in Tanzania.
- → Part of training delivered to external stakeholders as part of the UN Partnership on the Rights of Persons with Disability project on Care and Disability in Mozambique, Kenya and Tanzania.
- → The West and Central Africa Regional Office delivered training to Economic Community of West African States (ECOWAS), Intergovernmental Authority on Development, the United Nations Economic Commission for Africa facility, STAR facility on Social Protection and Organization of Islamic Cooperation.
- → International Development Research Centre is funding the East and Southern Africa Regional Office to extend the training to other countries, complemented by technical support to prepare national care road maps.

Photo: UN Women

Was the regional technical support model an efficient way to provide quality assistance and facilitate achievement of results?

FINDING 3

The regional technical support model was an efficient way to provide relevant and actionable assistance, particularly by contextualizing global tools; sustaining follow-through with country teams; and engaging regional bodies which can accelerate multi-country uptake.

Phase 2 intentionally strengthened regional capacity, which stakeholders viewed as efficient and necessary for effective delivery. Global, regional and country offices reported that dedicated regional expertise was critical to advancing the care agenda and supporting country implementation, a key value-add of the programme. The programme part-funded the East and Southern Africa Regional Office care economy analyst and leveraged the core-funded West and Central Africa Regional Office feminist economist, alongside other regional Women's Economic Empowerment specialists. For example, in the Europe and Central Asia region, following regional care training, care systems programming expanded to 14 of the 16 offices in the region.[34]

Regional Offices were particularly important in contextualizing global frameworks and materials for regional and country realities. In addition to the Regional Office's role on linking global normative work, regional processes and country implementation (see Finding 2), Country Offices and external stakeholders felt that the regional structure effectively adapted global frameworks and materials to country needs and priorities and developed useful region-specific guidance.[35]

Regional support improved speed, quality assurance and practical problem-solving. Country Offices valued timely technical inputs and funding-related support, including seed funding for catalytic work (e.g. the national care policy in Kenya) and resource-mobilization support through funding briefs and identification of opportunities for regional programming. Regional involvement also provided oversight[36] and continuity across projects, helping maintain institutional memory and support replication and sustained engagement despite staff turnover in Country Offices.

Photo: UN Women

[34] Interviews with Regional and Country Office colleagues, review of annual reports
[35] Interviews with Country Office personnel, review of regional knowledge products
[36] Aligned to reporting lines between Country Offices and the Regional Director

EFFECTIVENESS, SUSTAINABILITY AND GENDER EQUALITY

To what extent has the programme achieved progress towards the three target outcomes?

What contribution is UN Women making towards target outcomes? Were there any unintended outcomes?

Across Findings 4–6, contribution analysis tables summarize findings and rate the strength of evidence for the outcome's achievement, the programme's contribution and the contribution of other factors.

OUTCOME 1:

National and local governments develop/ strengthen laws, policies and services that recognize and address the disproportionate share of unpaid care work performed by women and girls

FINDING 4

There was strong evidence that the programme increased understanding and capacity among national, and especially local, government actors to address unpaid care work. There was moderate evidence that this translated into strengthened laws, policies and services, with the strongest verified results at local planning level in Senegal and in both local and national policy/legal uptake in Rwanda. National-level change in Senegal remained more process-oriented and not yet fully institutionalized.

There was strong evidence that national and local governments had greater understanding of the 3Rs and capacity to address unpaid care work. Across both countries, government stakeholders reported a change in their understanding of unpaid care as an issue relevant for public policy and resource allocation, rather than as a domestic, women's issue, signaling initial social norms change. In Senegal, government stakeholders, including regional development agency and health insurance officials, reported greater understanding of care issues and noted that unpaid care is now more likely to be discussed as a policy, planning and budgeting issue. The 2023 national policy dialogue engaged policymakers, territorial elected officials, parliament, ministries and partners, resulting in a call for care reform, stronger government initiatives and increased training on concepts.[37] At local level, communes reported integrating care considerations into diagnostics and planning, not only in relation to childcare, but also domestic work, eldercare, water, energy, fuel collection and energy and labour-saving equipment, indicating understanding of the comprehensive nature of care systems. Local plans in several communes incorporated concrete measures such as water points, childcare and diagnostics on gendered time use, demonstrating government stakeholders' ability to apply these concepts in practice. In Rwanda, government officials similarly reported stronger understanding of unpaid care and changes in how it is discussed, leading to its incorporation into provincial and district strategic plans.

The programme's contribution was well-evidenced. In Senegal, the programme combined evidence generation and advocacy, including Celebrations of the International Day of Care and Support and a National Dialogue with traditional and religious leaders, with practical capacity-building through gender-responsive budgeting and planning training for 1,119 government officials,[38] local diagnostics, methodological tools and technical support to Regional Development Agencies. In Rwanda, the programme delivered training to public institutions and training of trainers of district monitoring officials, held national conferences and dialogues, including a high-level consultative workshop on unpaid care work and a workshop on tools for strengthening the mainstreaming of unpaid care work, and produced policy briefs. Across both countries, the programme effectively blended training and technical assistance to support government stakeholders to identify concrete entry points.

[37] National policy dialogue workshop report

[38] Agreed to workshop report, and a sample were consulted

TABLE 4

Contribution to Outcome 1

Outcome component	Evidence of outcome	Programme contribution
National and local governments have greater understanding of the 3Rs and capacity to address unpaid care work	**Strong evidence of outcome**. In Rwanda and Senegal, government stakeholders reported increased capacity and recognition of care as a planning and public-policy issue. This was also reflected in greater integration of care considerations in planning and gender budgeting.	**Strong evidence of the programme's contribution** through policy dialogue, production of policy briefs, training and technical support to public institutions and local actors. In Senegal, this included support to time-use evidence, planning tools and technical support to regional development agencies; training of 839 government partners; and two national dialogues. In Rwanda, it included Gender and Economic Policy Management Initiative training for public institutions and four national dialogues.[39]
National and local governments develop and strengthen laws, policies and services that address unpaid care work	**Moderate evidence of outcome**. Evidence was strongest on the development and strengthening of laws and policies. In Rwanda, this included recognition of unpaid care in some district project proposals, the 2023 National Transformative Strategy Engaging Men and Boys for Gender Equality Promotion, and the 2024 Family Law revision to include unpaid care work provision. In Senegal, it included support to the draft law on women's economic empowerment, the first road map for care reforms, and support to 19 municipalities to integrate care into planning and diagnostics. [40] There were some early signs of follow-through into services, including strengthened childcare and health-insurance arrangements and a few financing models, although evidence of wider financing and implementation remained limited given the limited programme duration and depended on broader government and partner follow-through.	**Strong evidence of programme's contribution** through policy dialogue, technical support, training and advocacy. In Senegal, the programme worked with Regional Development Agencies to support municipal actors with diagnostics and planning tools. In Rwanda, the programme supported government staff through technical support, training and advocacy that positioned unpaid care within planning and gender budgeting.
Other contributory factors	Enabling factors included existing gender-policy commitments, time-use evidence, and commitment and engagement from parts of government and women's networks. Constraints included uneven local capacity and persistent social norms and uneven follow-through of plans into budgets. National developments in Senegal were affected by the 2024 elections and political transition.	

There was mixed evidence across this outcome area, with stronger evidence of national and local governments developing and strengthening laws, and policies that address unpaid care work, and emergent evidence on translation into financing and strengthened financing of services addressing unpaid care work, reflecting the programme timeframe and the fact that implementation depends on wider government and partner follow-through.

In Rwanda, the programme supported advocacy and technical inputs related to the 2023 National Transformative Strategy Engaging Men and Boys for Gender Equality Promotion, and Law No. 71/2024 governing persons and the family, which includes article 175 valuing unpaid care work in divorce proceedings. Programme-supported government training included a module on integrating unpaid care work into budgeting, and the Ministry of Gender and Family Promotion and Ministry of Local Government reportedly discussed and expressed commitment to this approach. Some district-level officials also reported early follow-through, including inviting women into public budgeting discussions and beginning to integrate care considerations into project proposals.[41] These shifts built on existing entry points for institutionalization, including gender-budgeting requirements and local leaders' performance-contract targets on early childhood development, energy-saving measures and environmental protection.[42] However, unpaid care work has not yet been reflected in a dedicated budget line in Ministry of Finance templates, indicating that budget integration remained at an early stage.

[39] Agreed to training and workshop lists

[40] Confirmed with a sample of municipalities

[41] Interview with a district official. For example, a district distributed improved cooking stoves (separate to the 3R Programme); installed public lights to enable women market traders to work safely in the evenings; subsidized electric stoves to reduce cooking time; and installed water kiosks in communities.

[42] Government interviews

In Senegal, the programme contributed to a stronger national policy enabling environment, although institutionalization remains ongoing. The programme supported the draft law on women's economic empowerment through technical expertise, consultations and advocacy; inclusion of care work in the national strategy for women's economic emancipation; and the April 2023 national policy dialogue validated a road map for care reforms and informed Phase 2 of the programme.[43] This was facilitated by engagement with the Ministry of Family and Solidarity and the Ministry's recruitment of a dedicated focal point on care systems. However, after the political transition,[44] discussions continued on finalizing the multipartite and multisectoral committee to monitor implementation of the initiatives and improve coordination, and in reviewing the road map.[45] A national childcare dialogue in December 2025, which brought together 65 stakeholders from government, civil society, communities and development partners, helped deepen policy discussion, strengthen alignment among key actors, and validate key orientations for the childcare reform roadmap.

Sub-nationally, 19 municipalities in Senegal received training and tools to integrate care into planning documents. In the south, eight of the communal development plans reviewed included explicit integration of unpaid care, women's economic empowerment and sex-disaggregated local diagnostics.[46] Municipal actors and the regional development agency also reported more participatory budget discussions, resulting in inclusion of budget lines related to gender-based violence and persons with disabilities.[47]

These developments are promising in terms of strengthening the policy and institutional basis for addressing unpaid care work, although evidence on subsequent financing and implementation remains more limited and would require a longer time horizon to assess.

There was some evidence that governments had strengthened childcare and health-insurance provision by bringing care priorities into local service and social-protection arrangements. In Rwanda and Senegal, the programme improved the infrastructure of government-run childcare facilities. In Senegal, it also supported the public health-insurance scheme through subsidized enrolment for vulnerable and rural women, partner-led registration and collaboration with the health insurance agency on more gender-responsive provisions.

Alternative financing mechanisms were less developed, but the programme tested several early approaches with scaling potential, including co-financed health-insurance enrolment, participant contributions, mutual-health arrangements, village savings and loan associations, and initial exploration by Enda (the service provider) of credit and guarantee-fund options for labour-saving equipment. Participants expressed strong interest in expanding these approaches, including through guarantee funds, larger credit lines, more working capital and additional training in management, processing and commercialization. See Finding 5 for more detail on these care services.[48]

The programme contributed to this sub-outcome through policy dialogue, technical support and evidence generation. At national level, it supported workshops and dialogue with government stakeholders, including the national care dialogue in Senegal and national conferences, dialogues and training workshops in Rwanda, helping to raise the visibility of care considerations in policy and planning processes. In Senegal, UN Women also strengthened the evidence base by supporting the National Agency of Statistics and Demography to apply international standards to measure unpaid care work. This evidence is now being used to inform the Sénégal 2050 plan and gender-responsive budgeting. At sub-national level, the programme supported Regional Development Agencies

[43] National care-policy dialogue report, April 2023

[44] After the post-election restructuring, the former Ministry of Women, the Family and Child Protection was restructured and is now the Ministry of Family and Solidarity

[45] Interviews with Ministry of Family and Solidarity

[46] Including Faoune, Diannah-Ba, Ndiamalathiel, Madina Wandifa, Boghal and Bambali communes.

[47] Partner reports

[48] Participant interviews

in Senegal and district-level actors in Rwanda to carry out diagnostics, train officials and apply methodological tools to integrate care priorities into planning. In Rwanda, government stakeholders reported that the Baseline Survey on Unpaid Care Work Status among Women and Men (2022)[49] was instrumental in highlighting the disparities in time use between women and men, contributing to the inclusion of unpaid care work in the 2020 revision of the family law.[50]

Positive, unintended outcomes were observed. In the South of Senegal, local dialogue and budgeting work widened beyond unpaid care and opened space for broader community priorities relevant to women and vulnerable groups, including disability, gender-based violence, health access and safer community services.[51]

Other contributory factors validate the three assumptions set out in the theory of change.

The political environment was an important enabling factor. Unpaid care was becoming more visible through national time-use evidence; willingness among government stakeholders to engage; and broader gender equality frameworks. In Rwanda, for example, gender equality is required to be mainstreamed in provincial and district strategic plans, and the Revised Gender Policy 2021 identifies valuing unpaid work in GDP as a policy priority. In Senegal, the 2023 national policy dialogue created a shared reference point for reform discussions, while the National Strategy for Women's Economic Empowerment emphasis on care systems and the time-use work of the National Agency of Statistics and Demography signaled growing government commitment.[52] At the same time, Senegal's 2024 electoral cycle and subsequent government transition slowed ministerial engagement, leading to the programme shifting to greater implementation at the local level.

Fiscal space was a key constraining factor. Dedicated budget lines for care were not yet secure. Stakeholders felt that the programme remained modest relative to the scale of need, which limited the depth and breadth of institutional change. While care priorities entered plans and budgeting discussions, there was more limited evidence of the resulting measures being financed and implemented at scale. Interviewees highlighted the importance of engaging with Ministries of Finance to unlock fiscal space (see Findings 7 and 10).[53] One practical response was support to generate costing evidence for future financing decisions. The Government of Rwanda engaged UN Women to use the engendering fiscal space tool in the education sector to assess needs, current provision and gaps, and to estimate the costs and benefits of addressing them, illustrating coherence between global tool development and country-level policy engagement.

Institutional capacity to integrate care considerations also remained uneven, particularly at local levels, with stakeholders highlighting the need for continued technical support and accompaniment. For example, partner reporting indicated that some municipal councils were slow to update their plans and required additional follow-up support.

[49] Baseline Survey on Unpaid Care Work Status among Women and Men in 8 Districts of Rwanda | Publications | UN Women – Africa

[50] Law N°32/2016 of 28/08/2016 governing persons and family, amended in 2020

[51] Partner reports

[52] The Ministry of Family and Solidarity's strategy also includes plans to introduce payments to family members providing long-term care to dependents.

[53] For example, in Rwanda, the programme worked mainly with Ministry of Gender and Family Promotion and Ministry of Local Governance rather than the Ministry of Finance and Planning.

OUTCOME 2:

Women's cooperatives and other organizations provide care services in rural and/or urban areas to reduce and redistribute unpaid care work.

FINDING 5

There was strong evidence that the programme improved women's access to care services and resources, especially childcare/ECD, health insurance, and energy and labour-saving technologies. There was moderate evidence that the programme also strengthened awareness, capacities and local organization, with women as mobilizers and intermediaries rather than providers, which helped them use care services and resources, and in some cases supported more equitable sharing of care.

The analysis distinguishes between two dimensions of Outcome 2: improved access to care-supporting services and resources; and strengthened local capacity and organization to support uptake and more equitable care practices. Evidence is stronger on women's cooperatives as mobilizers, intermediaries and organized users than as providers of care services.

TABLE 5

Contribution to Outcome 2

Outcome	Evidence of outcome	Programme's contribution	Contribution of other factors
Women had greater access to care, care-supporting services and resources to reduce and redistribute unpaid care work	**Strong evidence**, with rehabilitated and equipped childcare centres (19 in Senegal, 4 constructed and 2 rehabilitated in Rwanda[54]); training of caregivers in 26 ECDs in Rwanda; rehabilitation of a maternity facility, childcare arrangements at a salt extraction plant, with 9,000 women and their families enrolling in health coverage; and 1,653 (Rwanda) and 5,085 (Senegal) individuals accessing energy and labour-saving technologies[55]. Women participants reported that this enabled them to redistribute the time saved on unpaid care work to other areas, such as income generation and political participation.	The programme financed and strengthened existing mechanisms and systems through stakeholders such as the Senegal government's health insurance, government-funded childcare facilities, technical partners and Regional Development Agencies, rather than creating parallel systems. Partners also supported the Regional Health Coverage Agency to integrate women's specific needs around care. The programme produced knowledge products on innovative solutions to address women's unpaid care risks.	Contributory factors included use of existing public/community structures; local government commitment and support; and participant financial contributions to health insurance. Outcomes were affected by institutional and funding conditions and high staff turnover at some ECD centres; administrative problems with health insurance cards affecting use; and challenges with ongoing maintenance and design of some energy and labour-saving technologies.
Women's cooperatives and local actors were better equipped to understand unpaid care issues, support more equitable care practices, and use care services and financing mechanisms.	In Senegal, women's groups reported support to access health insurance, childcare and labour-saving solutions, and in some cases created maintenance or revolving funds to sustain use. Stakeholders also described some shifts in social norms around sharing care. In Rwanda, community members and local actors reported improved understanding of unpaid care; greater willingness to use ECD services and labour-saving technologies; and some changes in care practices towards more equal sharing of care.	The programme linked service delivery to support uptake. In Senegal, it worked through women's networks, Regional Development Agencies, health-insurance actors and other partners with technical know-how on how to enrol for health insurance; use of energy and labour-saving technologies; and local dialogue around social norms. In Rwanda, the programme delivered caregiver training, community awareness, distributed communication materials and collaborated with menEngage to promote more equal sharing of care responsibilities.	Contributory factors included the active involvement of local leaders, communities and some women's networks, building on existing work under Rwanda's National Strategy on Engaging Men for Gender Equality. Negative contributions included persistent social norms around care responsibility distribution and implementation in some areas that worked through individual women and households rather than women cooperatives.

[54] List of right holders obtained, and statistically significant sample was contacted to verify services.

[55] Information obtained from project reports and partly validated through visit reports.

There was strong evidence that women had greater access to care-supporting services and resources, specifically childcare, health insurance, and energy and labour-saving technologies.

Childcare centres

Through support for the rehabilitation and equipping of childcare centres, the ECD centres and parents reported improved safety and functionality.

In Senegal, 15 local childcare centres were rehabilitated in 2024.[56] In December 2025, it was reported that four additional childcare services had been equipped or rehabilitated.[57] The programme also supported community arrangements, such as communal childcare for women engaged in seasonal salt extraction. Women reported that as a result of these rehabilitated childcare centres, they were able to leave their children there and devote more time to small-scale farming and other income-generating activities. The programme also supported rehabilitation of the Eloubalir maternity facility. Women reported this saved them time in having to find alternative care arrangements.[58]

In Rwanda, the programme provided infrastructure support to ECD centres in Nyaruguru, Ngoma and Musanze, and 928 community members were sensitized on the importance of ECD.[59] The 2025 impact assessment noted that 66 per cent of primary caregivers of children using these ECD centres reported that using the centres freed up 1–2 days per week; 19.7 per cent reported saving 2–3 days per week; and 14.0 per cent reported saving 3–4 days per week. 100 per cent of men with children in these ECD centres reported increasing their time on unpaid care responsibilities.[60] Parents reported that this redistribution of unpaid care work from families to the community enabled them to increase income-generation activities, such as farming, small businesses and formal work.

Social protection

In Senegal, the programme reported enabling 9,000 women to benefit from health coverage,[61] above the target of 3,000. Many of these women were accessing coverage for the first time. Women reported better health outcomes with being able to use the health facilities more regularly as a result of being enrolled in the health insurance.

Energy and labour-saving technologies

In Senegal, it was reported that 5,085 women received energy-saving stoves against a target of 5,000.[62] Women reported saving 1.5–2 hours a day using the stoves.[63] Two biochar units were installed to support more efficient and green energy[64]. Women's groups are being trained in their use. Women's cooperatives reported using the time savings and increased resources to create small maintenance funds for the equipment.

In Rwanda, it was reported that 2,537 women were using labour and time-saving technologies by 2024 against a target of 3,000, through 866 improved stoves and 30 rainwater harvesting tanks.[65] The 2025 impact assessment suggests that the technologies generated substantial time savings. On average, households using improved cooking stoves saved six hours overall per day, per household.[66] One participant reported that the equipment had reduced her cooking time by half. For rainwater tanks, 80 per cent of participants reported saving 1–2 hours per day in time spent collecting water; 15 per cent saved 2–3 days per week; and 5 per cent saved 3–4 days per week.[67] With the distribution of improved cooking equipment that reduced smoke, men and boys reported being more willing to take part in cooking.[68] The assessment also links improved stoves to reduced fuel use, smoke exposure and carbon emissions; and rainwater tanks to reduced erosion, better

[56] Partner report, donor report
[57] PFPC December 2025 report
[58] Partner report, government interview
[59] Agreed to participant listing, and random sample consulted
[60] Muraya, A. M. (2025). Impact assessment of time-and energy saving equipment and technologies (TESET) provided to households' and women's cooperatives in Rwanda for the implementation of 3R programme. Simple random sampling used, total of 271 ECD respondents.
[61] Agreed to participant listing, and random sample consulted.
[62] Agreed to participant listing, and random sample consulted.
[63] Enda Energie report, participant interviews
[64] Biochar represents an alternative energy source that reduces pressure on forest resources and lowers greenhouse gas emissions
[65] Partner report, agreed to participant listing and random sample conducted
[66] Muraya, A. M. (2025). Impact assessment of time-and energy saving equipment and technologies (TESET) provided to households' and women's cooperatives in Rwanda for the implementation of 3R programme. Simple random sampling, sample size of 310.
[67] Muraya, A. M. (2025). Impact assessment of time-and energy saving equipment and technologies (TESET) provided to households' and women's cooperatives in Rwanda for the implementation of 3R programme. Simple random sampling. Sample size of 112.
[68] Evaluation interviews

water access, improved hygiene and wider environmental conservation benefits.[69] Participants reported reduced expenses on firewood and water.[70]

Evidence is more limited on whether these changes generated broader care-sector employment or women-led care enterprises at scale. The strongest evidence points instead to modest support for women's economic activities, early women-led entrepreneurship around improved stoves and biochar, and improved conditions for some childcare and maternal-health services, rather than to a significant expansion of care-sector employment for diverse jobseekers. In Senegal, private-sector development was most apparent in energy-related supply and finance partnerships with women's organizations, and some participants also reporting direct income gains, including from selling water to neighbours using programme-supported tanks. In Rwanda, employment effects were visible on a small scale through the supported ECD centres, where some caregivers moved from volunteer roles into paid positions. The programme also appears to have contributed to small-scale women's entrepreneurship, as some women used time savings and access to community savings groups to start or expand activities such as selling firewood, agricultural produce, water, sewing services and animal feed, and rearing livestock.[71] There is opportunity to strengthen this by incorporating economic empowerment components to future programming.

The programme contributed by convening and financing delivery through existing systems and stakeholders, rather than creating parallel systems. In Senegal, it worked through Regional Development Agencies, communes, the health insurance provider, local childcare structures and technology provider Enda to support childcare, health-insurance enrolment, and improved stoves and biochar. It also was reported that income-generating training was provided to 341 participants and agricultural equipment to support market gardening.[72] In Rwanda, the programme financed construction and equipping of ECD centres, training of caregivers and parents on the importance of ECD, and purchase and distribution of energy and labour-saving technologies, including energy saving stoves and water tanks. Partners worked with the health insurer to promote a gender-responsive insurance model designed to better reflect women's specific needs linked to unpaid care responsibilities (including care-related shocks within the household) through mechanisms such as a carer's allowance intended to support caregiving responsibilities.[73]

Other contributory factors included the use of existing public and community structures, such as government healthcare centres, maternity centres and health insurance systems; local government commitment and support; and participant financial contributions to health insurance, which helped reinforce uptake and build ownership.[74] Barriers affecting outcomes included administrative problems in the health-insurance scheme, including delayed and blocked cards and limited post-enrolment follow-up. While a committee was set up to monitor enrolment, collect complaints and follow up on implementation, participants reported that there were still issues with using cards despite contributions, and the need for better explanation of the health insurance procedures. Retention was a clear constraint, with reported drop-out after initial enrolment limiting continuity and reducing the durability of results. There were also challenges with the design and maintenance of energy and labour-saving technologies. In Rwanda some users reported that the one-hob stove design did not fully fit local cooking practices, affecting practicality and use. Challenges with maintenance and finding replacement parts also affected the sustainability of the stoves.[75] Finally, the assumption that childcare centres would be sustainable, with caregivers able to access adequate training and materials, was only partly met. While caregivers were reported to be properly trained, continuity remained vulnerable where there was turnover of trained staff. Childcare centres also reported issues with administrative management and sufficient funding to maintain equipment and infrastructure.

[69] Muraya, A. M. (2025). Impact assessment of time-and energy saving equipment and technologies (TESET) provided to households' and women's cooperatives in Rwanda for the implementation of 3R programme

[70] One participant estimated they used to spend 7,000 Rwandan francs per day on firewood, but this has reduced to 1,200 Rwandan Francs.

[71] Interviews with programme participants

[72] Partner report

[73] Partner report, interview with health insurance agency

[74] Partner report, interviews with health insurance officials, local authorities and women's groups

[75] Interviews with participants

There was moderate evidence that women's cooperatives and local actors were better equipped to understand unpaid care issues, support more equitable care practices, and use care services and financing mechanisms. Across both countries, there was limited evidence that women's groups provided care, but stronger evidence that they acted as intermediaries to support uptake, while also contributing to gradual shifts in community understanding and social norms around care responsibilities.

In Senegal, women's cooperatives self-organized to establish small maintenance and revolving funds to help sustain the use of care services and resources, including through organization into a federation of women stove sellers.[76] Community dialogues and related outreach appear to have helped make unpaid care more discussable as a shared household and public responsibility.[77] Participants noted that these discussions contributed to greater acceptance that men can participate in childcare and domestic tasks, as well as increased discussion within households about sharing responsibilities. In the South, stakeholders participating in training and community dialogue reported improved relations within couples and a more balanced distribution of domestic responsibilities.[78] Interviews with government and partners also suggested that religious and traditional leaders were supportive of the programme and helped reinforce its messages through existing community meetings and events, including weddings and discussions with young couples.

In Rwanda, participants reported that at the start of the programme, they did not understand the 3Rs and viewed unpaid care as non-productive work that belonged to women. In evaluation interviews, participants demonstrated recognition that unpaid care is disproportionately delivered by women, which affects their ability to participate in the labour market. Participants also reported practical changes in care behaviour, which they attributed to the programme's awareness campaigns, training and communication materials, which encouraged them to question the traditional division of domestic tasks. Some men were reported to have begun cooking, washing clothes, taking children to and from ECD centres and schools, and helping with homework. However, not all interviewees were convinced about the need to redistribute care responsibilities more equitably. Community members who had not benefitted from improved cooking equipment were reported to be less enthusiastic, suggesting that behavioural change was often linked to practical improvements in working conditions as much as to shifts in attitudes. In line with UN Women's social norms framework, partners also emphasized that changing social norms is a gradual process and considered sustained community engagement to be more effective than media broadcasting alone.

The programme contributed by linking service and resource delivery to awareness-raising, the organization of women's groups and community structures, and activities targeting norm change.

In Senegal, this included practical support to women's groups on how to enrol in and use health insurance, through meetings on the insurance plan and eligibility criteria, workshops to share agreements and training on the registration software used for enrolment. Partners designated agents to support women's groups through the enrolment process by mobilizing interest, collecting contributions and arranging registration with health-insurance agents.[79] The programme also reported engaging 70 religious and traditional leaders, 278 local leaders, 9 community dialogues reaching 348 participants and 15 discussion groups.[80] The programme established a partnership with Crédit Mutuel du Sénégal to facilitate women's access to credit for acquisition of improved stoves, and women's groups were organized into a federation of women sellers of improved cookstoves.

In Rwanda, the programme trained ECD caregivers, parents and community members on nutrition, home gardens, hygiene and child health; delivered community-awareness campaigns on positive parenting; integrated messaging on the unequal distribution of unpaid care responsibilities into the distribution of labour and energy-saving technologies; and distributed information, education and communication materials, including flyers in schools on unpaid care issues. Awareness campaigns were prepared in partnership with local leaders, and involved interactive sessions and games, attracting a broad mix of community members,

[76] Interviews with partners, women's cooperative members, partner reports

[77] Interviews and focus groups with partners, and men and women participants

[78] Interviews with partners and women cooperatives, one stakeholder gave an example of a husband who built a wall to secure the family's sheep so that his wife no longer needed to go outside at night, allowing her more rest.

[79] Interviews with partners, health insurer and participants; partner reports

[80] International Day of Care communication material, PFPC December 2025 report, Senegal donor report 2024, interviews and focus groups with participants

including youth, children and men. This was undertaken in partnership with stakeholders working on the menEngage initiative. These inputs in Rwanda and Senegal were intended to strengthen understanding of unpaid care, support uptake of ECD services and labour-saving technologies, and encourage more equal sharing of care responsibilities within households and communities.

Other factors also contributed to this outcome. The active engagement of local leaders, communities and some women's networks, and the community trust built through these partnerships, strengthened the relevance of care services and resources, and supported uptake.[81] In Rwanda, synergies with the National Strategy on Engaging Men for Gender Equality, helped reinforce local discussion of unpaid care and support uptake of services and technologies.

Barriers remained in addressing the social norms that underpin women's disproportionate responsibility for unpaid care work, particularly at household and community levels, even where awareness had improved. In Rwanda, social norms continued to limit equitable sharing of unpaid care responsibilities. Some interviewed parents demonstrated limited acceptance of more equitable gender roles and reported preventing sons from carrying out tasks traditionally done by daughters. The same pattern was observed in some schools, where girls were expected to carry out most "domestic" duties, such as lunch preparation. Women still have unequal access to land and property, despite the existence of a number of conducive laws and policies. In Senegal, evidence of increased male participation is promising but remains mainly qualitative, and partner reporting still points to the need for wider engagement of fathers, men, schools and communities. In Rwanda, redistribution of care was still partial: in some urban, middle and upper-income households, unpaid care is being transferred to domestic workers, leaving the gendered distribution and undervaluation of care largely unchanged. These findings suggest that, while the programme contributed to awareness-raising and some behavioural shifts, deeper social norms change requires sustained effort, material support and wider engagement across actors in the care diamond over a longer time frame.

A further constraint was limited fiscal space and mixed engagement with women's cooperatives. Municipalities showed willingness to integrate care into planning, but financing commitments remained limited, highlighting the need for local dedicated budget lines and stronger national financing pathways. In Rwanda, UN Women is supporting the government in building this investment case, including through estimating the costs and returns of investing in care. At the same time, implementation in Rwanda worked more through individual women and households than women's organizations, which may affect the sustainability of outcomes. Unlike in Senegal, participants did not establish collective maintenance mechanisms, and they reported challenges with maintaining equipment.

Unintended and spillover effects were more visible in women's community standing and wider household well-being than in formal leadership positions. In Senegal, women's groups supported through the programme were described as engaging more actively in local dialogue, budget discussions and programme governance.[82] The improved stove and biochar streams opened early entrepreneurship pathways through the federation of women stove sellers, community production units and links to credit, with 14 women engaged in producing and selling of biochar. In Rwanda[83], women reported that reduced time spent on unpaid domestic work and improved access to water increased their visibility and participation in public life, as they were more present, better integrated and seen as contributing to community well-being, including by providing water to neighbours. According to these accounts, this helped build trust among community members and local leaders, who increasingly invited women to take on community leadership roles. Spillovers also extended beyond direct participants: neighbouring households reportedly used ECD centres and rainwater tanks; families reported reduced conflict and stronger cohesion; older children were released from chores and attended school more regularly; and reduced smoke exposure and better water access contributed to improved health, hygiene and nutrition.[84]

[81] Partner reports, participant interviews

[82] Interviews with partners and government

[83] Partner programme reports and interviews with participants.

[84] Interviews with participants, 2025 impact assessment

OUTCOME 3:

National governments and relevant ministries (ex: sectoral and finance) scale up investments in care service provision.

FINDING 6

The programme helped strengthen the positioning of care as a public investment issue and improved UN Women's and wider UN capacity to support governments on care financing and policy reform. Its contribution was strongest in agenda setting, training, tools and technical support, which supported policy, planning and some emerging budget commitments. However, translation into sustained public investment depended on wider country-level factors, including fiscal space, political commitment, engagement of key ministries and continued follow-up support beyond the programme.

TABLE 6

Outcome 3A – Government and intergovernmental stakeholders scale up investments in care services

Evidence of outcome	Programme's contribution	Contribution of other factors
Strong evidence of increased government and institutional commitment to and financing of care through policy reforms, planning instruments, emerging budget allocations and regional/ global political commitments that create an enabling environment for investment.	**Moderate evidence.** The programme developed and piloted training curricula and financing tools, provided technical support, and helped set agendas. However, outcomes were also co-produced through UN Women support (funded through other sources) and Member State leadership.	Other key contributory factors included fiscal and political space, multi-stakeholder commitment and alignment to national plans.

There was evidence of the outcome being achieved. UN Women's technical support has supported the adoption of key resolutions and frameworks that increasingly position care as an investment priority, shaping national investment commitments. Personnel funded by the programme provided technical support to missions and acted as secretariat to drive forward key resolutions, ensuring the resolution texts retained transformative language on care society, shifting from care as a cost to care as an investment with potential socio-economic returns, and outlining the core principle of state accountability (see Box 5 below for examples). Negotiations reflected differing views on the respective roles of families and the state in care provision. Intergovernmental and governmental bodies considered the final resolutions important for setting a systems-approach agenda to care and supporting subsequent reform efforts by building interest and momentum for domestic reforms. For example, the launch of UN Women's tool for modelling alternative financing mechanisms at the financing for development conference secured several Member States' interest in its application.[85] These developments also strengthen prospects for continuity beyond the programme period (see Finding 9).

BOX 5

Examples of global commitments supported by UN Women

- UN General Assembly Resolution (A/RES/77/317) establishing the International Day of Care and Support on 29 October.
- Human Rights Council Resolution (A/HRC/RES/54/6) affirming the centrality of care and support.
- Economic and Social Council Resolution (E/RES/2024/4) promoting care systems for social development.
- Incorporation of a pledge to scale up investment in care systems in the Pact for the Future.
- Compromiso de Sevilla secured Member States' commitments to financing care, recognizing and redistributing unpaid care work.
- G20 Rio de Janeiro Leaders' Declaration committed to promoting gender equality in paid and unpaid care work.
- Steered the development of the agreed CSW conclusions on care, including the setting of care as the priority theme for CSW 72 in 2028.
- The landmark UN resolution, "The Care Economy and its Contribution to Sustainable

[85] UN Women interviews

UN Women's support to regional bodies through training, convening and technical support also led to growing traction for care as an investment agenda, partly funded by the programme.[86] A three-day training course for the African Development Bank led to development of a draft road map for expanding the Bank's work in the care economy. Stakeholders at the International West-Africa Symposium of Care and Women's Economic Empowerment adopted the Declaration to Recognize, Reduce and Redistribute Unpaid Care Work in October 2025. UN Women's Women Count experience on supporting Time-Use Surveys has shaped continental discussions through the United Nations Economic Commission for Africa.[87] Support to the ECOWAS commission part-funded by the programme led to development of a task force and action plan to support Member States to develop national road maps and to mobilize funding. UN Women has also worked with the United Nations Economic and Social Commission for Western Asia to develop a regional care agenda road map.[88] Following participation in training, the South Asian Association for Regional Cooperation has expressed interest in further exchange, drawing on the experiences of the Association of Southeast Asian Nations and Latin America. UN Women's advocacy work at the 2025 G20 resulted in the outcome document committing to scaling investment in care infrastructure. Through the G20, the African Union also engaged UN Women, with interest in establishing the African Continental Wide Roadmap on Care.[89] These developments were supported by wider donor engagement in multilateral processes, such as Germany's role in the G7, G20, Generation Equality and the Global Alliance for Care, which helped sustain normative and political momentum on care.

National and subnational examples indicate that care is increasingly being embedded in policy, planning and financing processes, with some early evidence of public investment scale-up as a result of UN Women Country, Regional and global office support.[90] This includes national care policies and planning frameworks (Kenya); expansion of care-supportive infrastructure and local budgeting through action plans and by-laws (Tanzania); reforms linked to labour protections and care workers' rights (South Africa); municipal budget allocations for care services (Kathmandu Metropolitan City); and a broader set of legal and policy measures related to childcare, family-friendly policies and care-related labour standards across the Europe and Central Asia and West Africa regions (including parental leave reforms, care road maps and care committees) (see Annex 11 for further detail). UN Women's contribution was typically multi-faceted, generating momentum and interest through 3R-funded training, tools and knowledge products, and sustained Country Office advocacy and technical support to apply these approaches.

The 3R Programme also supported strengthening the capacity and commitment of national stakeholders, (important precursors to scaling-up investments) through training, technical support and tools that broadened how decision makers understand care and equipped them to identify entry points. For example, training participants in Indonesia reported that the training helped broaden their understanding of care, from being focused on caring for children, older persons or people with disabilities towards a wider care systems and public investment agenda, leading to them commissioning a mapping of care infrastructure. A donor noted the UN Women-led UN system policy paper provided conceptual framing for its programming. In Selangor (Malaysia), participants highlighted that the programme helped them to understand the importance of care as a public good and the importance of quantifying women's time use and the social and economic returns on care investment. In India, this capacity strengthening fed into continued policy dialogue on a comprehensive National Care Policy and implementation road map; while in Viet Nam, government and private-sector participants of UN Women-supported care training reported that it had improved their understanding of the investment case and policy tools, contributing to incorporation of care into the country's Population Law. Following its participation in training, Fiji expressed interest in further strengthening care capacity for Pacific Island member states.[91]

[86] As set out in Finding 1, the programme funds some of the core positions with the global team, and part funds the East and Southern Africa Regional Office care economy analyst.

[87] Interviews with UN Women global, Regional and Country Office personnel; East and Southern Africa Regional Office Strategic Note evaluation.

[88] Interviews with UN Women personnel and review of workshop report

[89] Interviews with UN Women personnel, G20 outcome document

[90] As set out in Finding 1, the programme funds some of the core positions with the global team, and part funds the East and Southern Africa Regional Office care economy analyst.

[91] Interviews with training participants and UN Women; programme survey results.

The programme contributed to the target outcome through developing and piloting a standard training curriculum, delivered with a range of stakeholders, including civil society, national and local government stakeholders, development banks, UN partners and intergovernmental bodies, across all regions. The curriculum was widely perceived as high quality and relevant, with concrete examples and suggested actions, providing a foundation for country and regional teams to engage governments and partners with greater effectiveness and coherence. For example, government stakeholders in Tanzania attributed participation in the training as to leading to more policy discussion and greater appreciation of care's contribution to the economy. Strong participation selection of those already interested and engaged with UN Women on care was also noted as contributing to translation into implementation. At the same time, multiple stakeholders stressed that training is an entry point: translation into government decisions required contextual adaptation, sustained accompaniment and further support, particularly on financing and operationalizing tools.

The programme contributed through agenda setting and advocacy, including through sharing good practice from the programme. For example, evidence and good practice from Senegal were used to engage ECOWAS in developing a regional action plan on care. Programme-funded global personnel supported the coordination of advocacy efforts and provided technical support to Member States on sponsoring and negotiating global resolutions, building on partnerships developed through the Global Alliance for Care[92] to build political engagement and commitment. In Kenya, external stakeholders attributed the adoption of the national care policy in part to UN Women's strong convening across civil society and government stakeholders.[93]

Finally, the programme contributed through developing tools, including estimating the costs and returns of investing in care and financing for gender equality. These were developed with strong participation from internal and external stakeholders, contributing to their broad relevance. Regional and Country Office stakeholders noted that the tools were particularly valuable in securing government interest by linking care investments to decent job creation and helping facilitate budgeting and policy commitments by providing concrete data to guide decision-making.

Overall, the programme's contribution to the target outcome has been rated as moderate, reflecting the programme's catalytic and enabling role rather than weak results, as outcomes were co-produced through broader UN Women programing, wider political and fiscal conditions and Member State leadership.

Photo: UN Women

[92] Where UN Women serves as secretariat, co-launched by UN Women and the Government of Mexico at the Generation Equality Forum (2021), the Global Alliance for Care, a global multi-partner network, reframed care as a global policy priority and right, rallying governments, multilaterals, civil society and the private sector behind reforms, financing and commitments. UN Women leverages the Alliance to propel legal and policy change and share evidence through a growing knowledge platform.

[93] Funded by the Gates Foundation

Progress under Outcome 3 was mediated by other contributory factors, consistent with the three assumptions set out in the theory of change, along with an additional enabling condition. Where these assumptions were met, they supported the achievement of outcomes:

1. **Fiscal space exists for care investments (Assumption 1).** Fiscal constraints were frequently cited by government stakeholders as a key factor shaping whether commitment translated into budget allocations and service expansion. Governments requested more support on financing and costing, and greater coverage on these topics in the training curriculum.
2. **Gender backlash and political environment do not hinder investments (Assumption 2).** Political context influenced the pace and timing of reform. Where high-level commitment was present, this created space for care-related reforms and investment discussions. For example, South Africa prioritized care as one of the topics for the G20, building on Phase 1 of the programme's consultation and assessment on unpaid care work. Conversely, election dynamics in Senegal in 2024, and changes from the Ministry of Women, the Family and Child Protection to the Ministry of Family and Solidarity influenced national priorities and limited space for national policy reform. Country Offices reported that gender backlash and differing culture and values around empowerment affected norms change programming.
3. **Sufficient capacity to integrate care considerations (Assumption 3).** Internal and external stakeholders emphasized that tools and training were most effective when paired with targeted UN Women technical assistance to strengthen capacity especially at sub-national levels, particularly for complex costing/financing work and when embedded in multi-year partnerships with UN Women that build continuity and capability. Capacity needs were often most acute at local and sub-national levels.
4. **Engagement of key ministries and multi-stakeholder ecosystems (additional enabling condition).** Progress was stronger where ministries of finance/economy and planning actors, with the commitment and authority to take investments forward, were substantively engaged, and where broader coalitions (government, CSOs, unions, private sector, UN partners) were in place.[94] For example, Kenya successfully adopted a national care policy, building on strong engagement across government, CSOs, unions, the private sector and UN partners. Stakeholders pointed out that this requires deliberate selection of government and other stakeholders to support, and benefits from leveraging existing relationships with ministries and stakeholders. Country Office stakeholders also spoke about the importance of using existing national priorities, workplans and financing processes as entry points.

TABLE 7

Outcome 3B – UN capacity to support national stakeholders to finance care investments strengthened

Evidence of outcome	Programme's contribution	Contribution of other factors
Strong evidence, UN stakeholders reported stronger coordination on care systems. UN Women offices reported strengthened capacity to support governments and partners on financing care investments.	**Strong evidence** through capacity-building via training and community of practice, technical support, peer exchange and development of tools and frameworks.	Other resources for Country Offices to provide ongoing support to governments, and ongoing technical support to UN Women personnel.

There was evidence of strengthened UN coordination on care systems. UN Women led the development of the UN System Policy Paper on Transforming Care Systems with UNDP, ILO, OHCHR and ECLAC, which provides a system-wide framework and standard for supporting care systems as a cross-sectoral agenda [95]and informed the ILO resolution (June 2024) that urges policies and standards that place care systems at the centre of decent work, gender equality and social development. UN agencies attributed stronger coordination across the UN on care systems in part to UN Women's leadership, especially through its leadership of the inter-agency working group on the care economy.[96] The programme-funded positions of the 3R Coordinator and Policy Specialist led this work.

[94] Aligning with the UN System Policy Paper that sets out that transforming care systems is a structural and cross-sectoral agenda requiring sustained political will and multi-ministry alignment.

[95] Mandated by the Deputy Secretary-General

[96] As part of the Inter-Agency Network on Women and Gender Equality

There was also evidence of UN Women offices being better equipped to support governments on financing and policy work through the support received as part of the programme. Country Offices reported that Global and Regional Office training based on the curriculum developed under the programme was relevant, practical and useful.[97]

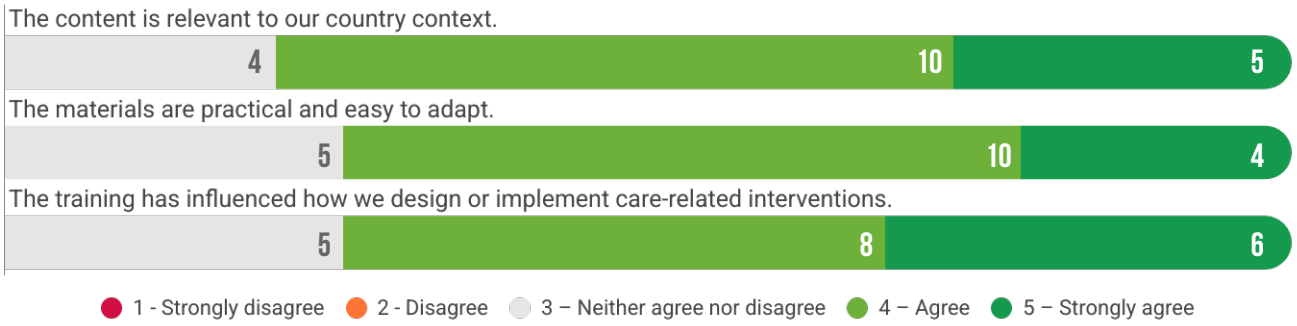
Combined with ongoing technical support, frameworks and tools funded by the programme, this strengthened offices' confidence and provided them with conceptual clarity and technical capacity to engage governments more credibly, including issues such as the application of costing tools, national assessments, policy dialogue and evidence-based programme design.[98,99] In some cases, it also enabled Country Offices to train external stakeholders[100] and convene multisectoral round tables to support national policy processes.

The programme contributed to strengthened UN Women and UN system capacity by providing a coherent package ofstandardized learning products, tools and technical backstopping. It funded the development and roll-out of the core training curriculum across three regions[101] and supported the development of key tools and knowledge products[102] based on Country Office demand, which helped operationalize the care agenda and identify entry points. Country Offices appreciated the common framework and tools to improve messaging consistency and facilitate programme development. This was complemented by the overall coordination of the global team, Global and Regional Office technical support and peer exchange through the community of practice, which provided offices with a repository of evidence-based good practice and the practical know-how for how to advise governments to adapt tools.[103] Regional Office technical support was also noted as key to supporting the South Africa Country Office to engage on the G20, positioning care as a key priority in the outcome document.

Resource constraints shaped the extent of support capacity. Even with stronger skills and tools, offices' ability to provide sustained support to government depended on the availability of funding. Country Offices appreciated the seed funding provided by Global and Regional Offices (some through the 3R Programme) to fund pilot initiatives.

FIGURE 7

Survey responses on training materials



Source: evaluation survey of training participants, n= 19

[97] The training was piloted in Rwanda with 45 UN Women personnel, including related areas of work such as labour market policies and social protection.

[98] Country office interviews and survey responses

[99] Examples of uptake from Country Offices included: the design and pilot of care and support services; the design of stakeholder training; and specifically, the UN System Policy Paper on Transforming Care Systems as a reference guide for policy dialogue, recommendations and diagnostics. For example, in Panama, the Country Office supported care diagnostics and the development of local care system proposals that reflect a rights-based, gender-sensitive and intersectoral approach.

[100] Examples of using the materials in other contexts include private-sector engagement in Georgia and Training of Trainers in the Western Balkans.

[101] Eastern and Southern Africa, Europe and Central Asia, Asia-Pacific and planned in the Arab States.

[102] Engendering Fiscal Space: A Policy Framework for Financing Gender Equality (UN Women, 2025). Tool on financing for gender equality (costing) fiscal and monetary policiesEngendering Fiscal Space: External Debt, Concessional Finance and Special Drawing Rights (UN Women, 2025) Debt and gender perspective
Engendering Fiscal Space: Modelling Alternative Methods of Financing Investments for Gender Equality (UN Women, 2025).
"what works to address care inequalities and transform care systems and key evidence gaps", the "UN Women-ILO Costing tool", the "UN System Policy Paper on Transforming Care Systems", and the "TransformCare Baseline Study";

[103] For example, what is needed to build buy-in, what data persuades governments, sequencing and operational details.

FINDING 7

Across programme components, effectiveness depended on whether technical support, advocacy and coordination were anchored in clear institutional entry points and national priorities, linked to cross-portfolio integration, sustained follow-up and peer learning, and supported by learning-oriented piloting and monitoring. Where these elements came together, interest and commitments were more likely to translate into concrete implementation, wider uptake and a stronger evidence base; where they did not, progress more often remained at the level of awareness, commitment or isolated pilots.Internal capacity development

Internal capacity development was a clear strength in Phase 2, with a standardized, co-designed curriculum and guidance strengthening shared understanding and coherence across regions. Its influence was strongest where offices could build on this foundation through ongoing mentoring and peer exchange (e.g. the *Community of Practice*) and where materials were further adapted, translated and packaged for practical use. Opportunities for improvement include enhancing usability/translation, regularizing peer learning and strengthening dissemination and institutionalization pathways beyond already-engaged stakeholders.

The 3R Phase 1 evaluation recommended standardizing capacity development, extending duration and improving sequencing, which became an area of strength in Phase 2. A standardized training curriculum developed based on learning from the 3R programming experience and co-designed between Global, Regional and Country Offices was delivered across regions and countries, effectively strengthening internal and external capacity (see Finding 6).

Regional and Country Offices nonetheless identified priority areas to strengthen, including expanding content on private-sector engagement, financing mechanisms, decent work/standards in paid care, alternatives to time-use surveys and care infrastructure, alongside regionally emerging themes (e.g. caring cities, AI and care); developing e-learning and adding videos; translating and simplifying of "jargon"; making materials publicly available; and developing a pool of vetted trainers to support scale.

Regional and Country Office personnel noted the training was a strong foundation, but emphasized its impact depended on supporting country-level operationalization through follow-on mentoring, practical guidance, country-adapted tools and continued cross-country learning, particularly in countries where personnel turnover is high. Regional and Country Office personnel shared many examples where the combination of training and ongoing technical support from global and regional offices (for example through regional *Communities of Practice*) enabled impactful national programming. Regional and Country Offices also suggested practical guidance on how to embed the curriculum into existing government, academic and UN Women training processes to support institutionalization and greater impact.

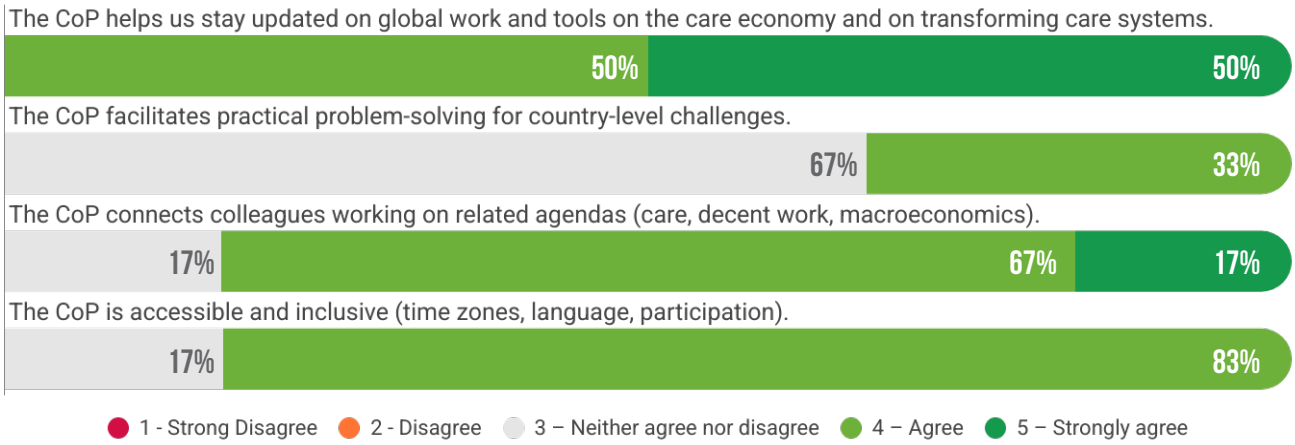
Packaging and usability of materials emerged as a key enabler of uptake. Country Office interviewees and survey respondents called for a global package of simplified advocacy materials in multiple languages, such as talking points, policy briefs and infographics that can be left with government counterparts after training or policy dialogues, supported by strong models of national care systems. Respondents cited external examples of well-packaged toolkits, such as ILO's "care systems package" that bundles Return on Investment style framing with policy options and curated good practice, which is a useful benchmark.

Beyond training, Country Offices highlighted the value of an emerging standard programming framework and guidance on care systems: comprehensive and evidence-based global frameworks and tools[104] supported programme design, resource mobilization and results reporting while allowing contextual adaptation, enabling offices to focus more on innovation and experimentation. Regional teams then played a key role in follow-up with Country Offices, including through peer-learning mechanisms. Country and Regional Offices also valued the cross-thematic strategy notes.[105]

The Community of Practice and related peer-learning mechanisms were valued as a way to sustain learning after training and support practical adaptation of tools. Respondents most valued the *Community of Practice* for connecting them to colleagues working on related agendas and providing updates on global work, finding thematic webinars and peer-to-peer exchanges most useful (see Figures 8 and 9 below).

FIGURE 8

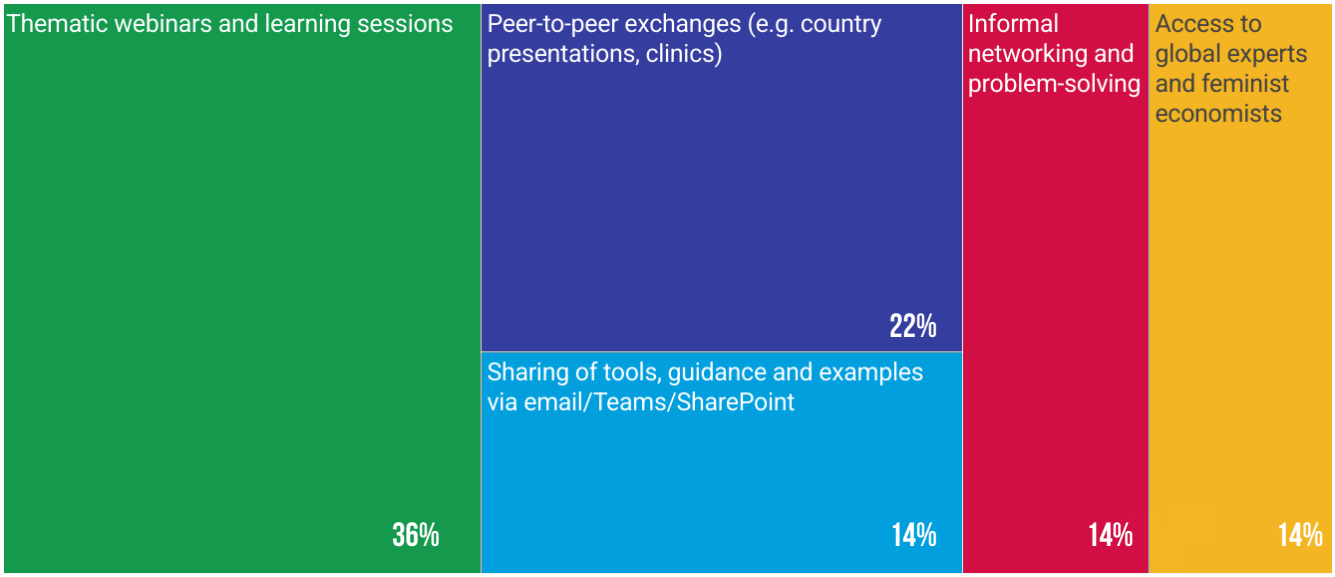
Survey responses on the Community of Practice



Source: evaluation survey of training participants, n = 6

FIGURE 9

Survey responses on Community of Practice activities



Source: evaluation survey of training participants, n = 6

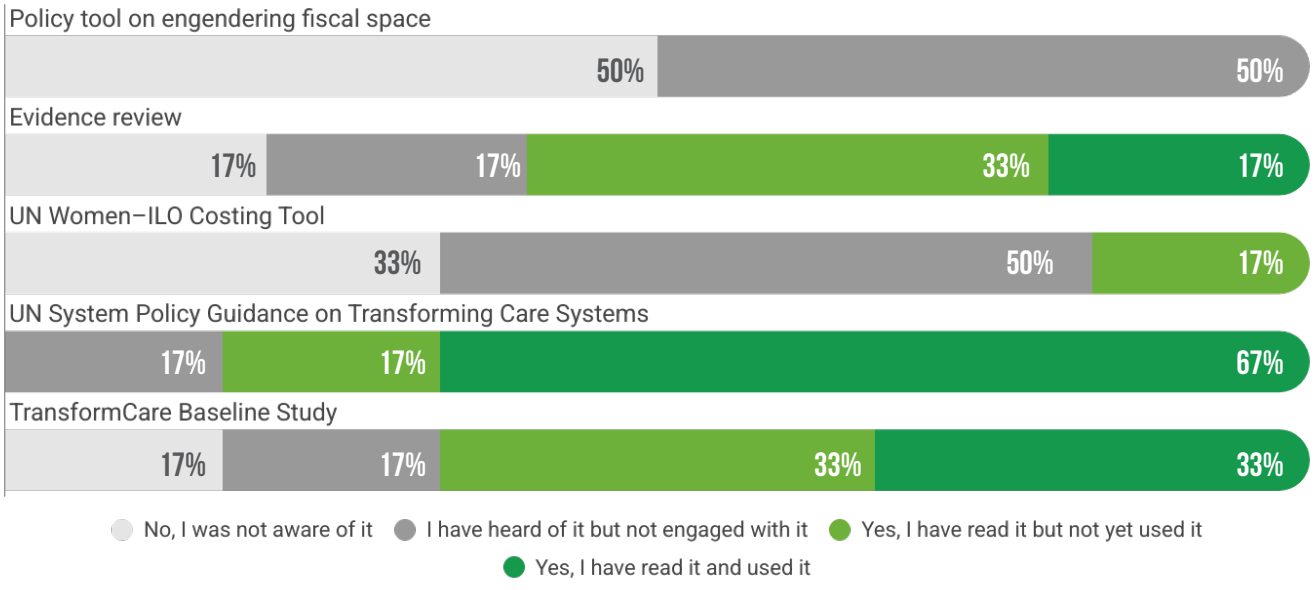
[104] Tools that integrated policy reform, service delivery, financing strategies and social norms change.

[105] Care & conflict and forthcoming care & climate.

However, respondents noted that the Community of Practice's usefulness depended on consistent convening and responsiveness to participants' needs. Regular, topical sessions supported momentum and peer troubleshooting, while periods of less regular engagement reduced participation and perceived relevance. Suggested improvements included focusing on translation support; predictable scheduling and accessibility across time zones; and thematic breakouts/sub-groups to enable more targeted and timely exchange (e.g. financing/costing, childcare, eldercare, community-based models, conflict settings). Respondents also emphasized sustaining a safe learning space, recognizing differing experience levels and the need for refresher training, rather than relying on one-off training. The recent member survey and move towards regular quarterly meetings is expected to strengthen the *Community of Practice*.

In response to a recommendation from the Phase 1 evaluation, knowledge generation and dissemination practices are also becoming more strategic. Regional learning platforms (such as the Asia Pacific learning week) provided a structured dissemination mechanism. Knowledge products, such as the recent care and conflict guidance, were developed collaboratively with partners, including women's organizations. Plans are under way to strengthen product planning and dissemination to align to key events and needs; strengthen partner engagement and develop more defined target audiences; and improve monitoring of reach and uptake (downloads, mentions and evidence of influence on national laws and policies). Survey respondents noted the highest level of familiarity and use were on the UN System Policy Paper, TransformCare Baseline Study and Evidence Review, and the UN Women–ILO costing tool. Familiarity with the engendering fiscal space tools was lower, reflecting their more recent release. External respondents cautioned that dissemination can be concentrated among stakeholders already engaged on care and called for stronger outreach, supported by more robust regional and national convening, to engage less-convinced audiences.

FIGURE 10
Survey responses on knowledge products



Source: evaluation survey of community of practice, n = 6

External capacity development and implementation

External capacity development was most likely to translate into implementation when UN Women combined tailored engagement of strategically selected stakeholders with follow-up support, advocacy linked to national priorities and practical support on financing and implementation.

Strategic selection of participants and follow-up support were key enablers of training effectiveness. Feedback from internal and external stakeholders on the quality of the training materials was strong. One development partner highlighted that the material effectively translated evidence into policy-relevant learning through concrete examples and actions, leading to the partner deciding to fund UN Women to deliver additional training. UN Women personnel noted the importance of tailoring the materials based on the requirements of the specific groups targeted.

Internal and external stakeholders emphasized that traction depends on who is trained, highlighting the importance of engaging others beyond gender machineries, such as the ministries of finance and planning and parliamentarians, who can commit funding, and senior leaders and civil servants who can sustain reforms across political cycles. For example, Rwanda training and workshop participants were mainly directors of planning and good governance, and planning and monitoring and evaluation officers at district and province levels. More limited engagement of decision makers such as chief budget managers and mayors was identified as a constraint, as these actors hold authority over priority and budget setting.[106] UN Women personnel highlighted the value of prioritizing stakeholders already engaged with UN Women to facilitate follow-up. Stakeholders also highlighted the importance of investing in structured follow-up technical support for national-level stakeholders to implement, and the value of aligning capacity development with national priorities and existing partnerships.

Country evidence from both Rwanda and Senegal points to the importance of working through existing structures and institutions. In Rwanda, stakeholders reported that involving local leaders, opinion influencers, community organizations and CSOs across programme stages helped strengthen acceptance, participation, targeting and cohesion among participants; while close communication and follow-up with partners helped keep activities on track and sustain engagement. In Senegal, the programme anchored its activities through existing systems, including local planning processes, health insurance structures, local authorities and organized women's networks, rather than creating parallel mechanisms.[107] In both Rwanda and Senegal, integration of care into development plans was an important milestone, but implementation depended on budget allocation, operational follow-through and monitoring, highlighting the need for inclusion of these components in future programming.

Building on evaluation recommendations from Phase 1, Phase 2 invested in strengthening the business case for care-system reforms, including updating the UN Women–ILO costing tool and launching the engendering fiscal space framework and associated guidance. Stakeholders acknowledged that advocacy work has resulted in interest and commitment, but there remains high demand for practical support on resourcing, through investment cases, costing, fiscal space analysis and budget integration, and stressed that ministries of finance/planning and other powerful institutions must be engaged. Costing tools, fiscal space approaches and modelling were cited as influential. Country Offices noted the value of tailored, technical assistance to support governments to apply such tools to develop investment cases to unlock investment.

[106] Interviews with government stakeholders
[107] Partner reports, government interviews

Phase 2 also responded to Phase 1 evaluation recommendations to strengthen the shift from 3R to 5R[108] framing, through training, advocacy, communications and media engagement. Interview and survey feedback with UN Women personnel consistently highlighted the 5R approach as important for connecting unpaid and paid care, decent work and representation, and for reinforcing the feminist economics narrative underpinning TransformCare. Most interviewed training participants also demonstrated understanding of the 5Rs, though some local government stakeholders still expressed greater familiarity with the 3R framework. Nonetheless, programming also demonstrated broadening to the 5Rs. For example, in Senegal, programme delivery combined gender-responsive budgeting and gender-transformative approaches in training with local diagnostics and pilots on childcare, social protection and labour-saving technologies.[109] Country Offices also noted that country resonance varies: in some contexts the original 3Rs remain the most intuitive entry point given the under-developed formal care sector, while aspects such as representation or paid-care labour rights are seen as the domain of ILO and worker organizations.

Engagement with the private sector showed mixed progress across contexts, consistent with another Phase 1 evaluation recommendation. In Senegal, the improved stove workstream tested a market-based model: Enda established a partnership with Crédit Mutuel du Sénégal to facilitate women's access to credit for acquiring improved stoves; while the women's community groups were organized into a federation of women sellers of improved cookstoves.[110] In Rwanda, private-sector engagement remained largely at steering committee level, with limited evidence of substantive partnership. There have also been some promising developments in other countries in terms of private-sector collaboration.[111]

Globally, the new TransformCare framework has an output to partner with the private sector. The team has already started to map opportunities, including through UN Women's existing Women's Empowerment Principles which includes supporting employers on family-friendly policies[112] and decent work provisions, and to support tax reforms that expand the national fiscal space for care. Nonetheless, internal and external stakeholders cautioned against defaulting to private-sector-led financing or service provision models that can undermine affordability and quality, and the need to maintain guardrails that keep care framed as a public good. The UN System Policy Paper advocates for a model with the state as the primary duty bearer responsible for care provision that guarantees the human rights of providers and receivers of care.

Advocacy was most effective in building traction when anchored in context-relevant entry points. Regional and Country Office personnel described the importance of tailoring the framing to political priorities, such as family, entrepreneurship and EU accession agendas, depending on the country context. Entry points also include existing national and regional normative frameworks.[113] Stakeholders noted that focusing on gender machineries limits influence given constrained budgets; and that broader engagement across ministries and UN agencies (including building on existing partnerships) was the most effective approach to building ownership and scale.

[108] 5R = Recognize, Reduce, Redistribute, Reward and Represent

[109] Interviews with health insurance officials, local authorities, women's groups and implementing partners

[110] Interview with Enda Energie

[111] For example, in Vietnam, partnerships with the private sector strengthened care service delivery. Internal and external stakeholders highlighted the importance of working with the private sector, in particular on strengthening labour rights for domestic workers. The G20 summit in South Africa ignited interest from private-sector entities on investing in care infrastructure and from development banks in financing these projects. The South Africa Country Office is taking these conversations forward.

[112] Such as paid parental leave, flexible hours and childcare support

[113] For example, UN Women effectively aligned the care systems agenda to social protection (Cote d'Ivoire); youth dividend and climate (Mali); and care entrepreneurship (Nigeria).

A key lesson was that care-systems programming was most persuasive when it translated care systems beyond sensitization into something concrete for local institutions, such as energy and labour-saving technologies, childcare support and health insurance enrolment, linked to local development plans. However, it is also critical to ensure all interventions are explicitly linked to changes in women's time use, care responsibilities and labour-market opportunities. The current support to ECD centres was not always sufficiently aligned with care objectives, which also made it difficult to track contributions to care outcomes.[114]

Finally, engagement with women's movements and civil society was widely seen as important for legitimacy and transformative change, but not always systematically embedded. External and internal interviewees noted that engagement has sometimes been opportunistic, with barriers for grassroots organizations to access convening spaces. A key lesson is to design more deliberate pathways for women's movements and CSOs within implementation strategies, both across normative and operational delivery. Senegal provides a strong example of what this can look like in practice. Women's networks were not recipients but key to implementation, serving to strengthen the legitimacy and accountability of programme activities and to support institutionalization.[115] Evidence from Rwanda similarly highlighted the value of involving local organizations and CSOs throughout implementation, which stakeholders linked to stronger acceptance, more relevant targeting and better prospects for sustainability.

Social norms programming

Country-level evidence suggests that norms-focused approaches worked best where they were embedded in existing community structures and linked to practical care issues, rather than delivered as stand-alone awareness activities. In Rwanda, this meant working through established family and community forums and leveraging the work of other CSOs, such as RWAMREC. In Senegal, local dialogues were most useful where they connected social norms work to concrete commune-level concerns. While these approaches appear to have generated awareness and dialogue, this was strongest at the household level. Evidence of their contribution to sustained institutional or policy change was less evident.[116] [117].

UN system coordination and UN Women positioning for uptake and scale

Stakeholders emphasized that effective coordination on care systems programming is critical to strengthen policy coherence, reduce duplication and scale efforts, and highlighted this as a core part of UN Women's value proposition. Internal and external stakeholders valued UN Women's role in aligning global, regional and national partners' priorities, including through convening mechanisms such as the inter-agency working group on care[118] and the Global Alliance on Care, coordinating joint advocacy around the International Day of Care and World Social Summit, supporting global normative processes (CSW, the UN System Policy Paper on Transforming Care Systems and global resolutions). UN agencies noted that collaboration has strengthened, in part due to UN Women's key convening role.

[114] Partner reports, ARD impact brief.

[115] Interviews with government and women's networks

[116] Including through the East and Southern Africa Regional Office partnership with Farm Radio International that worked with media outlets to generate broad listener engagement across the region

[117] Interviews with REFAN women's groups, PFPC/FAFs members and partner agencies

[118] As part of the inter-agency network on women's empowerment and gender equality

Global offices support to Country Offices on the Global Accelerator on Jobs and Social Protection, including application technicalities, timing, priorities and sector focus was repeatedly cited as critical for UN Women positioning.[119] Stakeholders noted that positioning for inclusion in the Global Accelerator at the country level can be politically and technically complex, requiring early engagement in relevant UN Country Team working groups, proactive framing of complementarity and sufficient capacity to meaningfully engage. Many Country Offices cited challenges around fragmented implementation, competition for resources, blurred mandates and lack of engagement during key decision-making points.

UN Women's comparative advantage in care systems programming was highlighted as its gender-transformative approach across the life course. Internal and external stakeholders highlighted expertise on the UN Women–ILO costing tool to meet government demand, and experience in community-level programming and engagement with the informal sector as entry points where UN Women can offer a distinctive contribution.

Several regional and country office respondents pointed to some challenges in collaboration with other agencies at operational level. Examples included perceived overlap with ILO and limited visibility at country level of how global engagement translated into UN-wide coordinated messaging and division of labour; requests to endorse UN-led initiatives (e.g. an Africa Care Index) without meaningful engagement in their development; and experiences in some joint initiatives (e.g. care and disability programming) where UN Women's contributions were subsumed under that of other agencies in consolidated reporting.

Regional and Country Office stakeholders therefore advocated for Global team to play a stronger role in advocating and positioning UN Women among other agencies and in supporting translation of global agreements into country-level practice. They emphasized the need for clearer articulation of UN Women's operational and programming focus, particularly on paid care and social protection, where roles are more contested than on unpaid care; and for collaboration models that prioritize complementarity building on respective value-add. At the same time, stakeholders recognized that joint programming can work where governance and roles are clear, citing Türkiye as an example where UN Women leads development of a UN joint programme on the care economy with UNICEF, UNFPA, ILO and UNDP, positioning care as a strategic sector in national development.[120] Additionally, UN Women's work on care at global level was initiated through the UN Women-ILO joint programme.

Integration of care across UN Women portfolios was consistently identified as central for political traction, stronger institutional anchoring, positioning, resourcing and scale. The 3R Phase 1 evaluation recommended integrating care systems programming across the Women's Economic Empowerment portfolio and related areas. Country evidence in Rwanda and Senegal points to concrete complementarities, rather than systematic mainstreaming of care across the wider portfolio.[121] Respondents emphasized that strengthening linkages to adjacent agendas can expand entry points beyond unpaid care and social protection, sustain political relevance and diversify funding opportunities. For example, personnel at the West and Central Africa Regional Office noted that the care systems-green economy nexus has generated significant interest and supported resource mobilization.

[119] For example, Nepal was cited as an example where UN Women supported the government application process and then secured funding for catalytic activities (e.g. provincial consultations and engagement with women workers), strengthening gender elements in the national road map. Uzbekistan is leading on a component on entrepreneurship and the care economy.

[120] UN Women. (2025, November). Mapping of trends and opportunities in care work in Europe and Central Asia [PDF]. UN Women Europe and Central Asia. https://eca.unwomen.org/sites/default/files/2025-11/caremapping.pdf

[121] In Rwanda, the 3R programme was delivered alongside other Women's Economic Empowerment programmes in the same communities, linking unpaid care, livelihoods and agriculture; partnerships with the Rwanda Men's Resource Centre, CARE International and ActionAid also connected social norms work, positive parenting and labour-saving technologies.In Senegal, the programme built on existing Women's Economic Empowerment and agriculture platforms, including REFAN and PFPC/FAFS, linking care to livelihoods, community mobilization, social protection and broader policy processes, including the Global Accelerator and emerging national care-related frameworks.

The regional evaluation similarly found that other thematic programming was contributing to care outcomes, although these links were not systematically tracked. This suggests that more deliberate mainstreaming of care across non-care and non-Women's Economic Empowerment programming could extend reach and strengthen results.

A consistent lesson from Regional and Country Offices was the need for more explicit global guidance on how to make these linkages systematic,[122] including articulation of how other UN Women programming frameworks contribute to TransformCare indicators, so that individual offices do not have to design these connections and holistic programmes from scratch. Stakeholders pointed to the mainstreaming of Ending Violence Against Women across programming as a practical benchmark for how care could be more deliberately integrated. The corporate narrative already positions care within "care and planet/just transition" framing.

Box 6 below sets out other examples of cross-thematic synergies.

Photo: UN Women

BOX 6

Examples of cross-thematic synergies

- In Asia and the Pacific, care programming has been linked to climate entrepreneurship and caring cities, using gender data and geospatial mapping to inform municipal care investments, including in informal settlements.
- Mozambique, Kenya and Tanzania are implementing a joint UN Partnership on the Rights of Persons with Disabilities project on care and disability.
- In Mali, UN Women supported a municipality to integrate care, climate and green economy priorities into its local development plan.
- In Tanzania, care systems programming has been linked to social protection, women's leadership and climate-related clean cooking initiatives.
- Under the Global Accelerator on Jobs and Social Protection, several countries are advancing care-related programming; for example, Nepal is leading provincial consultations to inform a national care road map.
- In East and Southern Africa, regional care landscape reports have informed programme design and resource mobilization across thematic areas, including Women, Peace and Security, Ending Violence Against Women and Humanitarian Action.
- In Ethiopia, support to domestic workers, migrants and returnees has linked care evidence to migration policy reform through the Making Migration Safe programme.

Sources: Country Office interviews, programme evaluations and

[122] For example, by systematically identifying linkages, and packaging different programming outputs, such as care and statistics, care and ending violence against women.

Piloting, learning and monitoring

Pilots were more useful for identifying promising approaches for further testing than in generating a strong comparative evidence base on the effectiveness and sustainability of pilots. Across Rwanda and Senegal, largely qualitative and testimony-based evidence suggested that pilots could reduce the time and energy required for unpaid domestic work; improve access to services; and, in some cases, create more space for income generation or political participation. Some components, including the Senegal improved stoves stream and the Rwanda energy and labour-saving technologies pilot, made efforts to monitor reductions in time required for unpaid domestic work. However, methodological limitations constrained the strength of evidence. In Rwanda, the impact assessment lacked a baseline and periodic follow-up, relied on participants' recall to estimate time saved, and did not systematically track how those gains were reallocated. These efforts were not underpinned by a consistently applied learning and measurement framework for tracking outcomes across pilot streams. This reduced the programme's ability to assess which models produced the most durable care gains, and under what conditions.

Monitoring and learning remain areas for strengthening, especially for the global and regional components. Given the critical role of the global function in supporting all UN Women programming, and the many sources funding the global and regional functions, the boundaries of Outcome 3[123] were not always sufficiently clear to distinguish programme-specific activities and results from broader UN Women care systems programming. The contribution of Global and Regional Office support to Country Office programming was not systematically tracked. Additionally, there were no outcome indicators, which limited systematic tracking of uptake and the influence of tools, training, expert group meetings and normative activity. Going forward, to complement the number of stakeholders trained, UN Women could seek to document evidence of trainees applying this to national policies, budgets or services. The lack of defined impact metrics, such as reduction or redistribution of unpaid care hours, affected the available evidence base for advocacy. Finally, stronger contribution tracking is needed to distinguish UN Women's contribution from broader contextual drivers and to strengthen the evidence base for resource mobilization and decisions on follow-up support. For example, to complement tracking of the national care policies adopted, UN Women could also document the percentage that cite UN Women products, and other contributions to these processes. Given the availability of funding and human resources for additional monitoring beyond corporate indicators, a feasible approach may be to invest selectively, prioritizing measuring impact metrics and tracking UN Women's contribution in prioritized cases.

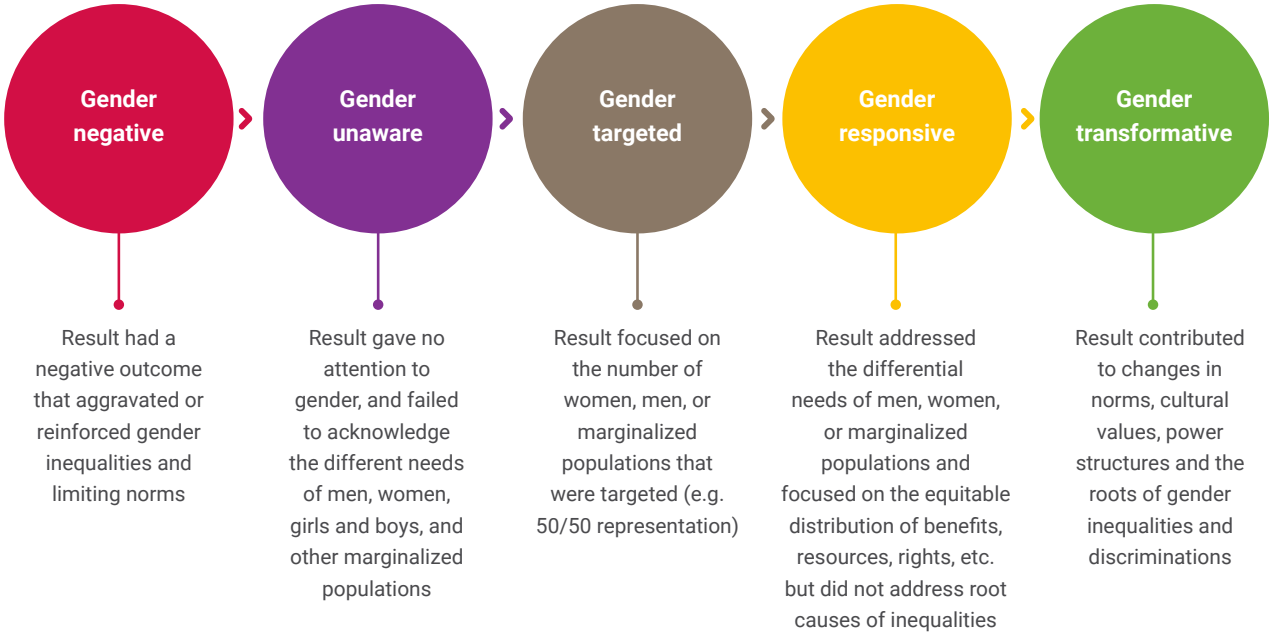
Photo: UN Women

[123] Covering global and regional components

How effectively were gender equality principles integrated into the programme?

FINDING 8

The programme's design and implementation sought to address structural barriers that constrain women's agency and opportunities, linking care systems to women's labour-market participation, access to services and need for public policy action. However, the evidence on gender-transformative results is mixed across programme components and countries. The programme's reach to vulnerable populations has strengthened in Phase 2, although systematic targeting and disaggregated monitoring still remains limited.



Source: UNDP Independent Evaluation Office Gender Results Effectiveness Scale

The programme was gender-transformative in design and implementation, but evidence of gender-transformative results was mixed across components and countries. The undervaluing and unequal distribution of care and domestic work is positioned as a root cause of gender inequality and poverty. The programme seeks to not only support women as participants, but to reshape care systems, norms and institutions that contribute to gender inequality. Training and materials developed under the programme take a feminist-lens to understanding the economy. The Senegal and Rwanda components seek to strengthen care systems by using a holistic model, working across local planning and budgeting, social protection, energy and labour-saving technologies, childcare-related systems and awareness-raising to change attitudes around gendered household roles. Both components went beyond simple targeting of women as participants.

There was also evidence of gender-transformative results; however, given the time frame of the programme, evidence remains stronger on outputs and intermediate outcomes than on transformative change in strengthened care systems or redistribution of unpaid care at scale. As discussed in Finding 5, there was some evidence of positive change in household distribution of care responsibilities and some improvements around care and care-supporting services linked to health insurance, ECD centres and energy and labour-technologies. However, overall results were uneven, with stronger evidence on agenda-setting, policy traction and selected household or community-level changes than on sustained inclusion outcomes across different groups of women or at wider scale.

Phase 2 strengthened its reach to vulnerable populations, including people with disabilities, responding to a Phase 1 evaluation recommendation. Globally, the TransformCare project doc highlights how comprehensive care systems should address differential needs and apply a life-course and intersectional lens. For example, Tanzania's Women's Leadership and Economic Rights programme focused on intersecting vulnerabilities by engaging sub-groups, including youth, local traditional leaders, entrepreneurs and savings groups. While the Rwanda and Senegal components focused on childcare, global and regional support to Country Offices made concerted efforts to expand into elder and disability care, such as through support to the UN Partnership on the Rights of Persons with Disability. Country Offices also called for stronger incorporation of disability inclusion. UN Women Global Office is currently supporting the Global Alliance on Care to create a community of practice on care and disability, which is expected to develop concrete guidance to support implementation.

In Rwanda and Senegal, there was strong focus on rural women and people with disabilities. The Senegal component supported an early childhood centre working with children with disabilities, excluded from other centres, in Ziguinchor. Women caregivers reported greater time savings and ability to take on paid work as a result. The centre director pointed to the need for additional differentiated inputs, such as teaching and classroom materials, support for mothers and stronger incorporation of accessibility and inclusion considerations across all supported childcare centres.

The programme also targeted women's groups in underserved localities in Senegal[124]**,** and involved young people in social norms dialogues. Of the 5,459 cooperative members who were reported to have received clean cook stoves, it was reported that 19 per cent were between the ages of 18 and 35; and of those enrolling in the health insurance, 18 per cent were young women aged between 18 and 35, and 1 per cent were people with disabilities.[125]

In Rwanda, the programme involved cooperatives and women's groups to select recipients of energy and labour-saving technologies, with many groups prioritizing those most in need. Teams also worked with representatives from the association of women with disability to strengthen responsiveness and deliberately included people with disability among participants. Across Rwanda and Senegal, there was no deliberate targeting of elderly women. Some accessibility issues also surfaced. In Senegal, participants in rural areas reported delays and blocks in health insurance cards. Despite the programme supporting rural women's capacity on the use of digital products, limited digital literacy and infrastructure gaps nonetheless affected enrolment rates.

Across both countries, there is an opportunity to strengthen systematic targeting and disaggregated monitoring across all components. The programme did not specifically identify target populations, disaggregate across participant data and track inclusion metrics.

[124] Including underserved island populations, such as the Eloubalir island

[125] This can be compared to the reference point of 29 per cent young people (18-35) in the Senegal population overall: https://mastercardfdn.org/en/our-research/an-empirical-review-of-youth-employment-policies-in-senegal, and 8 per cent of the total population reporting one or more disabilities: https://www.disabilitydatainitiative.org/country-briefs/sn/

SCALABILITY AND SUSTAINABILITY

To what extent are core 3R components likely to be sustained beyond the project? Which programme components show evidence or likelihood of being maintained and financed after the project ends?

FINDING 9

Sustainability prospects are strongest where interventions have been incorporated into public systems, local planning processes, policy frameworks or institutional tools, and where there is evidence that government or partner structures can continue implementation after programme closure. By contrast, sustainability is more uncertain where continuation still relies on project-funded support; where implementation models remain insufficiently defined; or where financing, maintenance and market arrangements are not yet fully in place.At global and regional levels, the programme-funded materials and normative developments show promising signs of sustainability.

The care systems curriculum has already been used across UN Women and with external stakeholders, with more plans to do so. System guidance and fiscal policy tools have received positive feedback on their relevance beyond Rwanda and Senegal (see Finding 6). Sustainability is further supported through global normative developments (see Finding 6) and through continuation into the UN Women TransformCare programming framework. While these advances do not by themselves guarantee implementation, they signal commitment and create a policy and institutional framework to support implementation.

At country level, sustainability prospects are strongest where 3R components are already linked to public institutions with defined responsibilities for financing, delivery, coordination or oversight, providing continuity even during changes in government or priorities. In Senegal, this was most evident in the public health insurance component, which was implemented through the existing system and combined participant co-contribution; formalized collaboration with the responsible government department, REFAN women's groups and local authorities; and a multi-stakeholder follow-up committee with monthly monitoring.[126] Nonetheless, risks to sustainability remain. The implementing partner subsidizes annual contributions, and stakeholders reported challenges with retention and delays and blockages to membership cards. Continuation will depend on developing a post-programme model with the health insurance and women's networks, including clear arrangements for subsidy, contributions and routine monitoring.

In Rwanda, sustainability prospects are relatively stronger for the ECD component because the government has taken over operation of supported centres, including covering teacher salaries. However, there are challenges with infrastructure maintenance, with broken fences, playground equipment and toilets observed during evaluation field visits. The programme also sought to anchor sustainability by working through provincial and district authorities, particularly Directors of Planning and Budgeting, who were trained under the programme and remained linked through a platform for ongoing exchange on integrating unpaid care work into local planning. It generated evidence and analytical products to inform future action.

In Senegal, childcare sustainability is more uneven because the programme supported different service models with different prospects, e.g. government-run pre-schools in the north, locally managed crèches and daycare centres in the south and a community childcare

[126] Partner report, interview with government stakeholders

model linked to women's salt-extraction work. The government-run pre-schools appear the most sustainable because they are linked to existing public structures, although their continued functioning still depends on maintenance and operating resources. By contrast, the locally managed centres and the community childcare model are more directly responsive to women's unpaid-care constraints but are less secure because they depend more on community organization, volunteer or low-paid care labour, household contributions and continued support for training, management and administration. Local authorities and women's groups also suggested that stronger engagement with agencies responsible for early education and childcare administration would improve sustainability.

A second sustainability pathway is the integration of 3R priorities into local planning and governance processes. As discussed in Finding 4, this strengthened institutional anchoring and improved sustainability prospects. However, evidence remains stronger for inclusion in plans and budgeting processes than for financing, implementation and follow-through at scale. For example, in Senegal, the national multiparty committee intended to monitor implementation had not yet been finalized and the care road map still required review and updating. In Senegal, communes still need to generate local data to support planning and introduce dedicated budget lines. Partners and local government stakeholders suggested the need for UN Women to provide more follow-through support on planning, costing, implementing and monitoring. This was effective in Kenya, where the government not only adopted the care policy but also developed a costed plan.[127]

Sustainability is weaker where continuation depends on post-programme operating models, maintenance systems, or local financing and market arrangements that are not yet fully in place. This is particularly visible in the energy and labour-saving technologies in Senegal, a promising pilot that has not developed into a self-sustaining local market system. There are some encouraging signs: women participants reported setting up maintenance and renewal funds;[128] and participants described using contributions to fix equipment and acquire additional stoves. Stakeholders also reported the organization of women into a Federation of Women Sellers of Improved Cookstoves, alongside a partnership with Crédit Mutuel du Sénégal to facilitate access to credit.[129] However, these mechanisms remain incomplete. While participants valued the product quality and training on use and maintenance, unresolved sustainability constraints remained, including limited capital, transport barriers, insufficient quantities relative to demand, the need for additional training and post-training accompaniment, constrained management and maintenance capacities, unstable raw-material supply and continued dependence on partner support. Similarly, in Rwanda, participants have reported issues with the goods not being available in the local market. No arrangements have been made to build community ownership or maintenance capacities; a number of participants reported that instead of trying to replace damaged equipment, they intend to wait for UN Women to supply replacements in the next phase. The Senegal evidence also suggests that community sensitization remain important for continuity, as many women interviewed had lower digital literacy, limited exposure to mobile banking applications and greater reliance on oral communication and community networks than on digital tools. Across both countries, continuation will depend on whether these interventions move beyond pilots and develop into functioning local demand and supply, with maintenance and financing arrangements capable of supporting repair, replacement and wider uptake over time.

There is also some evidence that key activities are already continuing beyond the programme or are expected by stakeholders to continue. Continuation is visible in the new global initiative called TransformCare (Transforming Care Systems for people and the Planet) that is now a core area of the new UN Women Strategic Plan (2026-2029) and implemented across all regions; as well as ongoing use of programme tools and training materials both at global and regional levels (see also finding 2).

127 UN Women regional evaluation on the care economy. 2025.

128 Including one site where 33 women contributed annually for repairs

129 Focus groups with participants, Enda Energie

In Senegal, the clearest indication of continuation has been expressed by Swedish International Development Cooperation Agency to fund one of the programme's implementing partners to consolidate programme activities in 2026–2029. In the south of the country, a steering committee was formed between the regional development agency and women networks, which helped create coordination and local ownership and could support sustainability if maintained beyond the programme.

In Rwanda, the most sustainable results appear to be policy and institutional: the 2023 National Transformative Strategy Engaging Men and Boys for Gender Equality Promotion; dissemination of the revised family law adopted in 2024; and the use of gender-budgeting and care-sensitive planning practices in public institutions. There were also some concrete indications of continuation beyond the programme in Rwanda: government stakeholders at district, provincial and national levels, as well as partners such as ActionAid and the Rwandan Organisation of Women with Disabilities, expressed interest in expanding interventions to additional communities if resources could be mobilized, and several CSOs involved across phases, including the Rwanda Men's Resource Centre and Help a Child, were described as continuing to work on unpaid care-related issues beyond the 3R Programme itself.

Overall, the programme partially addressed the previous evaluation's recommendation to strengthen sustainability and exit strategies. Phase 2 shows more attention to institutional embedding, continuity into TransformCare and some follow-on support, but the evidence still points to uneven post-programme arrangements. Policy development, local planning, training materials and guidance, and other institutionalized approaches provide the strongest evidence for sustainability. Childcare and energy and labour-saving technologies are promising pilots, but require clearer models for scaling, maintenance and financing, and more deliberate transfer of ownership to institutions, communities and markets. This broader pattern was also reflected elsewhere in the portfolio. In South Africa and the West and Central Africa Regional Office, stakeholders similarly noted that momentum was difficult to sustain once dedicated resources ended; some pilots could not be carried forward; and replication depended on the availability of follow-on funding.

Photo: UN Women

How best can UN Women leverage the 3R Programme to contribute to TransformCare and future programming? Which innovations were most effective?

FINDING 10

The 3R Programme provides a strong foundation for TransformCare and future care programming, not because the pilots are ready for replication, but because it demonstrated the value of integrated multi-country programming that links global normative and technical assets, regional support and convening, and country-level testing, policy uptake and institutional anchoring.

The 3R Programme's value for TransformCare lies in showing what is most useful to carry forward at global level, what warrants deeper follow-through in Rwanda and Senegal, and what remains less mature. This points to 3R not as a portfolio to be replicated wholesale, but as a foundation for a more selective, systems-oriented TransformCare model.

At global level, 3R's strongest contribution lies not only in the assets it generated to support a more comprehensive approach to care through the 6R approach[130], but in the multilevel model it helped test. The programme combined global tools, policy and normative work; regional technical support and convening; and country implementation in ways that were mutually reinforcing. It also generated a set of upstream assets that are directly relevant to TransformCare, including the care systems curriculum; evidence and analytical tools; the UN Women–ILO costing tool and engendering fiscal space package; and advocacy and normative products. This is consistent with TransformCare's emphasis on common tools, knowledge platforms, south-south exchange and a strong global policy, programme and learning function, which reinforces the report's earlier findings on coherence, catalytic design and capacity strengthening (see Findings 1–3 and Finding 6).

3R also showed the value of multi-country and multi-level programming as a delivery model in its own right. The evaluation found that Phase 2's architecture allowed global normative work, tools and curriculum, regional support and convening, and country implementation to reinforce one another. The strengthened regional support model was particularly important in helping contextualize global tools, sustain follow-up and support uptake beyond the initial countries. For TransformCare, this is relevant less as a fixed model to reproduce than as evidence that care programming is stronger where policy, programme and learning functions are deliberately connected across levels.

The programme also generated partnership entry points and institutional experience that remain relevant to TransformCare. At the foundational level, this included inter-agency collaboration around care policy and guidance with entities such as ILO, UNDP, OHCHR, UNICEF and UNRISD, alongside UN Women's wider role in the inter-agency care architecture and the Global Alliance for Care. At regional and financing levels, it also helped build relationships relevant to Regional Economic Commissions and bodies such as ECOWAS and the African Union, international financial institutions and public development banks, civil-society and worker-linked actors, and financing partnerships for continued regional capacity building. The main contribution here was not a fully developed partnership architecture, but practical experience in linking global, regional and country engagement more strategically.

3R also strengthened inter-agency coordination and positioning assets that are relevant to TransformCare, particularly through UN Women's role in the UN inter-agency working group on care and the UN System Care Policy Paper. As Finding 7 showed, these helped strengthen coordination and joint working at global level; clarify agency roles; and, in some cases, sharpen

[130] These are: **Recognizing** unpaid and paid care work as skilled and essential work, as the basis for equal participation and treatment in society by guaranteeing the rights of people who receive or provide care, and by prioritizing care in policies, budgets and metrics of economic progress; **Redistributing** unpaid care work between households and the state, businesses and community, and between genders through quality and affordable care services – such as childcare, disability care, long-term care; and care policies – such as parental leave and carers' leave, flexible working, and social protection; Reducing energy-intensive unpaid domestic care work tasks through labour and energy-saving technologies and equipment; **Rewarding** paid care workers through decent work, social protection and fair wages, safe working environments, and training and certification; **Representing** the needs and rights of paid and unpaid caregivers and care receivers through social dialogue, freedom of association, right to organize, and collective bargaining; **Resourcing** comprehensive care systems, especially through public financing for care policies, care services and basic infrastructure, as well as standards and training.

UN Women's comparative advantage on care. The programme also funded a global position closely engaged in this work. At the same time, the value of these assets was weaker where global clarity on how UN agencies should work together on care systems did not translate into Resident Coordinator engagement, UN Country Team processes and clearer country-level collaboration, particularly where mandates overlapped or complementarity was not articulated at an early enough stage in the process. This makes the inter-agency dimension of 3R relevant not only as part of its normative legacy, but also as part of its practical value for future programming (see Finding 7).

At country level, the evaluation found that the strongest pathways were those with clearer institutional anchoring, financing logic and follow-through, rather than stand-alone pilots. In Rwanda and Senegal, the central question was less whether an intervention should be expanded in the abstract than whether its next step was consolidation within an existing public system, deeper budgeting and implementation or redesign before broader expansion. This is consistent with the report's earlier sustainability finding that continuation was strongest where interventions were embedded in public institutions, local planning processes, policy frameworks or institutional tools (see Finding 9 on sustainability and Annex 12 for discussion on the pilots).

In Senegal, the clearest examples were the CMU/REFAN pathway and the local planning and gender-responsive budgeting package. The CMU/REFAN model was particularly significant because it linked care-related constraints to an existing public social-protection mechanism through organized women's networks and a more credible route to continuity. The local planning package was also important, but its next step is different: deeper institutionalization through budgeting, implementation and follow-up, rather than replication of diagnostics alone. The childcare stream remains relevant, but the evaluation indicates that its service model, including delivery, quality and financing arrangements, was not yet sufficiently defined to treat it as a mature model for broader expansion. Senegal is therefore most useful to TransformCare as a learning example on social-protection linkage, local planning and childcare, rather than as a single model for replication.

In Rwanda, the strongest innovations were those that linked reductions in women's time poverty to wider policy and financing conversations. The clearest examples were the energy and labour-saving technologies, related time-saving effects and the emerging fiscal-space work. Their value lay not only in practical household-level gains, but in the way these gains supported a broader systems argument on care as an economic and public policy issue. Rwanda is therefore most useful to TransformCare as a learning example on linking service or technology gains to policy uptake, financing dialogue and institutional entry points, rather than as a single pilot model to reproduce.

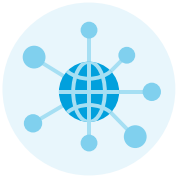
Taken together, Rwanda and Senegal are best understood as learning examples within TransformCare's wider portfolio, rather than as uniform models for replication. Senegal offers lessons on local planning, childcare and social-protection linkage; Rwanda on time-saving technologies, fiscal-space dialogue and linking unpaid care to wider economic policy debates. This is more consistent with TransformCare's global design, which relies on local adaptation, peer learning and exchange across contexts, than with any assumption that one country model should simply be rolled out elsewhere.

3R also opened a relevant pathway on paid care work, but this strand remained less developed and more contested than the programme's unpaid care, service and systems components. While TransformCare includes decent jobs in the purple economy, standards for paid caregivers and a social-norms outcome that treats care as valuable and skilled work, the 3R evidence is stronger on unpaid care reduction, social-protection linkage, local planning, service access and financing entry points than on paid care professionalization or private-sector engagement. The report also suggests that positioning and complementarity with other agencies were more difficult in this area, particularly where roles on paid care and social protection were less clear. Paid care therefore emerges from 3R as an important but still developing strand, rather than one where the programme had already demonstrated a mature model.

6. LESSONS LEARNED

This section provides general lessons learned for potential application to other contexts.

Linked to Findings 1, 2, 7 and 10



Linkages across global, regional and country levels strengthen uptake and influence.

The 3R experience identified that programming is more likely to achieve wider uptake when global normative and technical work, regional learning and partnership functions, and country-level implementation are designed as mutually reinforcing parts of one programme architecture. Country-level experience helped generate relevant tools, evidence and operational learning, while regional and global functions supported adaptation, dissemination, policy traction and exchange beyond the original implementation sites. In multilevel care programmes, explicit linkages between global, regional and country functions can strengthen adaptation, uptake and wider influence beyond the original implementation sites. Transfer depends on maintaining clear linkages across levels.

Linked to Findings 7, 9 and 10

Anchoring care innovations in existing policies and public systems is critical for sustainability and scale

Across the portfolio, the strongest innovations were those that combined tangible benefits for women with a clear institutional, policy or financing pathway. Interventions linked to public systems, local planning, budgeting or social protection offered more credible prospects for continuity and scale than stand-alone programme demonstrations. The wider lesson is that programming is more likely to be sustained and expanded where it is designed from the outset with a defined institutional home, clear ownership arrangements and a plausible route to implementation beyond the programme period.

Linked to Findings 6, 7, 9 and 10

Piloting should test pathways to scale, in addition to proof of concept.

The evaluation suggests that piloting can add most value where it is designed from the outset not simply to demonstrate promising activities, but to test which models are most viable for wider uptake under different institutional, ownership and financing conditions. In the 3R Programme, several pilots showed promise, but did not always define clearly enough what pathway to scale each pilot was testing, or generate sufficiently comparable evidence on the conditions under which different models were feasible, sustainable and transferable. This limited the programme's ability to draw firmer conclusions on which approaches were best suited for institutionalization or expansion. The broader lesson is that piloting can be more strategically delivered to test alternative models of delivery, ownership and financing – including, for example, the balance between public anchoring, community ownership, cost-sharing and partner support – and align monitoring to the scale questions that matter most, including feasibility, uptake, costs, institutional ownership, financing prospects and sustained benefits for women.

7. CONCLUSIONS

This section provides the evaluation's overall conclusions and are framed against the OECD-DAC criteria.

CONCLUSION 1

The programme was efficient and broadly coherent in using resources catalytically to generate influence beyond its direct footprint. However, this model also meant that results depended not only on what the programme delivered directly, but on whether other actors took up and sustained what it had helped to put in place.

The programme generated more than a set of country activities. Its added value lay in using a relatively small set of programme-funded roles and resources to leverage wider UN Women capacities, platforms, partnerships and complementary funding, and to turn country experience into tools, curriculum, policy work and advocacy assets that could be used beyond Rwanda and Senegal.

The programme was broadly coherent – with global, regional and country levels functioning as one reinforcing architecture rather than as separate streams. At the same time, because many results were realized through wider UN Women programming, government processes and partner action, the programme's catalytic contribution was not always fully visible in its own evidence base. This was especially the case where results were co-produced with other actors, some support was not fully documented, and monitoring was stronger on activities and immediate reach than on uptake, institutionalization and catalytic influence.

Efficiency and Coherence. Linked to Findings 1, 2, 3 and 10.

CONCLUSION 2

The programme was effective in building enabling conditions for stronger care systems and in generating tangible benefits for women, but only partially effective in converting these gains into deeper and more sustained change at scale.

The programme made a strong contribution to advancing care as a public policy, planning and financing issue. In several contexts, it delivered practical gains through childcare, labour and time-saving support, and links to social protection and local planning processes. Its strongest results were in opening policy pathways, strengthening capacities (across external and internal stakeholders), generating usable tools and producing service or technology-related benefits that mattered to women's daily lives. However, the evaluation evidence also indicates that the programme moved further on agenda-setting, intermediate outcomes and selected institutional pathways than on sustained public investment, durable redistribution of unpaid care across the care diamond[131] or expansion of promising models beyond the pilot stage. These latter shifts depended on broader political commitment, fiscal space, institutional ownership and follow-through that the programme could influence, but not determine.

Effectiveness. Linked to Findings 4–7.

[131] the four key institutions responsible for providing care are families/households, markets, the state, and the voluntary/community sector

CONCLUSION 3

The programme was gender-transformative in design and generated tangible benefits for women, but the depth of transformation was uneven across the portfolio.

The programme treated care as a structural gender equality issue rather than a service gap, using care-systems framing that recognizes care as a right and a policy, services, financing, infrastructure, governance and social norms issue. The programme generated evidence of women's improved access to care-supporting services and resources, thereby freeing up time for other income-generating activities, and some promising changes in household practices around care distribution. However, the depth of transformation was uneven. Evidence was stronger on reduction and recognition of unpaid care than on sustained redistribution across the care diamond, on systematic inclusion across all groups facing compounded disadvantage, and on a more developed paid care and labour-rights agenda. Future programming will need to connect material service gains, social norms change and paid-care pathways more deliberately if it is to achieve more consistent gender-transformative results.

Gender Equality, Human Rights and Effectiveness. Linked to Findings 5, 8 and 10.

CONCLUSION 4

The programme's sustainability prospects are mixed, but are strongest where interventions were institutionally anchored and where pilots were connected to a credible pathway to scale.

Interventions linked to public systems, local planning, budgeting or social protection offered more credible prospects for continuity and scale than those still reliant on programme-funded support or still lacking clarity on ownership, financing, maintenance or delivery arrangements. Sustainability depended not only on whether an intervention is valued, but on whether it has a sufficiently defined institutional home and a clear model for continuation and scale.

Sustainability and Scalability: Linked to Findings 6–7, 9–10

CONCLUSION 5

The main strategic value of 3R for TransformCare lies not in replicating the portfolio wholesale, but in showing which assets and pathways are ready for institutionalization and scale, which require redesign and which should remain exploratory.

The evaluation evidence indicates that 3R should be understood as a strong foundation for TransformCare rather than as a model to be reproduced in full. Its most valuable legacy lies in the upstream assets and relationships it helped consolidate across global, regional and country levels: training and capacity-development materials, evidence and analytical tools, financing and fiscal-space work, normative and advocacy products, and partnership infrastructure that can be deployed across countries.

At the same time, the evaluation evidence suggests that not all streams are equally mature. Some are ready for follow-through; others need sharper design choices on delivery, ownership, financing and the specific model of scale being tested. This requires deliberation on what to scale, what to adapt and what remains at demonstration stage.

Scalability and Sustainability. Linked to Findings 9–10.

Photo: UN Women

8. RECOMMENDATIONS

Discussion of the preliminary findings with the programme team on 19 February 2026, alongside the wider body of evaluation evidence and validation during the evaluation process, informed the recommendations below. The 3R Programme was pioneering in UN Women's care-systems work, and the recommendations are intended as forward-looking guidance for TransformCare, reflecting both implementation lessons and the significant evolution of the care-systems agenda over the life of the programme.

RECOMMENDATION 1:

Strengthen monitoring systems
Continue strengthening tracking of Global, Regional and Country Offices' contribution to target outcomes, uptake of knowledge products and time-use changes resulting from piloted interventions.

Based on Findings 2, 6 and 7

Priority:HIGH	**Timeline**:MEDIUM-TERM

Suggested steps to be taken:

- → Building on the TransformCare indicators, document Global, Regional and Country Office contributions to changes observed in outcomes. Set up routine data collection, e.g. via the Community of Practice or training follow-ups, to track outputs from Global and Regional Office support, such as uptake and replication.
- → Strengthen outcome measurement for pilots by undertaking pre- and post-surveys that measure time use for programme participants, rather than self-reported time saved; and track how saved time is reallocated across other care responsibilities, paid work, education, political participation, etc.
- → Implement proposed knowledge management strategy to strengthen the dissemination and uptake tracking of knowledge products.

To be led by:	**Rationale and impact:**
Policy Adviser, Macroeconomics and Global Lead on Care, with the support of the Care team and Data, Monitoring and Reporting Specialist	3R Phase 2 established a useful monitoring foundation through regular coordination, country and regional reporting, output tracking, and baseline and follow-up evidence that now supports TransformCare. However, monitoring remained stronger at activity and output level than in systematically capturing outcome-level change across the portfolio, uptake of knowledge products, comparable time-use effects across pilots, and the contribution of global, regional and country support. Building on this foundation would strengthen learning, advocacy and the evidence base for scale-up.

RECOMMENDATION 2:

Scaling and building sustainability
More deliberately plan for sustainability, institutionalization and supporting others to scale.

Based on Findings 7, 9 and 10

Priority:MEDIUM	**Timeline:**MEDIUM-TERM

Suggested steps to be taken:

- Design pilots with a clear transition, scale-up and sustainability plan from the outset, including exit arrangements, institutional ownership and realistic pathways for financing. Invest in advocacy and partnership-building to identify and engage government, civil society, UN agencies and private-sector
- actors that can take pilots to scale and institutionalize successful models (through policy, financing and delivery).
- Build sustainability considerations during programme design for energy and labour-saving technologies and infrastructure investment, such as maintenance, market supply of parts and ownership factors.
- Where care priorities are integrated into plans, structures and policies, support implementation through advocating for costing, budget allocation and operating arrangements and track whether they are included in budgets and operational plans. Support governments to explore alternative financing mechanisms to scale up care investments.
- Carefully engage the right mix government stakeholders, across both technical staff and decision makers, to support cross-ministry ownership, approval and implementation.
- Ensure a good balance across national and local-level implementation, and programming across normative, coordination and operational mandates, to maximize impact and scale, building on UN Women's comparative advantage

To be led by: Policy Adviser, Macroeconomics and Global Lead on Care, with the support of the Care team	**Rationale and impact:** Stakeholders agree that interventions need to be scaled to other geographies and ensure changes (e.g. around social norms on care and maintenance of energy and labour-saving technologies) are institutionalized to sustain gains. Pilots should be designed to be time-bound to demonstrate effectiveness and enable uptake. Strengthening plans for supporting institutionalization, sustainability and scaling would increase the reach and impact of UN Women's interventions.

RECOMMENDATION 3

Consolidate coordination across global, regional and national efforts
Institutionalize and further build on the strong approach to integrated programming (between global, regional and national efforts) in TransformCare.

Based on Findings 1, 2, 3, 4, 5, 6 and 10

Priority:MEDIUM	**Timeline:**MEDIUM-TERM

Suggested steps to be taken:

- Continue to ensure that funding raised and resources allocated are aligned with the respective roles of global, regional and country offices in delivering TransformCare, including adequate support for global coordination and technical functions alongside sustained regional capacity and engagement with regional bodies.Build on 3R good practices in TransformCare to better connect global normative work with regional and national normative processes and entry points, supporting the translation of global normative developments through regional policy platforms to drive national-level change, and ensuring country and regional priorities inform global processes.
- Continue leveraging and building on the Community of Practice to support linkages and knowledge-sharing across countries, and between global, regional and country programming.

To be led by: Policy Adviser, Macroeconomics and Global Lead on Care, with the support of the Care team and Regional leads on Care Systems	**Rationale and impact:** The 3R Programme has effectively incorporated global, regional and national components. TransformCare can build on this model by more clearly defining the interface between global, regional and country roles and ensuring resource-mobilization efforts are leveraged across global, regional, country levels, to accelerate pathways from global normative developments to regional policy shifts and tangible-level national change.

RECOMMENDATION 4

Strengthen UN Women's leadership role through TransformCare to advance systemic change in care.
As TransformCare scales as UN Women's core vehicle for care, the Entity must establish clear operational boundaries within the wider UN system. UN Women must deliberately map where it should lead, partner, or play a supporting role to better-placed agencies. Concurrently, internal links to related UN Women programming must be consolidated to ensure a coherent, system-wide approach to transforming care.

Based on Findings 7, 9 and 10

Priority:MEDIUM	**Timeline**:LONG-TERM

Suggested steps to be taken:

- As TransformCare is operationalized, explicate linkages with related UN Women interventions, both across Women's Economic Empowerment, including initiatives such as the Women's Empowerment Principles, social protection and private-sector engagement, and across other thematic and cross-thematic areas, such as social norms.
- Clarify UN Women's comparative advantage on transforming care systems and role within the wider UN system, including where the Entity should lead, where joint action with other agencies is required and how existing coordination mechanisms should be used to strengthen coherence and reduce duplication, for example in areas such as ECD and paid care work.
- Clarify TransformCare's approach to paid care work, private-sector engagement and professionalization, including the guardrails needed to ensure that care remains framed as a public good.
- Strengthen the theory of change to systematically include women's movements, beyond caregivers/care recipients, as key partners in changing norms, holding duty bearers accountable and contributing to follow-through.
- Expand the theory of change in terms of the links across the three outcomes, including the expected pathways from normative gains to financing decisions, service delivery and measures to enforce existing laws.
- Clarify how TransformCare-supported interventions are expected to contribute to reductions in women's time poverty, stronger labour market participation and expanded social protection coverage within a broader care systems approach. Where service delivery models are supported, such as childcare centres, their specific value added and links to the wider system should be made explicit. Further specify how leave no one behind considerations will be operationalized within TransformCare, for example, age and life cycle-related care responsibilities.

To be led by: Policy Adviser, Macroeconomics and Global Lead on Care, with the support of the Care team and in engagement with other relevant colleagues in the Global Office, leading on areas of work with synergies in care systems.	**Rationale and impact:** As early implementation lessons emerge, TransformCare's programmatic logic and positioning can be sharpened to increase coherence across UN Women's portfolio, improve influence within the wider UN system, and ensure UN Women's care leadership role is well understood and recognized. This is particularly important in areas where UN Women's contribution needs to be distinguished from more narrowly service-delivery-oriented support and where comparative advantage depends on linking services to the broader 6R-based care systems agenda, including financing, norms, policy reform and coordination. Coordinated actions would strengthen policy coherence and enable the scaling of promising models. Clearer linkages with other thematic areas would also support mainstreaming of care across programming and enable the capturing of care outcomes that are being advanced through related interventions outside TransformCare.

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As the lead United Nations entity on gender equality and secretariat of the UN Commission on the Status of Women, we shift laws, institutions, social norms and services to close the gender gap and build an equal world for all women and girls. Our partnerships with governments, women's movements and the private sector, coupled with our coordination of the broader United Nations, deliver lasting changes. We make strides in four areas: leadership, economic empowerment, freedom from violence, and peace, security and humanitarian action.

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