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Planning for the Trips Traditional Models Overlook: Gender, Caregiving, and Everyday Accessibility

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Abstract

Transportation planning has traditionally privileged the peak-period journey to paid employment. This orientation has shaped travel surveys, forecasting models, service schedules, investment appraisal, and accessibility metrics, even though much daily mobility consists of linked trips for childcare, education, food, health care, household maintenance, and support of dependent adults. Because women continue to perform a disproportionate share of unpaid care work, the analytical omission is gendered, but its consequences also affect children, older adults, people with disabilities, low-income households, and anyone traveling with dependents or carried goods. This article develops a Care-Centered Accessibility framework and applies it through a structured comparison of Delhi, Seattle, and Vienna. Delhi demonstrates how affordability initiatives can expand women's bus use while safety, fragmented services, restrictive social norms, and poor pedestrian access continue to constrain effective accessibility. Seattle illustrates the mismatch between complex suburban activity chains and a network whose strongest service is oriented toward major centers and conventional commute periods, while recent equity and mobility programs provide partial corrective mechanisms. Vienna shows how gender mainstreaming, dense mixed-use development, public transport, and attention to public space can institutionalize care-sensitive planning, although uneven household labor and peripheral accessibility remain unresolved. Across the cases, the analysis finds that the relevant unit of planning is not an isolated trip but a time-constrained sequence of activities undertaken with bodily, financial, and relational responsibilities. The article proposes measures for

temporal fit, chain reliability, accompaniment, safety, affordability, universal design, destination proximity, and participatory power. It concludes that transportation systems become equitable when they value the reproduction of everyday life as highly as the journey to formal employment.

Keywords: Gender and Transport, Mobility of Care, Trip Chaining, Accessibility, Caregiving, Transport Equity, Everyday Mobility.

1. Introduction

Transportation systems are commonly justified by their capacity to connect workers with jobs. Peak-hour traffic counts, home-based work trips, commuter rail demand, and travel-time savings to employment remain central to project appraisal. These measures capture an important part of urban mobility, but they do not describe the complete work of moving a household through the day. Taking a child to school, accompanying an older relative to a clinic, purchasing food, collecting medicine, visiting a public office, and returning home before another person requires care are not incidental detours. They are essential activities through which cities and economies function.

The mismatch between lived mobility and planning practice has a gendered structure. Women perform a disproportionate share of unpaid care and household labor in most societies. They are consequently more likely to make shorter and more frequent trips, travel outside conventional peaks, combine several purposes in one tour, accompany dependents, and rely on walking and public transport. These patterns vary by income, age, disability, race, caste, household composition, employment, and access to a vehicle. Gender is therefore not a simple binary variable added to a model. It is one dimension of a broader distribution of time, resources, risk, and responsibility (D'Agostino et al., 2024; International Transport Forum, 2018).

Traditional models can overlook these trips in several ways. Surveys may code a journey by its dominant purpose and obscure intermediate stops. Household models may assign time and vehicle access without representing bargaining or care obligations. Network evaluation may measure access from the home but not the feasibility of reaching several destinations within a school schedule. Transit planning may optimize frequent radial service while leaving circumferential, short, and off-peak trips slow. Cost-benefit analysis may value minutes saved during paid work travel more highly than time saved for unpaid care.

This article compares Delhi, Seattle, and Vienna to examine how different urban and institutional contexts recognize everyday accessibility. The cases are not presented as a ranking.

Delhi is a high-density metropolitan region where women's mobility is shaped by safety, informality, household norms, and unequal access to motorized travel. Seattle combines a strong central-city transit network with dispersed regional destinations, expensive housing, and care trips that frequently cross municipal and service boundaries. Vienna provides a mature public transport system and a long-running municipal commitment to gender mainstreaming in planning and public space.

The article asks four questions. First, how do conventional planning practices render care-related travel analytically marginal? Second, which features of transport and land-use systems determine whether complex daily activity chains are feasible? Third, how have Delhi, Seattle, and Vienna responded to gendered and care-related mobility needs? Fourth, which performance framework can make everyday accessibility visible in project selection and service planning? The central argument is that accessibility should be evaluated as the reliable completion of a linked activity chain under real constraints, not as a single origin-to-destination travel time.

2. From the Journey to Work to the Mobility of Care

The journey to work became a privileged planning category partly because it is regular, concentrated, and comparatively easy to observe. It also aligned with mid-twentieth-century priorities of highway capacity and central-city commuting. Feminist scholarship demonstrated that this apparently neutral focus reflected a particular social organization in which paid employment was treated as productive and household maintenance as secondary. The resulting models described the travel of a presumed unencumbered worker more effectively than the mobility of a caregiver coordinating several people's schedules (Hanson, 2010; Law, 1999).

The concept of mobility of care reframes household-supporting travel as infrastructure for social reproduction. Care mobility includes direct accompaniment, such as taking a child to school, and indirect provision, such as buying food or medicine. It can be unpaid or paid, routine or episodic, and undertaken by women, men, young people, or professional caregivers. Its gendered character arises from the unequal allocation of responsibility rather than from an essential difference in preference. Research on trip chaining

consistently finds that household composition and the presence of children intensify differences between women's and men's travel (McGuckin & Murakami, 1999).

Trip chains create distinct operational needs. A ten-minute delay can be more consequential when it causes a missed childcare pickup, medical appointment, or timed transfer. Travelers accompanying children may be unable to walk as far, transfer as quickly, or wait in an exposed location. Strollers, shopping bags, wheelchairs, and fatigue change the usability of vehicles and stations. A fare structure that is affordable for one direct journey may become expensive when several riders or multiple boardings are involved. The generalized cost of care travel therefore includes time, uncertainty, physical effort, emotional stress, and the risk imposed on dependents.

Time poverty is central. A destination can be geographically accessible yet functionally unreachable if its opening hours, service frequency, and travel time do not fit between fixed obligations. Conventional cumulative-opportunity measures often ask how many jobs can be reached within a threshold. A care-centered measure asks whether a traveler can leave home, deliver a child, reach work or another activity, purchase necessities, collect the child, and return safely within a defined time budget. The unit of analysis is the tour and the household schedule.

Safety also has an anticipatory effect. Harassment, poor lighting, isolated stops, dangerous crossings, and uncertainty about last-mile travel can cause people to avoid destinations, alter routes, pay for more expensive modes, refuse employment, or remain at home. Observed trips then understate suppressed demand. A low trip rate among women cannot automatically be interpreted as low mobility need. It may indicate constrained opportunity and adaptive avoidance (Ceccato & Loukaitou-Sideris, 2022; UN Women, 2013).

The literature consequently supports a shift from gender-disaggregated counts toward intersectional accessibility. Women are not a homogeneous group, and a policy that assists an employed middle-income traveler may not serve a low-income informal worker, a migrant caregiver, an older woman, or a person with a disability. Household resources, residential location, digital access, fare eligibility, cultural norms, and exposure to violence combine to shape effective mobility.

3. Care-Centered Accessibility Framework and Method

This study uses a structured qualitative comparison of planning documents, official programs, travel-behavior research, and peer-reviewed literature available through August 2026. Cases were selected for institutional contrast. Delhi represents rapid transit expansion and fare intervention in a setting of pronounced gendered constraints. Seattle represents a prosperous but spatially dispersed United States region in which transit equity increasingly informs policy. Vienna represents an established European model of gender mainstreaming, compact urbanism, and integrated public transport. The analytical unit is the daily activity chain. Table 1 presents eight dimensions: recognition of care purposes, temporal fit, chain connectivity, accompaniment and universal design, affordability, personal and traffic safety, destination proximity, and voice and accountability. The framework separates supply from capability. A bus route may exist, but a traveler lacks effective accessibility if service is too infrequent for a timed pickup, the transfer is unsafe with a child, or the combined fare is unaffordable. The method does not assign a composite score because travel data, gender categories, household structures, and institutional responsibilities are not directly comparable. It instead identifies mechanisms, policy strengths, and implementation gaps. Evidence about observed travel is interpreted cautiously because constrained travelers may make fewer trips than they need. The analysis therefore considers both realized mobility and the opportunities declined, delayed, or delegated because the transport system cannot support them.

Table 1. Care-Centered Accessibility analytical framework

Dimension	Core question	Illustrative measures
Care recognition	Are unpaid and paid care purposes visible?	Tour diaries, intermediate stops, accompaniment, suppressed trips
Temporal fit	Can activities be completed within fixed obligations?	All-day frequency, opening hours, schedule slack, missed deadlines
Chain connectivity	Does the complete sequence work reliably?	Transfers, circumferential links, chain completion probability
Accompaniment	Can travelers move with dependents and carried goods?	Level boarding, stroller and wheelchair space, elevators, seating
Affordability	Is the entire chain affordable to the household?	Transfer costs, accompanying fares, caps, backup-mode expense
Safety	Is every segment safe and perceived as safe?	Harassment, traffic danger, lighting, avoidance, reporting response
Destination proximity	Are essential services reachable together?	Childcare, schools, clinics, food, parks, affordable housing
Voice and accountability	Do affected travelers shape decisions and remedies?	Compensated participation, disaggregated reporting, assigned owner

Source: Author's synthesis of cited research and policy documents.

4. Delhi: Affordability, Safety, and Constrained Mobility

Delhi's extensive metro and bus systems provide access to employment, education, markets, and services across a large metropolitan region. Yet aggregate network scale does not ensure equal mobility. Women's travel is shaped by lower labor-force participation, unequal household responsibilities, lower access to private vehicles, concerns about harassment, and social restrictions on where and when they may travel. These factors can reduce observed trip-making while increasing the importance of reliable and affordable public transport.

Research in Delhi shows that safety concerns extend across the entire journey. Risk can be experienced while walking to a stop, waiting, boarding, traveling in a crowded vehicle, transferring, and completing the last segment. Women may select a longer or more expensive route, avoid early or late travel, or ask a household member to accompany them. UN Women's Delhi work documented insecurity and harassment in buses, streets, and other public spaces, demonstrating why vehicle-only safety measures are insufficient (UN Women, 2013).

The Delhi government's fare-free bus program for women, introduced in 2019, addresses an important constraint. Evidence indicates that the initiative increased women's presence on buses and can support access to employment, education, and discretionary activities. It also recognizes that intra-household allocation of money may limit women's travel even when the nominal fare appears modest (Shah et al., 2023). Fare policy, however, cannot correct infrequent service, crowding, unsafe access, inaccessible boarding, or gaps between bus, metro, paratransit, and walking networks.

Care trips expose network fragmentation. Schools, clinics, neighborhood markets, and domestic-work destinations are often dispersed and may not align with high-capacity radial corridors. A caregiver may need a bus, an informal shared vehicle, and a walk through streets without continuous sidewalks. Separate fares and uncertain transfers magnify the burden. Metro service can provide rapid trunk mobility, but station depth, security procedures, vertical circulation, and first-last-mile conditions can be difficult with young children, luggage, or an older companion.

Street design is part of the transport system. Wide roads, missing crossings, encroached sidewalks, poor drainage, heat exposure, and mixed traffic can make a short walk physically demanding. These conditions affect many travelers, but accompaniment reduces flexibility. A caregiver cannot always run across a gap, use a footbridge without a functioning elevator, or wait indefinitely with a tired child. Goel et al. (2023) found a notable gender gap in active travel

in Delhi, reinforcing the need to interpret walking conditions through unequal exposure and autonomy.

Delhi also reveals the limitations of treating women's safety as surveillance alone. Cameras, reserved seats, women-only spaces, and policing may provide value, but they do not replace frequent service, active streets, trained staff, responsive complaint systems, or land-use proximity. Nor should protective policy restrict women's mobility or shift responsibility to passengers. A rights-based approach makes ordinary travel safe and legitimate at all times rather than defining narrow protected spaces.

A care-centered Delhi strategy would combine fare affordability with frequent neighborhood buses, integrated transfers, shaded and accessible stops, safe crossings, reliable elevators, public toilets, and better links among homes, schools, health services, and employment. Travel surveys should record accompaniment, intermediate stops, suppressed trips, perceived safety, and household decision-making. The objective is not merely higher female ridership but greater control over time and opportunity.

5. Seattle: Care Chains in a Dispersed Region

Seattle's central city and major regional corridors have benefited from expanding light rail and frequent bus service. Nevertheless, the metropolitan geography of care is dispersed. Affordable housing, childcare, schools, health care, service-sector employment, and family support networks may be located in different jurisdictions. Households displaced from transit-rich neighborhoods can retain a nominal regional connection while facing longer local access trips, less frequent service, and more transfers.

The traditional commute orientation remains visible in radial service patterns and investment narratives focused on major employment centers. Such service is valuable, but care trips frequently move laterally between neighborhoods or combine a central commute with school, shopping, and medical stops. A network can perform well for a direct peak journey while imposing substantial penalties on a traveler whose chain crosses routes and service periods. The relevant reliability measure is the probability of completing the entire chain on time.

Seattle's transportation equity work provides an institutional basis for correction. The City's Transportation Equity Framework emphasizes community-defined priorities and the historical distribution of harms and investments. King County Metro's Mobility Framework similarly broadens the agency's mission toward equitable mobility and access to opportunity (City of

Seattle, 2022; King County Metro, 2019). These frameworks create room to evaluate who benefits from frequency, safety, sidewalk, and fare investments, although their care-specific implementation remains uneven.

Fare policy matters for linked travel. Regional transfer integration reduces the cost of moving among agencies, and reduced-fare programs can expand access for low-income riders. Yet caregivers may pay for accompanying children or dependents, and the cost of an occasional ride-hail trip can become necessary when a late bus threatens a pickup deadline. Financial evaluation should include the cost of backup mobility and the penalties associated with lateness, not only the scheduled transit fare.

Physical accessibility is equally important. Low-floor vehicles, elevators, curb ramps, seating, shelters, and space for strollers or mobility devices determine whether accompaniment is practical. Snow, hills, darkness, and incomplete sidewalks create seasonal barriers. A stop that meets a technical accessibility standard may still be unusable when the approach lacks a safe crossing or when a stroller and wheelchair compete for limited vehicle space.

Housing and childcare policy shape transportation outcomes. If affordable childcare is far from either home or work, the caregiver absorbs the geographic mismatch. If lower-income households move to peripheral areas, the public cost appears in longer subsidized trips and the private cost appears as lost time. Care-centered accessibility therefore requires coordination among transit agencies, school districts, housing authorities, health systems, and local governments.

Seattle's strongest transferable lesson is the value of community governance, but participation must reach those with the least discretionary time. Evening meetings, unpaid advisory work, technical language, and remote platforms can exclude caregivers. Compensated engagement, childcare, interpretation, accessible venues, and asynchronous participation are not administrative conveniences. They are conditions for representative planning.

6. Vienna: Institutionalizing Gender Mainstreaming

Vienna offers a different institutional pathway. The city has applied gender mainstreaming across municipal administration and has used gender-sensitive analysis in housing, public space, transport, lighting, and neighborhood planning. Its official principles include gender-disaggregated data, equal access to services, balanced participation, and assessment of differential effects (City of Vienna, n.d.-a, n.d.-b). The importance of this approach is

procedural: gender is considered during problem definition rather than added after a project has been designed.

The built environment supports this work. Dense mixed-use neighborhoods, extensive public transport, walking, public housing, parks, schools, and local services can shorten daily chains. Frequent service reduces the scheduling penalty associated with missed vehicles, while integrated fares reduce transfer costs. The city's compact form does not eliminate care burdens, but it can reduce the distance and uncertainty through which those burdens are performed.

Vienna's gender-sensitive public-space projects have emphasized lighting, visibility, path width, seating, and the distribution of recreational space. These interventions demonstrate that everyday accessibility extends beyond vehicles and stations. A park route, housing courtyard, school approach, or public toilet can determine whether a caregiver can combine activities. Planning for diverse users also benefits older adults, children, people with disabilities, and people carrying goods.

The model's strength is institutional repetition. Gender analysis is supported by administrative guidance and specialist capacity rather than depending entirely on an individual project champion. This encourages departments to ask who uses a service, whose needs are missing, and how benefits and resources are distributed. It also links data with design and budgeting.

Vienna should not be romanticized. Women still perform unequal care work, and migrants, lower-income households, and peripheral residents may experience different accessibility than citywide averages suggest. High-quality public transport does not automatically redistribute household labor. Moreover, Vienna's fiscal capacity, housing institutions, and compact urban form cannot be transferred wholesale. The transferable principle is the durable requirement to test policies against different daily realities.

The case shows that gender mainstreaming becomes most consequential when it changes ordinary technical practice. Stop placement, signal timing, sidewalk width, housing allocation, service frequency, and data categories may appear mundane, but their cumulative effect structures everyday freedom. Care-sensitive planning is therefore not a niche program. It is a method for improving the baseline competence of urban planning.

7. Comparative Findings

The cases reveal three different entry points. Delhi has used a visible affordability intervention within a mobility environment still constrained by safety and fragmented access. Seattle has

developed equity-oriented governance in a region where land use and service geography complicate care chains. Vienna has embedded gender analysis within municipal procedures and a comparatively supportive urban form. None provides a complete model, but together they clarify the conditions of care-centered accessibility.

First, affordability is necessary but relational. Fare-free or reduced-fare travel can expand mobility, particularly where women have limited control over household resources. Yet the value of a free trip declines when service is unreliable, transfers are unsafe, or a backup mode is required. Fare analysis should cover the full chain, accompanying travelers, transfer rules, and emergency alternatives.

Second, frequency is an equity instrument. Frequent all-day service reduces waiting, allows flexible departure, and limits the consequences of a missed connection. These benefits are particularly important for travelers operating between fixed care deadlines. Peak capacity cannot substitute for an all-day network that connects neighborhood destinations.

Third, proximity and mobility are jointly produced. Delhi's dense neighborhoods can still be inaccessible because of hostile walking conditions, while Seattle's high-quality regional services may not overcome dispersed destinations. Vienna demonstrates the advantage of coordinating services, housing, and transit. Accessibility planning should therefore combine network investment with schools, childcare, health care, food, parks, and affordable housing.

Fourth, safety is a system outcome. Personal security, traffic danger, lighting, staff response, crowding, and social legitimacy interact across the journey. Women's observed route and mode choices often reflect risk management. Safety metrics should record avoidance, unwanted accompaniment, additional expenditure, and foregone opportunities, not only reported incidents.

Fifth, universal design should include accompaniment. Technical compliance commonly evaluates an individual traveler. Care journeys involve two or more bodies with different speeds and needs. Design should be tested with a stroller, wheelchair, child, luggage, groceries, and fatigue. The ability to board is not equivalent to the ability to complete a chain with dignity.

Finally, data and participation determine what institutions can see. Vienna's gender-sensitive data principles, Seattle's equity engagement, and Delhi's need for better measurement all point toward a common requirement: travel surveys must represent unpaid care, intermediate stops,

household negotiation, perceived safety, and suppressed demand. People who perform care work should participate in defining performance standards.

8. A Care-Centered Accessibility Planning Framework

A care-centered planning process begins by redefining the baseline. Household travel surveys should collect tour-level diaries rather than only isolated trips. Each segment should record purpose, accompaniment, carried items, flexibility, payment, perceived safety, and whether an activity was delayed, delegated, or abandoned. Data should be disaggregated by gender while also examining income, age, race or caste, disability, tenure, household structure, and employment.

The second step is to build representative activity chains. Agencies can work with residents to identify common sequences, such as home, childcare, work, grocery store, childcare, and home, or home, older-relative pickup, clinic, pharmacy, and home. These chains should be tested at different times and under disruption. The output is a distribution of feasible completion times and costs, not a single average travel time.

Third, project appraisal should include a care accessibility benefit. Benefits may include fewer transfers, greater schedule slack, shorter walking distances, accessible boarding, reduced need for expensive backup travel, and lower exposure to danger. Travel-time valuation should avoid treating unpaid time as economically inferior. Time saved in care can support paid work, rest, education, social participation, and health.

Fourth, service standards should be based on chain reliability. Agencies should measure the share of representative chains completed within their required time window, including transfer uncertainty. Missed-connection penalties should be incorporated into scheduling and network design. All-day frequency, timed local connections, and short circumferential routes may produce larger care benefits than an additional peak express.

Fifth, the built environment should be audited as part of the chain. Stop access, crossings, lighting, shade, seating, toilets, elevators, stroller and wheelchair space, wayfinding, and winter maintenance are transport infrastructure. Audits should include accompanied journeys and should extend to schools, clinics, childcare, markets, and public services.

Sixth, implementation should be accountable. Table 2 proposes a monitoring sequence from baseline through long-term operation. Agencies should publish gender- and household-sensitive measures, compensate community participation, and assign responsibility across transportation,

land use, housing, education, and health departments. Without an owner, care accessibility becomes a broad aspiration that no institution is required to deliver.

Table.2. Care Accessibility Monitoring Sequence

Stage	Priority measures	Accountability requirement
Baseline	Representative care chains; household time and cost	Publish before corridor or service decisions
Design	Chain travel time; transfers; accompanied access audit	Compare alternatives and disclose distribution
Operations	All-day frequency; missed connections; elevator and stop access	Monthly reporting and rapid remedies
Outcomes	Completed activities; avoided trips; safety; time poverty	Annual disaggregated evaluation
Long term	Access to care, work, education, health, and participation	Independent review at 2-, 5-, and 10-year intervals

Source: Author's synthesis of cited research and policy documents.

9. Policy Implications

National and regional governments should require major transport plans to evaluate nonwork and care accessibility. Funding guidance should specify tour-based analysis, off-peak performance, safety, universal design, and household cost. A project should not receive a high equity rating solely because it serves a disadvantaged area if its timetable and access conditions do not support residents' daily chains.

Transit agencies should protect and expand frequent all-day service. Network redesign should evaluate short and cross-town trips as carefully as radial commutes. Fare systems should provide free or low-cost transfers, simple eligibility, daily and monthly caps, and affordable accompaniment. Reliability standards should reflect the consequences of missed timed obligations.

Municipalities should plan fifteen-minute access to essential care destinations without assuming that every service can be localized. Childcare, schools, clinics, food, parks, and social services should be coordinated with frequent transit and affordable housing. Development review should examine whether relocation lengthens care chains for existing residents.

Safety programs should integrate traffic safety and personal security. Lighting and surveillance should be combined with active land uses, visible staff, responsive reporting, safe crossings, maintenance, and reliable late service. Agencies should measure the travel people avoid and the money they spend to feel safe. Protective measures should expand autonomy rather than confining women to segregated or restricted mobility.

Employers, schools, and care institutions also influence transport demand. Flexible schedules, predictable shifts, guaranteed emergency rides, secure bicycle and stroller storage, and coordinated opening hours can reduce chain fragility. Transportation demand management should recognize care obligations rather than assuming every worker can travel directly at a fixed time.

Planning organizations should build care expertise into staffing and governance. Gender mainstreaming units, caregiver advisory panels, and cross-department accessibility teams can make the issue durable. Participation must include compensation, childcare, interpretation, and accessible formats. The quality of a plan depends partly on whether people with constrained time can shape it.

10. Limitations and Research Agenda

This study relies on secondary evidence and compares cities with different data systems, welfare institutions, household structures, and legal contexts. Gender categories are not measured consistently, and binary reporting can obscure transgender and nonbinary experiences. Care activities are frequently undercounted, while safety data reflect both underreporting and unequal exposure. The analysis therefore identifies mechanisms rather than estimating a uniform causal effect.

Future research should develop tour-based accessibility measures that are interpretable to agencies and communities. Models should incorporate opening hours, service variability, accompaniment speed, vehicle capacity, fare rules, and the probability of completing all required activities. Validation should compare modeled accessibility with diaries, interviews, and participatory journey audits.

Longitudinal research is needed to determine whether transport improvements redistribute care or merely make unequal care work more efficient. Gender-equitable transport should expand autonomy and opportunity, but transportation policy cannot substitute for childcare, labor,

housing, and social policy. Studies should examine how changes in service interact with household bargaining and men's participation in unpaid care.

Research should also address paid caregivers, domestic workers, older adults, adolescents, people with disabilities, and multigenerational households. Their travel can be essential yet absent from standard categories. Digital ticketing and mobility applications create opportunities for measurement but also risks related to privacy, exclusion, and surveillance. Ethical data governance is necessary when recording sensitive household routines and safety experiences.

11. Conclusion

Transportation planning overlooks care travel when it treats the direct journey to paid employment as the normative trip. Delhi, Seattle, and Vienna demonstrate that everyday accessibility depends on a wider system of fares, frequency, transfers, sidewalks, safety, public space, housing, and service location. The burden of system gaps falls heavily on women because care remains unequally distributed, but the benefits of reform extend to all travelers whose mobility is accompanied, time constrained, or physically demanding.

The comparison shows that no single intervention is sufficient. Delhi's fare policy can increase women's mobility but must be paired with safe access and reliable networks. Seattle's equity frameworks can broaden institutional priorities but require care-specific performance measures across a dispersed region. Vienna's gender mainstreaming shows the value of embedding differential-impact analysis in ordinary planning, while reminding researchers that strong transit does not by itself equalize household labor.

A care-centered system measures whether people can complete the linked activities that sustain daily life. It values all-day frequency, reliable transfers, affordable accompaniment, universal design, destination proximity, safety, and meaningful participation. These are not secondary social benefits appended to efficient transport. They are dimensions of transport performance.

The practical shift is from counting trips to evaluating capability. A city is accessible when a caregiver can reach several essential destinations, with another person or carried responsibility, within available time and money, without unacceptable risk or exhaustion. Planning around that standard would produce networks that are more equitable, more resilient, and more faithful to how urban life actually works.

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Data Availability
The raw data supporting the findings of this research paper will be made available by the authors upon a reasonable request.

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Author Biography

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