

Policies and care provision in Latin America

A view of regional experiences

Karina Batthyány Dighiero



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This report was prepared under the auspices of the United Nations Development Account by Karina Batthyány Dighiero (Professor at the Faculty of Social Sciences, UDELAR, Uruguay), in her role as consultant at the Division for Gender Affairs of the Economic Commission for Latin America and the Caribbean (ECLAC).

The author is grateful for support from the Ministry of Foreign Affairs of Norway, provided under the “Programme to Promote Equality in Latin America and the Caribbean”, for the English translation of this report; and also from the Spanish Agency for International Development Cooperation (AECID) for its publication in English and Spanish.

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United Nations publication

ISSN 1564-4170

LC/L.3958

ORIGINAL: SPANISH

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Printed at United Nations, Santiago, Chile

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Abstract

This study identifies the key challenges facing the region in the domain of care provision. To that end it describes, analyses and discusses the concept of care, the rights approach and the public policies implemented in Latin America and the Caribbean on the social organization of care. The document describes care policies in the region generally, and it specifically analyses experiences of the social organization of care provision in four countries. In Chile, it studies the *Chile Crece Contigo* national child-care programme; in Costa Rica it reviews the National Care Network; in Ecuador, it analyses the recognition of unpaid reproductive work in the 2008 Constitution and the National Plan for Good Living; and in Uruguay it considers the National Care System. The report highlights the role played by time-use surveys in formulating care policies in the region; and it makes the case for public policies that recognize, reduce, and redistribute the work of care provision and foster change in the current sexual division of labour. Until now, two redistribution mechanisms have coexisted in the region: redistribution within the household, in other words the sharing of tasks between men and women so as to increase the share of domestic chores undertaken by men; and participation by public and private institutions in the social organization of care services, to assume part of the work that hitherto has mainly been a family, and hence a woman's, responsibility. These analyses reveal the urgent need for countries to organize care provision consistently, so as to strengthen gender equality and progress towards a development model based on individual rights and gender equity.

Introduction

This report describes and analyses experiences in the region on policies and care provision. Motivated by its constant concern to promote gender equity in the region's public policies, the Division for Gender Affairs of ECLAC, which serves as the Technical Secretariat for the incorporation of public policies in the region, organizes a Regional Conference on Women in Latin America and the Caribbean which meets every three years. At each conference session, the governments of the participating countries approve a Regional Consensus, consisting of a compilation of agreements on initiatives to be undertaken by the countries with the aim of achieving gender equity. In the most recent regional consensuses (those of Santo Domingo in 2013; Brasilia in 2010; and Quito in 2007), the participating countries have highlighted the need for the topic of care to be placed at the centre of their concerns. The disproportionate burden of work time borne by women compared with that of men, and the lack of possibilities in terms of care for children, the sick and older persons, have led the governments of the countries to consider actions in this area, as part of the search for new development forms and models.

In the Santo Domingo Consensus (2013), national governments highlight the centrality of gender equality in the development debate, considering the productive and reproductive dimensions needed for social welfare, and putting the accent on changing the sexual division of labour. Owing to inequalities in the reproductive domain, women are in a situation of productive disadvantage compared with men, owing to reproductive overload, and this perpetuates the structural inequalities that exist between men and women. The Consensus includes agreements adopted on gender equality and the economic empowerment of women, in particular agreement 54, "Recognize the value of unpaid domestic work and adopt the necessary measures, including legislative measures, and public policies that recognize the social and economic value of domestic work"; and agreement 57, "Recognize care as a right and, therefore, as a responsibility that must be shared by men and women of all sectors of society, and by families, private companies and the State, and adopt measures, policies and programmes on care and on promoting the joint responsibility of women and men in family, working and social life in order to free up women's time so that they can engage in employment, studies and politics and enjoy their autonomy to the full".

The topic of care has been one of the countries' key concerns over the last few years. During the eleventh session of the Regional Conference on Women in Latin America and the Caribbean, the countries agreed (Brasilia Consensus, 2010): "To adopt all the social and economic policy measures

required to advance towards the attribution of social value to the unpaid domestic and care work performed by women and recognition of its economic value” (agreement 1(a)); and “To foster the development and strengthening of universal care policies and services based on the recognition of the right to care for all and on the notion of sharing the provision of care between the State, the private sector, civil society and households, as well as between men and women, and of strengthening dialogue and coordination between all stakeholders” (agreement 1(b)).

In the Quito Consensus (2007), ECLAC Member States agreed, among other things, “To adopt measures of co-responsibility in family and working life that apply equally to women and men, bearing in mind that sharing family responsibilities equitably and overcoming gender stereotypes create conditions conducive to political participation by women in all their diversity” (agreement xiii); and “To formulate and apply State policies conducive to the equitable sharing of responsibilities by women and men in the family, overcoming gender stereotypes and recognizing the importance of caregiving and domestic work for economic reproduction and the well-being of society as one of the ways of overcoming the sexual division of labour” (agreement xx).

The foregoing provides a framework for bringing care issues and the formulation of care policies on to the public agenda, which are analysed in this report for four countries: Chile, Costa Rica, Ecuador and Uruguay.

The Division for Gender Affairs also serves as the technical secretariat of the Gender Equality Observatory for Latin America and the Caribbean, under a mandate from the region’s governments. The main focus of the Observatory’s work is on research and the development of gender-equality indicators based on the three autonomies (economic, physical and political) that are essential for women to be on an equal footing with men. To achieve this, it is essential to resolve the issue of care provision in the different countries, rather than relying on women’s altruism. As women’s economic autonomy implies the ability to generate income from their productive work under equal conditions with men, resolving the care issue is fundamental.

Accordingly, this study analyses the experiences of policies and programmes on the organization of care provision in the four selected countries. In Chile, which has a mixed care system, it analyses the leading State care policy developed in the country: the early childhood programme known as *Chile Crece Contigo* [Chile grows with you]. In the case of Costa Rica, it analyses the National Care and Child Development Network, which forms part of the Gender Equality and Equity Policy (PIEG), implemented in 2007. In Ecuador, the report discusses the recognition of unpaid reproductive work in the 2008 Constitution, and the inclusion of the strategic guidelines and respective targets in the *Plan Nacional del Buen Vivir* [National Plan for Good Living]. In Uruguay, it reviews the National Care System in the context of a broader process of social reforms launched in 2005, which include reforms to the health system and social security, along with tax reform.

These country initiatives on the organization of care provision are analysed by describing, examining and discussing various aspects of the concept of care, the rights approach and, more specifically, care policies, and hence the social organization of care provision in society.

I. The starting points: care provision and the sexual division of labour

The introduction of the notion of gender in social research implied a series of epistemological breaks with the past, in terms of how women's position in the different human societies had previously been understood. Although gender roles differ across cultures, the common defining issue in all countries is segregation, since men and women do not operate in the same areas of society. Although the type and degree of segregation differs in each society, historically and traditionally the most basic and common form is the division between public and private life.

As noted by Batthyány (2004), adults in all societies throughout history have had to undertake three essential activities. The first of these is productive endeavour, of a social or collective nature, to produce the goods that make up social wealth. How this work is organized depends on the historical conditions that have prevailed in each society, giving rise to the different modes of production observed throughout history (slavery, feudalism, capitalism). The second is domestic work, of an individual nature, which satisfies daily needs such as food, hygiene, health, and home maintenance. The third is the raising of children, which involves inculcating and transmitting the community's usages and customs, thereby making sure the society's cultural identity is reproduced.

Productive work is undertaken during a defined time period, for certain hours of the day, over a certain number of years, although this obviously varies greatly according to the mode of production and social organization of each community.

Unlike productive work, domestic work has to be done every day throughout a person's life. If there are people who do not participate in this work, for whatever reason (social status, age or health factors), others do it for them, thus undertaking a multiple domestic work load. The same is true of child-rearing, supposedly the responsibility of both progenitors, which has to be done all day every day over a period of years.

Female participation has traditionally occurred, par excellence, in the private domain of reproduction and family life, and that continues to be the case. Consequently, women's spheres of activity revolve around the home: bringing up the children, along with health and social welfare and hygiene matters. Women have been forced to be interested in specific issues within human society,

generally relating to the home. In contrast, the role of men includes public life, dominated by business, the economy, industry, energy, international relations, politics and government. Although activities in the public domain may seem to be genderless, in practice they are both historically and structurally masculine. The structure of society promotes male participation in public life, but discourages women from leaving the home or pursuing careers outside the traditional areas of female employment. These ultimately are the subjective foundations of the sexual division of labour that find expression as objective features of gender systems.

A. A conceptual approach to care

The notion of care in social protection and social welfare policies has become crucial for analysis and research with a gender perspective. This is a concept for which there are several definitions, and consensus is still far off. Given its theoretical wealth and density, care is a potent and strategic concept in both academia and politics, capable of articulating previously disparate debates and agendas, generating basic consensus, and furthering a gender equity agenda in the region.

Academic debates on the content of care date back to the 1970s in some English-speaking countries, promoted by feminist currents in the field of social sciences. Without claiming to offer an exhaustive definition, it could be said that the notion of care signifies the action of helping a child or a dependent person to attain development and daily well-being. It therefore encompasses responsibility for material care, which involves “work”, economic care which involves an “economic cost”, and psychological care, which involves “an affective, emotional and sentimental” bond. Care can be provided on an honorary or charity basis by family relatives; or else it can be provided as a paid service, either within the family or outside it. The nature of the activity will vary according to whether or not it is undertaken within the family setting, and whether or not it is considered a paid service (Batthyány, 2004).

The specific nature of care work is that it is based on relationships, whether in the family context or outside it. Within the family, its obligatory nature and the fact that is often perceived as selfless, lends it a moral and emotional dimension. It is not just a legal obligation established by law (the obligation to provide assistance or help), or an economic obligation, because it also involves emotions that are expressed within the family, while the family space simultaneously helps to construct and maintain them.

Outside the family setting, care work is defined by the relation of service, care, and concern for others. The work is undertaken face-to-face between two individuals, and it generates ties of proximity, in a situation of dependency, because one person depends on the other for his or her well-being and maintenance. Nonetheless, what unifies the notion of care is that, hitherto, it has essentially been undertaken by women, whether it is kept within the family or outsourced in the form of the provision of personal services.

The feminist literature uses care as an analytical category of welfare regimes that has the capacity to reveal important dimensions of the life of women and men and, at the same time, capture more general properties of social arrangements for satisfying personal and welfare needs. Care is understood in terms of interpersonal work and relationships, but also as a socially constructed responsibility which is framed by specific social and economic contexts.

Much of the problem of providing welfare and quality social protection to individuals in a society stems from an inadequate distribution of the corresponding responsibilities between its members. This care distribution problem has been resolved in various ways, in different historical, social, cultural and economic conjunctures. Although such factors have meant social responsibility for care provision being shared between different social actors such as the State, the market, families or community, a significant proportion of this burden has fallen, and still falls, on the families; and in most cases this means the families’ women.

Different welfare regimes will thus be associated with different care regimes, according to the ways in which care responsibilities are assigned and the costs of providing care are distributed (Sainsbury, 1999). Characterizing a care regime entails knowing where care is given, who provides it, and who bears the costs of its provision (Jenson, 1997).

Analysing care from this perspective means that the starting point is not a specific component of social policies, but that the existing set of policies is analysed on an integrated basis, starting with the care of dependent persons. As noted above, care is a very powerful conceptual framework for analysing social policies, because it affords a cross-cutting view of policies that are usually considered sector by sector, thus revealing the assumptions made about the care-giving role that families and women are expected to play, in the design and application of care services.

The issue of care is emerging as a central aspect of the welfare system, as a result of women's widespread entry into the labour market and the recognition of their citizenship rights. In the Western world, women engaging in paid work undoubtedly constitutes a new social norm.

B. Care as a right

An important dimension to be considered is that of care viewed as a right, which is still underexploited in terms of research and knowledge production in most countries. The debate on how to incorporate the complexity of care into a rights framework concerns equality of opportunities, treatment and paths in a context of expanding individual rights, thus leading to a new concept of citizenship.

Within this framework, the State has assumed the role of protector against the risks and contingencies experienced by individuals as their lives unfold. This introduces a new focus for new-generation social policies, in addition to the classic pillars of the welfare State (health, social security and education), namely the care of children and older persons, not just when no family is available to fulfil that responsibility, but as a new social norm. This implies a new conception of the relation between individual, family and State, founded on social responsibility for the care of individuals.

The right to care should also be considered as a universal right for all citizens, based on the twin circumstance of persons who need care and those who provide it, in other words based on the right to provide care and the right to receive it.

This right, which is recognized and included in international covenants and treaties, is still a “work in progress” in terms of its enforceability; and it involves various aspects of major importance. The first of these is the right to receive the necessary care in different circumstances and at different points in the life cycle, avoiding situations in which the satisfaction of that need is determined by a market rationale, depending on the availability of income, or the presence of relational networks or affective ties. The second aspect, and possibly the least studied, is the right to choose whether or not to provide care on an unpaid basis within the family setting. This means not viewing care-giving as a full-time obligation that precludes any right of choice, but recognizing the possibility of choosing care alternatives that are not necessarily and exclusively unpaid family care. This is not to deny the care obligations contained in civil laws and international treaties, but it means finding ways to share them. This is a particularly sensitive issue for women, who are culturally and socially assigned to this task, as noted above. Lastly, the right to decent working conditions in the care sector needs to be upheld, as part of a higher social and economic valuation of the care task (Batthyány, 2013).

The “right to receive care” should be a universal right that is recognized and exercised under equal conditions. This consideration, which is possibly incipient in our region, already has a long track record in the European welfare States. The three classic pillars of welfare, namely health, education and social security, are now being complemented by a “fourth pillar”, which recognizes the right to receive care in situations of dependency (Montaño, 2010).

According to Pautassi, certain social and political actors view care services merely as a benefit for women who are looking for work, under the fallacious view that women who need or want to work ought to be “supported”. From the rights perspective, however, care is a right for everyone and should be guaranteed through institutional and budgetary arrangements; and it should be regulated and receive State support. It is not, therefore, a benefit for women, but a right of those who need it (Pautassi, 2010).

From the regulatory perspective of social protection proposed by ECLAC (2006), care should be understood as a right assumed by the community and provided through services that maximize the

autonomy and welfare of families and individuals; it is thus a direct State responsibility. This is precisely one of the major challenges of care: fostering its recognition and positive inclusion in public policies.

The rights approach questions the role of the State as a subsidiary actor which is called upon to make up for benefits that are not obtained in the labour market; and it favours the role of the State as the guarantor of rights. When the State acts on a subsidiary basis, it serves the needs of certain women, often the least privileged, generally by subsidizing low-quality services or community networks that exploit women's "natural" know-how. Although these services alleviate women's needs, they also reinforce the sexual division of labour instead of questioning it.

It is therefore an approach in which the State serves as guarantor of rights and exercises the authority of the law; a State that assures care as a universal right of all people.

II. Care provision and public policies

Given the challenges being raised by ongoing social, economic and demographic changes, most countries have made significant legal and regulatory changes in relation to care provision.

As a result, there are now laws and even constitutional norms that recognize care and the need to find a more equitable way of distributing responsibilities, both within the family and between public institutions. Nonetheless, progress has been slower than desired, because the care of children and other family members, such as the sick and older persons, is a responsibility that weighs disproportionately on women, owing to inequality and the unbalanced distribution of paid and unpaid work between women and men.

As occurs at all turning points, the public-policy approach to rights-based care coexists with another that sees care as a women's problem which the State may choose to support (or not), as noted above.

At the same time, care is also considered as one of the domains to be taken account of by social protection, and which should be resolved through an institutional equation involving the State, firms, families and the third sector. ECLAC (2010) argues that the path to equality between men and women involves: (i) a change in women's and men's use of time; (ii) de-segmentation of the employment system; and (iii) a redistribution of tasks between men, women, the State and the private sector. This approach raises the need for an articulated set of care policies based on social protection, employment policies and development policies.

In this regard, there is currently a crisis in the social organization of care, which until now has been a female responsibility owing to the sexual division of labour. Montaña (2010) argues that, as the sexual division of labour is so old, it needs to be asked why it is now being considered an urgent social problem. The answer clearly relates to demographic factors such as longevity and the quality of life of men and women; the demographic transition which means that women go from looking after children to looking after older persons; family changes; global care chains in which female migration becomes important for remittances and family subsistence; and, last but not least, because women with some degree of schooling want economic autonomy, to have their own income, and to make use of the educational capital they have obtained. The so-called "care crisis" is merely a symptom of women's emancipation.

Governments in the region are developing a variety of policies on the social organization of care. These include the development of care services, parental leave to provide care, measures framed by proposals to reconcile work and family life, vouchers for care provision, and the organization of care systems.

The study of care regimes considers the division that exists between the State, families, the market and the community, in terms of the work, responsibility and cost of caring for children and adolescents, the sick and dependent older adults. It involves empirically analysing the services and the transfers of money, goods and time provided by the different spheres, and how care provision is distributed between them. In this context, it is important to disaggregate the functions fulfilled by the families, so as to more clearly discern which of them can be “de-familiarized” and how, and what implications they have for gender relations.

On this point, Aguirre (2008) takes up the arguments put forward by feminist analysts on care regimes, describing two opposing scenarios: “family-based” and “de-familiarized”. In the family-based scenario, the chief responsibility for welfare rests with the families and women in networks of relatives. Care is provided without payment, and the beneficiary unit is the family. This is the most widespread form of care provision in Latin America and in Mediterranean countries. It assumes a central role for the institution of legal matrimony, together with a rigid and traditional sexual division of labour. In contrast, the “de-familiarized” regime is biased more towards public institutions and the market. This does not exist in a pure and absolute form, but there are widely varying regimes that are evolving at different speeds. The care work is paid for, and the unit receiving the benefits is the individual.

Another possible scenario for social and gender equity involves developing policies of co-responsibility between families, the State and the market, to promote a broader exercise of women’s social, economic and political rights.

Tobío (2010) makes an interesting comment on the forms and effects of care policies. The author notes that the State is gradually taking on the social reproduction tasks that families are no longer able to fulfil, either owing to the type of knowledge required or because family members today have less time available for this. This encompasses many of the activities related to individual care, in addition to those in the education and health domains, which are increasingly viewed from a rights perspective, as a social right.

The debate on care provision has finally led to it being recognized as a public-policy problem to which governments must respond. It is therefore not an individual and private problem which each person deals with as best they can using the available resources; instead it is a collective problem that requires collective, and therefore social, responses. Reducing it to an individual dimension exposes women to individual and disadvantageous bargaining processes.

Women’s increased labour market participation has considerably lengthened their total working day, because they still have family responsibilities to fulfil, whereas men spend their time on paid work almost exclusively. Despite problems of international comparability, the most recent time-use surveys conducted in the region confirm the existence of a common pattern. This can be seen in both rural and urban settings, with rural women spending more hours per week doing unpaid domestic chores in nearly all cases. The dual working day leaves less time for paid work and, therefore, means a lower monetary income. The income and rights that are obtained from caregiving are inferior to those obtained in regular employment, and they are never sufficient for women to acquire economic autonomy and protect themselves against poverty over the life cycle.

While women today have greater economic autonomy than before, they face major problems in articulating their hours of paid work and the times when they need to be caregiving, owing to the disparity in the amount of time spent on the latter by mothers and fathers, and the inadequacy of child-care policies.

The time-use survey is a fundamental tool for ascertaining and understanding gender inequalities and role reproduction, through data that reveal the unequal distribution of time spent on paid and unpaid work, and the amount of time women and men have available for other daily activities.

Time-use surveys are excellent tools for this purpose. They have been developed in the region in recent years, and allow for an empirical approach to the sexual division of labour within households, making it possible to observe changes and constants. Although the time-use surveys performed in different countries are not mutually comparable, interesting trends can nonetheless be discerned:¹

- Women have a greater overall work load than men;
- Men participate less and spend less time on domestic and care activities;
- Compared with men, women on average spend more than twice the amount of time per week caring for children and other household members. The longer time spent on these activities by women increases significantly in parts of the life cycle associated with childbearing, whereas, in the case of men, the time remains virtually constant throughout their life cycle;
- On average, a woman's total working day in terms of paid and unpaid tasks is longer than a man's. Women's paid labour market participation is also less when the family includes children of preschool age;
- When women do paid work, even full-time, the distribution of domestic and care tasks remains unequal;
- On average women spend less time than men doing paid work, owing to the need to also fulfil domestic and family responsibilities; and;
- The work of looking after children, the sick, and older adults increases women's share of domestic activities and the time they spend on them. Moreover, this increases further when there are preschool age children in the household, whereas the time men spend on such activities tends to remain stable.

The concern for individual care and public responsibilities have become an urgent issue in the light of ongoing demographic changes and the consequent social demands and needs for care. Increasing numbers of dependent people require special care, and few public and private services are available. For that reason, women continue to bear the chief responsibility for the growing numbers of older adults and still numerous child population, not to mention changes in the public health system that leave health-sickness issues with the family, and thus once again in the hands of women.

The problem facing the region's countries is how to respect the rights of all, while providing the necessary care and guaranteeing respect for the rights of caregivers. Care is mainly provided by women, either as unpaid work in their own homes or as one of women's main paid activities, namely paid domestic employment, as well as working in crèches, kindergartens, and as nurses in hospitals or companions for older persons.

A. The social organization of care

The interrelationships that exist between the economic and social policies on care provision comprise the social organization of care; in other words the way the provision of care services that sustain economic and social functioning are distributed and managed. For this purpose, consideration needs to be given to the demand for existing care services, the persons who provide the services, and the welfare regime that responds to this demand. The social organization of care is how the responsibility for care provision is distributed between the market, families, the community and the State (Arriagada and Todaro, 2012).

¹ For further details on progress in time-use surveys see "Incorporando un módulo de uso del tiempo a las encuestas de hogares: restricciones y potencialidades" by Vivian Milosavljevic and Odette Tacla (2007); *Asuntos de género series* 117 "La población uruguaya and el cuidado: Persistencias del mandato de género. Encuesta Nacional sobre representaciones sociales del cuidado. Principales resultados"; and *Asuntos de género series* 119, "La utilización de las encuestas de uso del tiempo en las políticas públicas" and *Asuntos de género series* 122 "Las encuestas sobre uso del tiempo y trabajo no remunerado en América Latina y el Caribe. Caminos recorridos y desafíos hacia el futuro".

Focusing on care means observing the distribution of tasks and responsibilities between the family, the State and the market, to make it possible to analyse the different combinations of resources used in the practice of caregiving. At the macro level, institutions are responsible for establishing both a general and a distributive framework, whereas at the micro level, individuals perform care activities either directly or indirectly within the existing institutional framework (Daly and Lewis 2000). This includes not only the material infrastructure for care services, but also the regulatory dimension, which may be explicit or implicit (obligations, responsibilities, values). The current regulatory framework for care is still profoundly sexist: it is mostly women who bear the ultimate responsibility for looking after their family members. Nonetheless, despite the difficulties, changes and lack of resources, persons who need care do receive it — one way or another and almost without knowing how. It is provided by the women who have traditionally assumed that responsibility and continue to do so; and perhaps this generates a sense of complacency that prevents care from being assumed collectively as everyone’s problem.

A review of international experience shows the route followed mainly by European countries, where care policies are further developed and there is greater female engagement in the labour market, and simultaneously greater care for children and older adults and the sick. The evidence also shows that, while these policies alone cannot transform gender relations to the extent of attaining a fully equal distribution of care between men and women, they do make it possible to move in that direction.

In contrast, the predominant feature in Latin America is the weakness or total absence of public policies and private actions to foster articulation between work and family life. When this is combined with the specifics of the region’s labour markets and the unequal distribution of opportunities that characterize the region, the result is persistent socioeconomic and gender inequity. The social organization of care in Latin America varies greatly, owing to highly differentiated family dynamics, labour markets, and economic structures, not to mention States that have different strengths and traditions. Nonetheless, current data show a number of common features that characterize the social organization of care in the region —including the fact that care continues to be a function mainly of families, and, as is well-known, of the women within families. It is therefore a matter that is considered to be mainly private. For example, the idea that children should be looked after by their families (in other words by the mothers) when they are small, underpins the very low coverage of day care, crèches, and kindergartens in the region.

B. The different care-policy options

If care is understood as a right that is assumed as such by society and provided through services that maximize the autonomy and welfare of families and individuals, with direct responsibility pertaining to the State, the challenge arises of working towards its recognition and positive inclusion in public policies. This entails actions in three directions at least: redistributing care provision, valuing care activities more highly, and reformulating the concept of care services (Pérez Orosco, Amaia, 2011)

Redistributing means building a collective responsibility for care services, ceasing to consider care exclusively as a private concern and starting to view it as a collective responsibility and, therefore, as a matter of achieving universal access to decent care services. *Valuing more highly* means according work status to care-provision activities and recognizing care as an essential dimension of welfare. *Reformulating* means breaking the exclusive association that exists between care services and femininity and family. These three elements are not mutually independent and can only be separated for analytical purposes. Redistributing without a higher valuation will be impossible, and vice versa. Unless care is valued, it will only be done by persons with the least capacity to choose; at the same time, people who do not provide care cannot value the work of care giving, because they will continue to consider it a female activity by nature.

Public policies on care services can be classified in different ways, one of which distinguishes policies on care time, from policies relating to money for care giving, and the care services themselves.

Policies on care time specify periods of leave from work to provide unpaid care services (maternity and paternity leave, baby-feeding breaks, leave of absence to care for family members,

shortened working days, etc.). These periods may or may not be paid, and the time absent from work may or may not be included as time contributed to social services. When unpaid, they reinforce the role of women as free care providers and thus accentuate their greater employment and life-cycle vulnerability. Although most of the measures in question are recognized for women and men alike, the rights are almost exclusively exercised by women. The exception is paternity leave, which in many countries is not recognized; and, if it is, its duration is completely disproportionate to maternity leave.

These measures are articulated around paid work in the formal sector. The benefits are generally linked to employment by third parties, so they have minimal relevance and applicability in contexts involving the informal sector. In the case of measures that provide money for care services, the benefits are granted in return for looking after someone within the family environment. They recognize that some people, generally women, are not in the labour market because they are providing care services, and that the care task in question should entitle them to pay or social rights.

These measures cast both light and shadow; they can be seen as having an effect that perpetuates inequality, because the benefits tend to be very small and they perpetuate the sexual division of labour; but they are also a way of valuing the work that women already do in their homes, and thus grant them a degree of economic independence. The challenge is how to recognize and value the tasks which already exist, by granting economic and social rights to the individuals who perform them, without reinforcing the situation in which most care services are provided in this way.

Care services may be provided in the home (home-based assistance), or in institutionalized settings (residences for older persons, child-care centres), or in the work place. The fundamental issue when generating such services is their universality and how they are shared between the public and private domains. This debate will not be specifically addressed in this document however.

Care policies have an entity of their own which is distinguishable from other policies such as those on health and education. But, at the same time, they are directly linked to other policies, and their implementation needs these other policies to take account of people's care needs (both in the provision and in the reception of care services). In other words, for care policies to be functional, the objectives of constructing a collective responsibility and redistributing and up-valuing or reformulating care services must be embedded in all policies.

The most important policies, with measures that have consequences and effects on care services, include the following: social protection policies; education policies; health policy; housing, urban-development and transport policies; infrastructure policies; and labour market regulation policies, among others.

The three types of provision aimed at providing care for persons —services, leave of absence and transfers— have different effects and implications for gender equality and for the different family models which they implicitly or explicitly support.

The welfare model that seems to be emerging is characterized by a strong State presence in developing social policies that promote new individual rights. These are combined with gender-equality policies as a crucial element of a new model.

III. Care policies in Latin America

Reconciling the demands of work and family life, by redistributing care tasks between the State, the market and families, remains the blind spot of public policies in Latin America and the Caribbean (ECLAC, 2010). Despite the progress made on gender-equality policies, economic, social and political institutions still operate under the assumption of a rigorous sexual division of labour that continues to stereotype women as care providers and men as income providers.

Most of the labour codes and specific regulations in Latin American countries have prioritized maternity protection, and this situation has not changed over the last 30 years. State action on care is generally confined to protecting the working mother within the framework of formal employment and child-care provision.

Gender equality forms part of the public-policy agenda of the region's governments —many of which have adopted national laws on care quality, implementing budgets with a gender perspective and mainstreaming gender in planning systems.²

The Bolivarian Republic of Venezuela, the Dominican Republic, Ecuador and Plurinational State of Bolivia have recognized women's unpaid work in their political constitutions. In Costa Rica, Ecuador, Jamaica, Suriname and Uruguay care needs are gaining the status of a specific public-policy domain.

For more than two decades all Latin American countries and most Caribbean countries have recognized the care rights defined in various international instruments (the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Convention 156 of the International Labour Organization (ILO) on equal opportunities for workers with family responsibilities); and the entitlement to care has been enshrined in the political constitutions of several countries. Nonetheless, a study of labour regulations on maternity and paternity leave reveals the need to deepen the recognition of care and co-responsibility as a universal right. At the same time, it is important to review the gender bias that

² For further information, see the chart displaying the care laws in each of the countries of Latin America and the Caribbean and the Iberian peninsula on the website of the Gender Equality Observatory for Latin American and the Caribbean [on line]: <http://www.cepal.org/cgi-bin/getprod.asp?xml=/oig/noticias/paginas/2/46652/P46652.xml&xsl=/oig/tpl/p18f.xsl&base=/oig/tpl/top-bottom-economica.xsl>.

exists in care regulations, which tends to focus basically on the person who is entitled to care, while neglecting the rights of those who provide it.

Policies on care, both for children and for dependent persons, need to be framed in an approach that integrates and harmonizes the rights of children, persons with disabilities and other dependent persons with the rights of women caregivers and gender equality.

States have a central responsibility for care provision, both in the public domain and in the market and civil society, ensuring that the care rights of dependent persons (children, persons with disabilities and older persons) are upheld, but also that the rights of caregivers are recognized (such as unpaid or voluntary work).

Following the tenth session of the Regional Conference on Women in Latin America and the Caribbean, held in Quito, Ecuador in 2007, the commitments assumed by the participating governments have resulted in numerous initiatives to recognize and value unpaid care work, including legal and constitutional reforms and the production of the official data on the use of time. There have also been a number of pension reforms, together with an increase in the supply of child care and other measures in that direction. The 2007 Quito Conference highlighted women's contribution to the welfare of society, and it argued for the need to recognize and socially redistribute unpaid work, against a background of changes that have rendered the traditional models of welfare organization unsustainable.

These commitments were ratified at the eleventh session of the Regional Conference on Women in Latin America and the Caribbean, held in Brasilia in 2010. The keynote document presented by ECLAC, entitled *What kind of State? What kind of equality?*, argues that, to achieve equality, it is essential to redistribute the total work load, both paid and unpaid, especially the unpaid care work done basically by women in the home. It also recommends greater involvement by the State, market and society, along with male participation in caring for individuals, which are seen as necessary conditions for moving towards a society in which men and women are both income providers and caregivers (ECLAC, 2010).

The influence of the World Conferences on Women (Montaño, 2010) and the regional consensus approved by the governments over the last decade reflect the changes made in individual countries, including constitutional reforms (such as in the Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia), legislative changes, changes in the use of time, household satellite accounts and, lastly, the design of care systems.

In that regard, 20 of the region's countries today have laws on leave for maternity and maternal breast feeding; 12 countries have legislation on paternity leave (albeit very limited in terms of the number of days granted); 18 countries have laws on disability; four have legislation on domestic work; and nine have signed ILO Convention 156 on equal opportunities for workers with family responsibilities.³

A number of laws relating to the care of individuals have been passed by different countries; and there have been significant legislative developments on parental leave in the region in recent years. In Latin America, 13 countries have introduced paternity leave following the birth of a child, which often also applies in the case of adoption. Leave periods vary from two days in Argentina and Paraguay and three in the Plurinational State of Bolivia, to 14 days in the Bolivarian Republic of Venezuela and 15 days in Costa Rica. Colombia, Peru and Puerto Rico grant between four and eight days, while Ecuador allows 10 days. In Chile, under its new postnatal law, mothers can transfer up to 1½ months' leave to the father. In several countries, the number of days' leave is extended in the case of multiple births or if an illness is involved. In Uruguay, as elsewhere, the extension depends on whether the private or public sector is involved.

³ For further information, see the website of the Gender Equality Observatory of Latin American and Caribbean, [on line]: <http://www.cepal.org/cgi-bin/getprod.asp?xml=/oig/noticias/paginas/2/46652/P46652.xml&xsl=/oig/tpl/p18f.xsl&base=/oig/tpl/top-bottom-economica.xsl>.

BOX 1
THE INTERNATIONAL RECOGNITION OF CARE

Fourth session of the World Conference on Women (Beijing, 1995): political recognition of need to alter the sexual division of labour as a sociocultural construct.

Tenth session of the Regional Conference on Women in Latin America and the Caribbean and the Quito Consensus (2007): governments recognize care a central issue for gender equality.

Eleventh session of the Regional Conference on Women and the Brasilia Consensus (2010): governments undertake to “adopt all social and economic policy measures required to advance towards the attribution of social value to the unpaid domestic and care work performed by women and recognition of its economic value.”

Source: Prepared by the author on the basis of regional consensuses and the fourth session of the World Conference on Women (Beijing, 1995).

The most far-reaching steps taken in the region, towards greater equality in terms of care are of a legal and regulatory nature, contained in legislation and in regulations, and also in constitutional provisions.

TABLE 1
LATIN AMERICA AND THE CARIBBEAN: LEGISLATION ON CARE
BY TYPE OF LEGISLATION

Type of legislation	Number of Latin American countries
Maternity leave legislation	20
Legislation for breast-feeding mothers	20
Paternity leave	12
Disability laws	18
Legislation on domestic work	4
ILO Convention 156 on workers with family responsibilities	9

Source: ECLAC, Gender Equality Observatory for Latin America and the Caribbean. International Labour Organization (ILO). See [online] <http://www.ilo.org/ilolex/spanish/index.htm>.

Note: Latin America (20 countries).

Moreover, while substantial systemic changes are not yet discernible, in some countries the consolidation of national systems or care-service networks is starting to appear on policy agenda. Elsewhere the debate includes the issue of care as one of the pillars of social protection. Service coverage is expanding, and steps are being taken to organize systems in some countries, such as Uruguay and Costa Rica, as this report describes in detail.

Care services generally have low coverage rates and, in particular, operate in a weak institutional framework. As the care dimension has traditionally not formed a pillar of public policies, programmes that fulfil external functions are generally subsumed under other rationales. In many cases, national programmes that directly or indirectly refer to care services are included in programmes of poverty reduction or social assistance to poor or vulnerable families or individuals.

They often take the form of conditional transfers that seek to encourage access by children and, sometimes, older adults, to health services (nutritional programmes, immunizations, periodic checkups, among others) or education, and hence to school canteens. Others address care on the basis of provisions related to child or older-adult nutrition, and many are linked to health components.

TABLE 2
LATIN AMERICA AND THE CARIBBEAN: LEGISLATION ON CARE BY TYPE
OF LEGISLATION AND YEAR OF ADOPTION OR RATIFICATION

Countries	Legislation on maternity leave	Legislation for breast-feeding mothers	Paternity leave	Disability laws	Legislation on domestic work	ILO Convention 156 ^a	ILO Convention 189
Latin America							
Argentina	1976	2013		1981-1996	1995	1956-1988	2014
Bolivia (Plurinational State of)	1992	2006	2009 and 2012	1995-2008		1988	2013
Brazil	1988-2007-2002	1943		1989	2006	1957	
Chile	2011	2007	2005-2009-2011-2013-2014	2010		1994	
Colombia	2010		2009	2002-2007	2010-2014		2014
Costa Rica	1996	1994		2007	2009		
Cuba	1974-1987-2003	2003					
Dominican Republic	1995						
Ecuador	2009	1995-2012	2008	2001-2012	2008	1957	2013
El Salvador	1972					2000	
Guatemala	1998	1973				1994	
Honduras	1959-2000	1959				1956	
Mexico	1963-1970	1963-1970		2005			
Nicaragua	1996	1999				1967	2013
Panama	1967	1967-1995				1958	
Paraguay	1993	1993				2007	2013
Peru	1996-2001	2001-2006	2009	1999		1986	
Puerto Rico	1942-2011	2004	2002-2007-2011	2008			
Uruguay	1980-1990-2005	1999	2001-2005-2008	2010	2006	1987	2012
Venezuela (Bolivarian Republic of)	2007	2007	2007	2006		1984	
The Caribbean							
Anguilla	2003-2004						
Antigua and Barbuda	1972						
Aruba							
Bahamas	2006					2001	
Barbados	1972					1999	
Belize	2000					1999	
Cayman Islands	2007						
British Virgin Islands							
Dominica						1983	
Dutch Antilles							
Grenada						1994	
Guyana						1975	2013
Haiti	2003					1958	
Jamaica	1979						
Saint Kitts and Nevis	1986					2000	
Saint Vincent and the Grenadines						2001	
Saint Lucia						1983	
Suriname							
Trinidad and Tobago	1988					1997	

Source: Gender Equality Observatory for Latin America and the Caribbean, Economic Commission for Latin America and the Caribbean (ECLAC), 2012. International Labour Organization (ILO).

^a Countries that have ratified the Convention.

BOX 2
LATIN AMERICA: THREE TYPES OF CARE POLICY

- Short-term policies, which tend to involve welfare hand-outs, lack quality-assessment processes.
- Systemic and integrated systems, aimed at redistribution and the promotion of an active role for the State; they involve a process for recognizing unpaid work. They are policies with links to the education and labour sectors.
- Policies for a new social covenant, aimed at questioning the sexual division of labour and promoting sustainable development, where the care pillar is central for development.

Source: Prepared by the author on the basis of studies undertaken by the Division for Gender Affairs of ECLAC.

In the longest-standing welfare States, the three classical pillars (health, education and social protection) are now being complemented with a “fourth pillar” that recognizes the right to receive care in situations of dependency. This is an emerging dimension of welfare that is very closely associated with population ageing; and it represents the beginning of recognition of the right to receive care.

IV. Progress towards care policies and systems

Care as a policy pillar represents an opportunity to envision a new, more intersectorally consistent State architecture, which strengthens a specific institutional framework that makes it possible to integrate care policies and services, according to the specifics of individual countries. Work is beginning on the development of new focuses for these policies, to enable them to respond to women's need for integration into the labour market, and the need for investment in people by providing care for young children, older persons and persons with disabilities, framed by international agreements on women's rights and those of the aforementioned care subjects.

Systems can thus be defined as a set of intersectoral public and private actions that are implemented on an articulated basis to provide direct care to persons and to help families care for household members. This includes care for dependent persons (children, persons with disabilities, older persons, the sick), which is a central component of the social protection system and is based on the definition of care as a public good, a right and a dimension of citizenship, as noted above.

The plan being implemented by the Government of Costa Rica, along with the National Care System in Uruguay, and vouchers (*bonos*) for providing care to persons with disabilities in Ecuador, are all examples of systemic and integrated policies aimed at redistribution and the promotion of an active role for the State, including a process to give recognition to unpaid work.

On this point, this study will analyse experiences in the development of care policies in four of the region's countries (Chile, Costa Rica, Ecuador and Uruguay), chosen for the progress they have made on various aspects of care provision in recent years. The analytical strategy in each case entailed reviewing documents and holding interviews with qualified informants, as well as direct observation of processes and exchanges of opinion and points of view with members of the technical personnel involved.

A. Chile: the *Chile Crece Contigo* programme

Chile's welfare model—liberal single-supplier or market-centred (Sunkel, 2007)—has undergone a rapid shift from State provision to private service supply, particularly in the cases of health, education and pensions. The organization of care services in Chile, as in the rest of Latin America, is mixed; care

can be provided by public and private organizations, and it is done both within and outside households and families.

Over the last few decades, the care crisis in Chile has intensified, owing to a supply deficit and increased demand for care, driven by several factors related to demographic changes (an increase in the population's life expectancy and a decline in fertility), the incorporation of women into the labour market, family changes, and the persistence of a rigid sexual division of household labour.

Since the 1990s, under the coalition governments of the *Concertación*, and particularly since the administration of President Bachelet (2006-2010), greater emphasis has been placed on the rights-based social protection system. This has included several initiatives centred on improving education and health conditions, targeting specific population segments: older adults, housewives and children under six years of age belonging to the poorest 40% of the population.

The measures implemented include reform of the pension system; reform of the health system, including the creation of the *Auge* universal-access explicit-guarantees health plan; and the *Chile Crece Contigo* [Chile grows with you] programme. Policies and programmes to articulate family and working life are currently less developed, apart from maternity-protection policies for working mothers, where Chile is in the vanguard.

In the case of older adults, the expansion of the supply of care services stems mainly from an increase in monetary resources for the poorest population groups, achieved through pension reform. Alongside the establishment of a social protection system for older adults in Chile, various more specific government programmes have been implemented, such as the National Fund for the Older Adult; the *Derecho a Techo* [Right to a roof] protected housing programme for adults; the training schools programme; and the older adults social tourism programme, among others.

Pension-system reform has included the establishment of a solidarity pillar guaranteeing a minimum universal benefit to all older adults. While the reform pursues greater equity and equality, measures are also being implemented to benefit women directly given their unequal status in terms of pensions. These include the Basic Solidarity Pension, the solidarity pension contribution, the child allowance, the division of asset balances in the event of divorce or annulment, the survivor pension for family members of the woman, among others.

Despite these initiatives, the coverage of care services for the older-adult population remains inadequate, and the programmes and services on offer stress welfare-handout type activities.

1. The *Chile Crece Contigo* programme

In the case of childhood, the analysis will focus on the *Chile Crece Contigo* programme, which is considered the main care-policy implemented in this country. Despite improvements in the Chilean population's socioeconomic indicators, the incidence of poverty and indigence is highest among children under four years of age, while poverty rates in the older age brackets are below those reported for the total child population.

At the same time, women's low rate of labour market participation is directly related to the lack of child-care coverage in the form of crèches and kindergartens. Under Chilean labour legislation, the right to crèche facilities (for children under two), paid for by the employer, is only available to women who work in firms with more than 20 female employees.

The problem that the *Chile Crece Contigo* programme aims to address is the inequity that exists within Chilean society; and it targets its actions on regulations and programmes to assure the integrated development of children in their early years and women's participation in the labour market.

In this context, child-care policies, mainly targeting children of preschool age, are an important component of the system for reducing inequality levels. These policies make it possible to alleviate the burden on women, which stems from the sexual division of labour and prevents them from achieving economic autonomy.

BOX 3 DRAFT LAW

Chile's new law on crèches will include a special fund, financed through a contribution payable by the employer for each worker employed, male or female, regardless of whether or not they have children. The benefit will be under central administration and subject to competitive tender. Although the benefit is currently only available to women working in firms with more than 20 female employees, its coverage will be expanded to include all dependent female workers; and, in the case of self-employed workers, it will be applicable as from the moment they are required to contribute. It will also be applicable to women who do not work and those who are in the 60% lowest-income bracket and affiliated to the *Chile Crece Contigo* programme. The draft law will replace Article 203 of the Labour Code, which requires all firms with 20 or more female workers to pay for crèche services.

Source: Government of Chile, draft law on crèches [online] <http://2010-2014.gob.cl/especiales/proyecto-de-ley-de-salas-cuna/>.

2. Objectives of the *Chile Crece Contigo* integrated early childhood protection system

The system originated in proposals made by the Presidential Advisory Council on the Reform Childhood Policies, which, in its diagnostic assessment of the situation across the country, drew attention to the fact that Chile has one of the lowest rates of female labour market participation in Latin America, particularly among women from low-income households. The diagnostic highlighted the importance of assuming the functions of caring for and educating children as a social responsibility and a public-policy issue, with the aim of helping families achieve success in their efforts to improve their living standards and provide an adequate upbringing and education for their children.

Chile Crece Contigo is an integrated system of social interventions and benefits that aim to provide comprehensive support for children and their families, from the stage of gestation until they enter the school system at four years of age, by providing the tools needed for them to develop their potential to the maximum. Modular implementation of the social-protection system should activate an increasingly wide-ranging welfare system that would include all citizens.

The aim of the system is to ensure that all children have the tools needed to cope with and face the specific risks of each stage of their growth, and thus promote more egalitarian childhood development and better life prospects for all children in Chile. To that end, it proposes an expansion of care coverage, by creating crèches and expanding kindergarten places for children whose fathers and mothers are working, looking for work or studying.

Another of the objectives of the system is to engage men/fathers in the tasks of caring for and accompanying their children. This is based on the notion that involving fathers in caring for their children generates positive changes, not only in the child's development but also in social relations, which means fostering more egalitarian relations between men and women and in the notion of co-responsibility.

The intervention strategy consists simultaneously of legislative initiatives to improve the relation between women and work; social services and provisions targeting children and their families; together with monetary support provided through subsidies for families with children who need it. Implementation is based on the construction of protection networks that prioritize the role and participation of the family and articulate the public supply of goods and services.

3. Participants

The administration of President Ricardo Lagos had begun work on designing a comprehensive child protection system as part of the social protection system that was in the initial stages of implementation. Then, in the early days of the Bachelet government in 2006, the new President convened the Presidential Advisory Council for the Reform of Childhood Policies, which was tasked with “making a diagnostic assessment of the current status of child protection and existing shortcomings, to then formulate and

propose a set of suitable policies and measures for implementing a child-protection system” (Government of Chile, 2006).

The creation of consultation mechanisms, advisory councils and ad hoc commissions was a policy widely used by the Bachelet government, with the aim of generating consensus before formulating specific policies. The mechanisms in question included the Advisory Council for the Reform of the Pension System and the Advisory Council for Labour and Equity.

The Council consisted of 14 members who were personally appointed on the basis of their experience on issues relating to childhood policies, while also considering political balances. During the Council’s period of functioning, a variety of social organizations and groupings related to childhood, both public and private, were convened, through public hearings held throughout the country.

The Councils fulfilled a consultative role; and the fact that their proposals were not binding meant that public-policy-making prerogatives remained in the domain of the Government and Congress. Subsequently, a Ministerial Committee was set up explicitly to analyse the Council’s proposals, and was tasked with analysing the technical, financial and political viability of the proposals, preparing draft laws, and setting political and technical guidelines for implementing the reforms.

The Ministerial Committee was chaired by the Minister of Planning (equivalent to today’s Minister of Social Development), and consisted of the Ministers of Labour, Health, Education and Finance. The Committee was supported by a technical secretariat and technical committees consisting of legal and professional teams from the participating ministries.

The end product consisted of draft legislative proposals on the issues addressed, and the design and improvement of the social programmes needed to execute the reforms. The processing of these proposals elicited broad consensus, thereby making it possible to introduce new benefits targeting children and beneficiary families, expanding the coverage rates of health, care and education programmes, and of the provisions and subsidies targeting families with children under four years of age. Parliament approved the necessary legal amendments, together with the corresponding budgets for implementation of the system as from 2007.

Subsequently, Law 20.379 of 2009 was passed, regulating and guaranteeing the provisions of the *Chile Crece Contigo* system and giving it permanent status. In other words, the early childhood protection became enshrined in the law.

Implementation of the programme began in 2007, covering children from gestation until their entry into the first year of formal education in the school system, at four years old in the Chilean case. The system encompasses health care, early stimulation, childcare and preschool education, together with specific provisions for children in special situations of disability or backwardness.

Implementation of the *Chile Crece Contigo* system has resulted in child-care policies being greatly strengthened, as reflected in a considerable increase in the coverage of crèches and kindergartens, resulting from the action of public institutions responsible for preschool education: the National Kindergarten Board (JUNJI) and the Integra Foundation. The supply of new places targeted children whose mothers are either working (either formally or informally), looking for work or studying, and who belong to the lowest 60% of the income distribution. Coverage grew progressively from 2005 to 2010 to attain the 60% target specified in the programme’s design.

The care policies implemented under the *Chile Crece Contigo* system are progressively changing the national tendency for children under two years of age to be cared for at home, mostly by women.

The system is emerging as a result of the political desire to enhance social protection, seeking to guarantee equal opportunities from “the cradle” and make headway on policies that reduce the inequality gap. The focus is placed on family as a whole.

The system aims to generate a set of provisions that ensure harmonious development in early childhood, and it includes women in care provision for that purpose. It is not a programme designed for women’s advancement or enhancing their economic autonomy; but it grants benefits to them, based on

the interests of their children. Nonetheless, its rationale also includes the need to provide women with tools for development in the domain of paid work; and it assumes that the State should share responsibility for care services.

A factor to be considered is that, over the last three years, the system has reduced its child-care benefits (the creation of new crèches has been frozen since 2010, and no investments have been made to expand kindergarten coverage rates). Instead the focus has been on providing benefits in the bio-psycho-social development system, and in health provisions, allowing the national child care system to follow its course without expanding its growth.

Overall, it can be concluded that the design of this system incorporates a gender perspective, by seeking to generate benefits that give greater economic autonomy to women and their incorporation into the labour market under equal conditions; but it lacks a more integrated view of the topic of care and women's work times.

B. Costa Rica: the National Care Network for Children and Older Adults

In 2010 the strategy of the Chinchilla government (2010-2014) sought to strengthen care options within its social policy, by creating a network of care and development services for children and older adults, and for workers of both sexes and their families.

As part of its social policy, and in recognition of the urgent need to provide care for the most vulnerable sectors and promote the exercise of a rights-based citizenship, the Costa Rican government has been developing an institutional network of care services for children and older adults, known as the National Care Network.

This network of care services for children and older adults aims to increase the coverage and quality of the integrated care that children receive from their first few months of life; and it proposes to create mechanisms enabling older adults to socialize and satisfy their vital recreational and leisure needs, thereby helping to enhance their quality of life.

Although the National Care Network for Children and Older Adults is based on an expansion of existing services, it also promotes new services and care modalities. The need has been identified for a national care strategy, to make it possible to move towards a national network of child care and development and care for older adults. This would articulate public, private and civil-society organizations and resources, providing services within an agreed-upon and shared framework of objectives, values, principles and common rules, thereby making it possible to ensure the relevance, comprehensiveness and quality of the benefits in question. This requires clear definition of the forms of intervention; the components of the networks and the modalities of their interaction; as well as operating rules; regulation and inspection capacity; coordination, definition of hierarchies and roles; the establishment of quality standards with respect to the services; and inspection, supervision and regulation by the State.

The programme is based on an expansion of existing services, but it also promotes the implementation of new services and care modalities. In relation to child care, the programme focuses on expanding services to children between birth and six years of age living in poverty, through the Education and Nutrition Centres programme and Comprehensive Child Care Centres (part-time and full-time, respectively); and it seeks to elicit greater involvement by the municipalities and other actors in the provision of these services, together the definition and provision of new services (such as the Child Care and Development Centres, run by municipalities and private entities).

In 2010, various draft laws were presented to the Legislative Assembly, with the aim of recognizing and guaranteeing the fundamental right of children to State care while their fathers and mothers are at work.

BOX 4

DECREE CREATING THE NATIONAL CHILD-CARE AND DEVELOPMENT NETWORK

The President of the Republic and the Minister of the Office of the President:

Pursuant to the powers and attributions conferred on them by Articles 140, paragraphs 3, 8, 18 and 20, and Article 146 of the Political Constitution; paragraphs 25, 27 (1) and 28 (2), subparagraph (b) of the General Law on Public Administration; the Convention on the Rights of the Child, ratified by Law 7184 of 18 July 1990, Law 7739, the Childhood and Adolescence Code of 6 January 1998; Law 7648 the Organic Law of the National Child Welfare Agency (*Patronato Nacional de la Infancia*) of 9 December 1996; the Law Promoting the Social Equality of Women, Law 7142 of 8 March 1990; the General Law on Integrated Care Centres of 29 August 2000; Law 8017, and Executive Decree 21391 of 1 July 1992.

Whereas:

1. It is a duty of the State to ensure the physical, psychosocial and educational well-being of children, which includes satisfying their primary health and nutrition needs.
2. It is possible to nurture children's intelligence and, in general, improve their bio-psycho-social development, if they are stimulated and cared for on a comprehensive basis from the stage of gestation.
3. The country's development and the value of its human capital depend largely on the quality of child-rearing and the care received by children in their first few years of life.
4. The Convention on the Rights of the Child, ratified by Law 7184 of 18 July 1990, and the Childhood and Adolescence Code, provide that children shall receive special protection and have opportunities and services to enable them to develop physically, mentally, morally, spiritually and socially, in a healthy way and in conditions of freedom and dignity.
5. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), incorporated into Costa Rican law through Law 6968 of 2 October 1984, calls on States Parties to adopt appropriate measures to encourage the provision of the supporting social services needed to enable parents to combine family obligations with work responsibilities and participation in public life, in particular by promoting the establishment and operation of a network of child-care facilities.
6. The Law Promoting the Social Equality of Women, Law 7142 of 8 March 1990, along with other regulations in the country's legislation, require the State to promote the necessary conditions for the full development of the female population, and to adopt the measures needed to guarantee the exercise of their rights, including that of working, under equal conditions with men.
7. The General Law on Integrated Care Centres of 29 August 2000, Law 8017, regulates the creation, development and adequate functioning of public, private and mixed integrated care centres, for persons of up to 12 years of age, except those under the guardianship, support and supervision of the Ministry of Work and Social Security and the Ministry of Public Education.
8. Executive Decree 21391 of 1 July 1992 requires the Joint Social Support Institute (*Instituto Mixto de Ayuda Social*) to create entrepreneurial capacities among low-income persons, to enable them to develop small-scale businesses providing integrated child care.
9. The different public and private mechanisms that currently provide integrated child care and development service on a fragmented basis need to be articulated, with the aim of improving the quality of coverage of the services offered.
10. Early childhood policies, plans and programmes need to be founded on integrated, multisectoral and participatory strategies, based on the rights approach and not only on socioeconomic or employment considerations, as established by the Convention on the Rights of the Child and the Childhood and Adolescence Code.
11. Agreement No. 6 of 8 May 2010 confers the rank of Minister of Social Welfare and Family on the Executive President of the Joint Social Support Institute.

Accordingly decree as follows:

Declaration of Public Interest in the formation and development of the "*National Child Care and Development Network*"

Article 1 - The formation and development of the National Child Care and Development Network is declared a matter of public interest.

The *National Child Care and Development Network*, along with integrated care centres for children, will be formed by the various social, public and private actors that have a legal mandate or legitimate interest in relation to integrated child care, protection and development, including the children themselves; parental or guardianship organizations; the staff, directors and supervisors of care services; professional groups from various disciplines; and both governmental and non-governmental entities.

Article 2 – Actions aimed at conducting studies, and the design, regulation, constitution and formulation of the development plans of the National Child Care and Development Network, will be coordinated by the Ministry of Social Welfare and Family, notwithstanding the powers granted by the law in this domain to various other public institutions.

Article 3 – State institutions, within their field of competency and according to their possibilities, are called upon and authorized to collaborate actively and to contribute human, physical, and economic resources to the development of activities leading to the formation and development of the National Child Care and Development Network.

Article 4 – To take effect upon publication.

Source: Extracted from the Official Gazette of San José de Costa Rica "*La Gaceta*", 20 January 2012, [online]: http://www.imprentanacional.go.cr/pub/2012/01/20/ALCA10_20_01_2012.pdf.

1. Institutional legal process

A direct antecedent is the National Policy for Gender Equality and Equity (PIEG), which was formulated in 2007 with priority objectives that include the following: *“That by 2017, every woman who requires child-care services to be able to undertake paid work should have at least one public, private or mixed care alternative, of quality, thereby taking practical steps towards social responsibility in care and valuation of domestic work”* (INAMU, 2007).

To attain that priority objective, it proposes an expansion of the care infrastructure, along with the implementation of actions to promote cultural changes in favour of co-responsibility between men and women in this domain, and also social responsibility: *“Viewing care as a social problem means making progress not only in creating services but also in terms of cultural change... care must shift from being a female matter, to one that is also male, and from being a private family issue, to being a public, State and enterprise concern”* (INAMU, 2007).

In 2008, a plan of action was prepared for implementing the PIEG in 2008-2010 (INAMU, 2008). This included 17 specific actions to be undertaken in the period, divided into two broad categories —the social infrastructure of care and the promotion of cultural changes to enhance co-responsibility between men and women.

A review of the aforementioned plan shows that of all the actions considered, only two focus on promoting cultural changes in favour of co-responsibility between men and women.

2. Existing services

The child-care services that exist in Costa Rica can be classified in three types:

- (i) Services provided by public institutions with public funding (irrespective of whether the service is partly paid for by the families);
- (ii) Services provided by private entities and also financed privately;
- (iii) Services provided privately but which have public-sector financing (with or without a co-payment by the families).

This report will adopt the proposal made by Sauma of referring to the first of these types as public services, the second as private, and the third as mixed (Sauma, 2012). In the case of public services, two modalities can be distinguished: those open to the public (irrespective of requirements related to the poverty status of households and others), and child centres run by public institutions that exclusively or mostly serve the children of their employees.

The beneficiary selection criteria for this programme consider the following factors: (a) a per capita family income not exceeding the poverty threshold; (b) the parents in the family live or work in the catchment area the establishment in question; (c) the existence of malnutrition or development problems; (d) situations of social risk; and (e) the mother needs to leave her child at the centre to be able to work. The programme is financed from the Social Development and Family Allowances Fund (FODESAF) in conjunction with the central government budget; and it also receives various grants from the community and a voluntary contribution from the father/mothers of the families in question.

The Chinchilla administration (2010-2014) has prioritized setting up the National Care Network for Children and Older Adults. The target for child care involves a 75% increase in current coverage in open establishments, as stipulated in the National Development Plan for 2011-2014.

Private services can be divided into two types: those that are merely commercial, in which private firms produce and sell care services to third parties; and those provided by private organizations, with their own financing, to certain specific groups.

In the case of private services provided on a commercial basis, the country presumably has a large number of private child-care centres, preschool education centres and private schools which serve a population that pays for their services.

Services provided by private organizations with their own financing, include child-care in firms for their employees; but only a very small number provide this service, and business associations have argued on several occasions that this issue is not one of their priorities, mainly owing to its high cost.

In the case of mixed services, Costa Rica has the *Hogares Comunitarios* [Community Homes] programme, which is privately implemented but financed by the Joint Social Assistance Institute (IMAS). The programme was launched in 1991 to promote the creation of microenterprises specialized in child care, set up by mothers who could provide the service to a small number of children in their respective homes (“community mothers”), thereby facilitating labour market participation by low-income persons. The programme beneficiaries are children under seven years of age belonging to poor families; and the care service is provided by the “community mothers”, who look after, feed, educate and provide affection to the children. In principle, the service is provided for a 12-hour period (from 6 a.m. to 6 p.m.) from Monday to Friday (Sauma, 2012).

For older adults (65 years plus) there are three care modalities: old peoples’ homes, shelters, and day centres. Old peoples’ homes are establishments in which older adults live permanently and receive integrated services.

Shelters are a variant on old peoples’ homes, which arose to solve the housing problem for individuals without family resources. The community assumes responsibility for them and takes care of their basic needs; the shelter is open, and the old people receive visits and go out from the home into the community. Day centres operate on a daytime schedule and provide older persons with basic services in the areas of nutrition, recreational therapy, and so forth.

Home-based services for older persons constitute a fourth care modality, which forms part of the National Care Strategy. This involves care and assistance for older adults according to their level of dependency, provided in their place of habitual residence. Actions range from helping with daily bathing, preparing and providing food; as well as home cleaning, medical care; as well as accompanying to medical appointments, the use of public transport, shopping or making payments, for example. There are no public services as such for older adults, but mostly mixed services along with a few private ones.

The National Council for the Older Adult (CONAPAM) was created by the Integrated Law for the Older Adult (Law No. 7935) of 1999, and serves as the authority on ageing and old-age issues. The functions assigned to it by the law include some that are directly related to the care services provided to this population group, such as: “to participate in accreditation processes, within the scope of their competency, and to promote the granting of accreditations or recommend withdrawal of accreditation from the respective home”; and “to keep an up-to-date record of individuals and corporate entities accredited by the Ministry of Health to provide services to older adults.”

The data provided by Sauma clearly show that the coverage of publicly financed care services is low, since no more than 2% of the older adult population in 2010 was being cared for through the three main modalities existing in Costa Rica —homes, shelters, and day centres (Sauma, 2012).

Research undertaken in Costa Rica shows that the country does not have a genuine care system for children and older adults, understood as a system of universal coverage for those who need it, in which all institutional actors play a relevant role, duly coordinated and adequately balanced in terms of the distribution of responsibilities and care tasks, including, in the latter case, distribution between each of the domains, in particular the domestic one.

C. Ecuador: unpaid reproductive work in the 2008 Constitution and the National Plan for Good Living

Unpaid care work, the excessive work load borne by women and the sexual division of labour have gained a high profile in public debate, and also in constitutional provisions and official documents in Ecuador.

Two factors seem to have contributed to this profile-raising process. The first is the existence and widespread dissemination of data that unquestionably reveal the excessive work load borne by women.

The data in question are obtained from time-use surveys, which have been developed and become institutionalized since 2003. The second factor is the relative openness and spirit of participatory reform displayed by the political, economic and social system, which the women's movement has been able to harness in presenting their demands and getting them included.

In relation to the first factor, time-use surveys have been an important tool in several countries for promoting laws and public policies that recognize, reduce and redistribute unpaid reproductive work. In the specific case of Ecuador, the higher profile of the sexual division of labour made possible by time-use surveys has been a key factor in the formulation of current care policies and the presence of care services on the public agenda.

In the opinion of the main actors, the availability of data produced by the time-use surveys has played an important role in subsequent achievements—for example the recognition of unpaid reproductive work in the 2008 Constitution and the inclusion of strategic guidelines and the respective targets in the National Plan for Good Living. The support provided by the ECLAC Division for Gender Affairs has also been decisive for progress in this domain.

In relation to the second element of the political context, the national gender mechanism played a significant role in this process, coordinating with other State agencies to promote gender mainstreaming in institutions and to transmit views and demands articulated by women's organizations in civil society.

1. The legal framework of the process

In 2008, Ecuador adopted a new constitution (Constitution of the Republic of Ecuador), which requires the State to formulate and implement policies to achieve equality between women and men and to mainstream gender in plans and programmes. The fact that it recognizes, as part of the economic system, self-supported unpaid domestic work and care for human beings provided in the home, along with family-based and autonomous forms of work, is pioneering in the region.

This recognition gives rise to specific labour rights under the Constitution, namely: “The State will guarantee respect for the reproductive rights of female workers, which includes the elimination of workplace hazards that are injurious to reproductive health; access to and stability in employment, without restrictions owing to pregnancy or the number of children; maternity and breast-feeding rights, and the right to paternity leave. The dismissal of a female worker associated with her condition of gestation and maternity is prohibited, as also is any discrimination linked to reproductive roles” (Art. 332); “Unpaid work of self-sustenance and human care undertaken in the home is recognized as productive labour. The State will promote an employment regime that functions in harmony with human-care needs, by facilitating services, infrastructure and adequate working hours. In particular, it will provide child-care services, care for persons with disabilities and other provisions needed to enable female workers to fulfil their work activities; and it will promote co-responsibility and reciprocity between men and women in domestic work and family obligations. Social-security protection will be progressively extended to persons undertaking unpaid family work in the home, pursuant to the general conditions of the system and the law” (Article 333).

The Constitution places special emphasis on the rights of vulnerable population groups, which include older adults, children and persons with disabilities. It stresses that the State will establish public policies and programmes on care for older adults, which will take account of the specific differences that exist between urban and rural areas; along with gender, ethnic and cultural inequities; and specific differences between individuals, communities, peoples and nationalities.

In the case of childhood, the State undertakes to promote “care services for children under six years of age to guarantee their nutrition, health, education and daily care in a framework of integrated protection of their rights” (Article 46). With respect to disability, Article 49 provides that “Individuals and families who look after persons with disabilities requiring permanent care, will be covered by Social Security and will receive periodic training to improve the quality of care they provide”.

The issue of unpaid work, women's excess work load, and the lack of co-responsibility between men and women, had previously been identified in the diagnostic study undertaken for the Equal Opportunities Plan for Ecuadorian Women 2005-2009 (CONAMU, 2005).

More recently, the National Plan for Good Living (2009-2013) also recognizes the importance of reproductive work as a fundamental pillar of the solidarity-based and equitable-development model: "This recognition means simultaneously identifying the nodes of inequality engendered by these care and social reproduction activities, which relate to the sexual division of labour whereby our societies overload women with care activities. This gives rise to class-based inequalities that result in women of precarious employment status assuming a disproportionate share of these activities, and intergenerational differences that also relate to an unequal sharing of tasks between ages" (National Good Living Plan).

This Plan gives practical expression to the regulations put forward in the 2008 Constitution, in terms of both priorities and concrete objectives, and also in policies and guidelines to achieve them. For example, it is proposed to prioritize the allocation of public resources to progressively increase social-security coverage for individuals who undertake unpaid domestic work and care tasks, together with the promotion of public, family and community co-responsibility in caring for dependents.

2. Child-care services

An initial feature to highlight in the Ecuadorian case is the fact that since the 1990s a range of programmes has been launched, including child-care programmes, with different levels of targeting on lower-income population groups. These are chiefly financed by multilateral development banks operating in Latin America, with the result that nearly 80% of child-care services are publicly supplied.

The most important of these is the Child Development Programme, which has been running since 1988. Operated by the National Childhood and Family Institute (INFA), it serves about 500,000 children of between six months and five years of age, whose families are living in poverty and whose parents work in the Childhood Development Centres (CDIs). These centres, which are jointly managed by the communities, employ "community mothers", who provide care in the areas of nutrition, health and initial education. The service operates in the homes of the community mothers, five days a week and for between six and eight hours each day. In November 2010, the MIES announced a widespread reform of the programme; and since January 2011, the management and coordination of the centres, renamed *Centros para el Buen Vivir* [Centres for Good Living], has been run directly by MIES employees. Their working hours will be adapted to better serve the needs of "working mothers, single fathers and student mothers" (MIES, 2010). The caregivers will be referred in a less maternalistic manner as "promoters".

Care services today are mostly provided by State institutions, whereas their private counterparts have very low coverage and generally serve the wealthier sectors of the population.

It should be noted that, at a municipal level and in the context of Ecuadorian emigration, the action plans of several local governments have incorporated care for the family members of migrant workers. A recent study mentions the case of the municipality of Quito, which provides psychological support for care-providing grandmothers, and offers hygiene services to the children of migrants (UNDP/ILO 2009).

3. Older adults

The new 2008 Constitution identifies older adults as a vulnerable and priority group. Its Article 37 asserts that: "The State will guarantee the following rights to older adults: (1) free and specialized health care and free access to medicines; (2) paid employment according to their capacities, for which their limitations will be taken into account; (3) a universal retirement pension; (4) discounts on public utilities and private transport services and entertainment shows; (5) tax exemptions; (6) exemption from the payment of notary and registry fees, according to the law; (7) access to a home that guarantees a decent life style, while respecting their opinion and consent." The most innovative and significant of these provisions seems to be the universal retirement pension, since this grants economic autonomy to this population group.

4. Care for persons with disabilities

Lastly, several substantive measures have been adopted for persons with disabilities, such as creation of the National Council on Disabilities (CONADIS) and the Directorate of Care for Persons with Disabilities at the Ministry of Economic and Social Inclusion. CONADIS fulfils its mandate nationally, by issuing policies, coordinating actions, and undertaking and promoting research on disabilities.

The Directorate's main activities include providing economic assistance to meet study and/or rehabilitation expenses for low-income children and young people from Ecuador's marginal urban and rural sectors; subsidies for the purchase of medicines; for integrated care and the necessary medical instruments (prostheses, wheelchairs, etc.); as well as for surgery, rehabilitation, medical inputs, laboratory tests and other items. Many of the services in question are provided under agreements with nongovernmental organizations (NGOs) and foundations. In the case of persons with disabilities, the supply of services also targets families that are unable to meet the full costs of their respective vulnerability. The policies generated target the poorest population strata and are also based on residual policies.

This second factor means that the policies in question operate when the families themselves cannot meet the demands of this population group. The role of families as care providers par excellence is the second idea that this document aims to make clear, along with the validity of targeted social programmes.

In 2010, the *Joaquín Gallegos Lara* mission was launched in Ecuador, which provides a US\$ 240 voucher every month to the family member or other individual responsible for taking care of persons with severe intellectual or physical disabilities, who have been identified by the Manuela Espejo mission, and require comprehensive care from the Ecuadorian State. They also receive medicines and training in areas such as health, hygiene, rehabilitation, nutrition, rights and self-esteem.

D. Uruguay: the National Care System

In Uruguay, a country with a strong historical legacy of social protection, care provision is currently at the centre of the public agenda and is an emblem of social public policy. The design of a care service system forms part of a wider-ranging process of social reforms that began in the country in 2005, encompassing changes to the health system and social security, and also tax reform.

Several actors have played a key role in the process of conceptualizing care, building the notion of the "right to care", as referred to in the first part of this document, and placing the topic on the social policy agenda. Leading players include academia, women's organizations, the National Women's Institute and international cooperation. The need to construct a system of care services has also been expressed in different activities organized by the national government, academia, civil society and international cooperation (Batthyány, 2012).

Information and knowledge have played a central role in recognizing the care crisis and in placing the subject of care with a gender perspective on the public agenda, basically through indicators that have been provided by the time-use surveys and the conceptual-dialectical contribution of academia.

In 2010, the Government issued Resolution 863/2010 creating a working group within the Social Office to coordinate the design of the National Care System (SCN), with representatives from ministries and public organizations.

BOX 5 THE NATIONAL CARE SYSTEM

The Resolution stated that:

1. “The care of dependent persons and the promotion of their personal autonomy is a challenge for the social policies to be developed by the State;
2. The recognition of persons in situations of dependency involves participation from society as a whole through a specific legal framework embedded in a social protection policy;
3. In general, it is women who assume care tasks; most children are born in families living below the poverty line; the majority of these families are single-parent households headed by women, most of whose time is devoted to caring for the children; and, if they continue participating in the labour market, this investment is usually partial, for their children are left unprotected or cared for by family members or neighbours for long periods of the day;
4. It is advisable to design a National Integrated Care System to avoid, among other things, the duplication of women’s work load, and a social loss from their potential contribution to production and the country’s economic growth.”^a

Source: Care system of the Government of Uruguay, [online] www.sistemadecuidados.gub.uy.

^a Extracted from the working paper of the group, available at: http://www.sistemadecuidados.gub.uy/innovaportal/file/13329/1/documento_de_trabajo.pdf.

The National Care System in Uruguay is headed by a working group with participation from representatives of the Ministries of Social Development, Public Health, Work and Social Security, the Office of Planning and Budget, the Social Security Bank, the Ministry of Education and Culture, the State Health Services Administration, the Children and Adolescents Institute of Uruguay, the National Institute of Statistics and the Ministry of Economy and Finance.

This system seeks to channel and promote the changes that are unfolding in the population at large (birth rate, ageing), and also in families (the sexual division of labour, care and deficit) and in the labour market (an increase in the female participation rate, reduction in the female unemployment rate and equal conditions for men and women in the labour market). It proposes to formulate a care system framed by social-reform policies of a rights-based universal type. It will also combine the creation of services with the possibility of helping families contract care services in the home or outside it. Geographical decentralization will be a fundamental pillar of this system, with the aim of generating “neighbourhood services” that have the flexibility to take account of the specific needs of each community in the service provided. Community participation, in new formats and taking advantage of those that already exist, is a cornerstone of any rights-based care system. Lastly, it will strengthen and professionalize the care task by providing training to caregivers, both family members and formal care providers, paying special attention to the gender, generational and ethnic-racial perspectives.

The definition of care with which they worked was as follows: “This is a social function that implies both the promotion of personal autonomy, and care and assistance for dependent persons. Dependency may be transitory, permanent or chronic, or associated with the individual life cycle” (www.sistemadecuidados.gub.uy).

Among the fundamental concepts underlying the need for a care system, the work group highlighted following:

- The recognition of social rights by the State, and the definition of co-responsibilities in caring for dependent persons, is based on the notion that persons are rights-holders and that the State has a responsibility to ensure that their rights are upheld.
- Consideration of the country’s demographic dynamic —basically in relation to population ageing and the consequent increase in the number of non-autonomous persons, resulting from longer life expectancy. In addition, the current demographic model consists of upper socioeconomic segments with late fertility producing few children; and socioeconomically vulnerable sectors with early fertility and many children. The care requirements of these groups are different in this regard.

- The economic fundamentals: firstly the progressive increase in female activity rates over the last few years, the rise in formal education levels, and the need to be able to earn an income to achieve higher levels of economic autonomy; secondly, the foundations for long-term economic development, if we succeed in improving the education levels of the entire population, starting with the new generations; and thirdly, the provision of care services by the market which poses problems that justify State intervention.

In relation to the target population, three large groups were identified for targeting by the system: children of both sexes from birth to 12 years of age, specially focusing on the 0-3 year age bracket; dependent persons with disabilities; and dependent older adults.

The system is intended to be universal, so it should ultimately reach all persons belonging to these population groups. Nonetheless, as of today, criteria are being discussed for targeting the most vulnerable population groups, at least for initial implementation of the system.

A review of the documents prepared by the working group reveals the following as guiding principles for the design and current implementation of the care system in Uruguay.

- As a rights-based policy, the care system should be constructed under universal criteria, although initially targeting the most socially vulnerable population groups. The design will include medium- and long-term commitments, with different population segments being incorporated successively until universal coverage is achieved.
- Based on the notion that persons are rights-holders and that the State is responsible for ensuring those rights are effectively upheld, the design of social policy will incorporate gender, generational and ethnic-racial perspectives.
- The Care System will be designed by combining service-creation strategies and the possibility of monetary transfers.
- Change needs to be promoted in the current sexual division of labour; and, to this end, the care system should integrate the concept of co-responsibility as a guiding principle.
- Geographical decentralization should be a fundamental element, seeking to generate “neighbourhood services” that are flexible enough to take account of the specific needs of each community in the service provided.
- Strengthen and professionalize the care task by providing training to caregivers, whether family members or formal care providers.
- Collective and increasingly coordinated functioning of the organizations involved in this system, particularly public agencies.

In the process that has unfolded since the creation of the working group in 2010, three stages can be clearly identified. The initial stage which occupied most of 2010, involved work within the group and also among the public institutions to unify the State’s position on a series of principles and conceptual guidelines.

The second stage, in 2011, involved a national public debate on the issue of care provision. This attracted participation from over 3,000 persons, including politicians, technical experts, firms, labour unions and representatives of social organizations, and parliamentarians. Lastly, the third stage, which began in 2012 and is still ongoing, has involved the preparation of proposals and the drafting of a framework bill on the National Care System (SNC), setting out fundamental guidelines for the corresponding institutional framework, financing, regulation, training and services.

The National Care System requires the construction of a new collective institutional framework—the National Care Board (JUNACU)—and the constitution of a National Care Fund (FONACU). It also entails adjusting the training of caregivers, both male and female, and the regulation of employment and services in the care task; and, lastly, the establishment of a series of services, provisions, and

licences for the provision of care services. These pre-requisites have not yet been developed and the process is to some degree stalled.

1. International agreements and covenants

The SNC responds to the country's need to align its social policies with international regulations and the agreements signed in this domain.

The Childhood and Adolescence Code and the Education Law provide criteria for implementing the system nationally; and the design of the National Care System for Childhood has been based on this. The General Education Law (Law 18.437) deepens the guidelines particularly for the SNC in early child care centres.

The current regulations, along with international agreements and conventions on disability, which are forerunners of the National Care System, include the following. On 19 March 2010, Law 18.651 “Comprehensive protection for persons with disabilities” entered into force. Article 1 of this law “establishes an integrated protection system for persons with disabilities, aimed at assuring their medical care, education, physical, psychological, social, economic and professional rehabilitation, and social-security coverage, as well as granting the benefits, provisions, and stimuli that make it possible to neutralize the disadvantages caused to them by disability, and give them the opportunity, through their effort, to play a role in the community that is equivalent to that played by other people.”

On 13 December 2006, the International Convention on the Rights of Persons with Disabilities was approved. In each of the rights defined by the Convention, the text evokes principles concerning the dignity, autonomy and independence of persons with disabilities. Specifically, allusion to the SNC can be inferred in its Article 19 which proclaims the right of persons with disabilities to choose where and with whom they live, and be able to access services that facilitate their inclusion in the community, including personal assistance. Uruguay ratified the Convention on the Rights of Persons with Disability through Law 18.418 (ONU, 2006).

Issues relating to the care of dependent older adults occupy an extensive chapter of concern in the area of human rights, which in recent decades have led to the creation of international protection mechanisms. Targeting Uruguayan State actions on situations of older-adult dependency makes it possible to fulfil the binding international regulations that Uruguay has ratified or adhered to.

2. The process towards the proposal

The need for a National Care System has travelled a long road from the social agenda to the political and government agendas. Women's organizations placed the topic of care on the social agenda; and the National Institute of Women laid down guidelines for action in this regard in the 2005-2010 government period.

In 2009, the government programmes of the four political parties with parliamentary representation all mentioned the need to increase social responsibility in care services.

In 2010, the President of the Republic issued Resolution 863/010, creating an interagency working group in the SNC. This group was constituted in the framework of the National Social Policies Council on 15 June 2010, and has had regular participation from the Ministry of Social Development (MIDES), the Ministry of Public Health (MSP), the Ministry of Work and Social Security (MTSS), the Office of Planning and Budget (OPP), the Social Security Bank (BPS), the Ministry of Education and Culture (MEC), the State Health Services Administration (ASSE), the Children and Adolescents Institute of Uruguay (INAU), the National Institute of Statistics (INE), and the Ministry of Economy and Finance (MEF).

In 2010, the working group agreed upon a series of guidelines and defined a work plan for 2011, which included wide-ranging social debate, involving representatives from public institutions, social and private actors, etc. To that end, it drafted three basic documents and put them forward for national debate. The invitation centred on debating the problem of care and proposals for responding to it. This “debate stage” attracted participation from 3,200 people representing over 1,800 organizations and institutions of all types, thereby demonstrating the importance of this proposal and the need for it.

3. Existing services

The issue to be resolved in the case of early childhood is how to define a public policy that guarantees both the right of children to comprehensive development, through quality care, and the right of families to receive support in this co-responsibility through actions that reverse the unpaid female work load that this care entails.

The proposals presented on early childhood combine services, leave periods and benefits, with children younger than 12 months being treated differently than those of between one and three years old.

In the first place, a lengthening of maternal, paternal and breast-feeding leave periods is proposed, covering private-sector female workers, single-person businesses and small-scale taxpayers affiliated to the simplified tax regime (*monotributistas*). In addition, a National Home-based Care Programme will be created to provide care services in the home, prioritizing the youngest children. Thirdly, services outside the home, both public and private are promoted. In the case of public centres, the aim is to universalize daily care (four hours minimum) for children between two and three years of age belonging to poor and poverty-vulnerable households, through the Early Childhood and Family Care Centres (*Centros de Atención a la Infancia y la Familia – CAIF*) model. In addition, it is proposed to implement a one-year pilot programme of daily care for this population group. A further proposal is that the services be made flexible so as to include children between birth and 12 months, for cases in which home-based care is not recommendable or desired by the family.

In the case of private centres, the aim is to harness the idle capacity that currently exists in private centres, giving vouchers to the families that can be redeemed in authorized centres. As the construction of a public centre could be very costly and take a long time, this scheme allows for a swift quality response in terms of care for children needing it. A further aim is to promote the creation of child-care units in firms to look after the employees' children and others living in the zone in which the firm is located, so as to foster inclusion in these centres.

4. Persons in situations of dependency owing to disability

The application of care policies for the population living in situations of dependency owing to disability requires unified criteria to determine the provisions and services in question. This involves creating instruments to assess degrees of dependency (severe, moderate and light), which take account of the need for assistance by third persons and support to undertake daily activities, along with the socioeconomic and cultural contextual factors.

Care services, both in and outside the home, include personal and non-personal support. Personal support involves a third person (a caregiver or personal assistant other than a family member), whereas non-personal support includes technical and technological support of all kinds, along with support for home adaptation and accessibility.

Although this population segment shares characteristics with the other subgroups identified, the need to provide care services to disabled people in situations of dependency encompasses a heterogeneous group as a result of the disability itself, the socioeconomic context and the presence or absence of social support networks.

The services proposed outside the home in the SNC framework involve both the incorporation of new services and the adaptation of existing ones to fulfil the requirements of the system being created.

At the present time there are services being supplied by the market and by civil society organizations that could potentially be suited to care needs in situations of dependency. Nonetheless, the services in question are not regulated and there are no minimum quality standards, either to regulate private activity or for activities that could be included within dependency care services implemented through agreements with the State.

Progress therefore needs to be made on the proposal for regulating these standards, observing SNC criteria: contribute to the autonomy and social inclusion of persons living in situations of

dependency. The term “services outside the home” encompasses day services, residential centres, and sheltered housing.

Services provided within the home involve the existence of a caregiver who is not a family member. Specifically, for persons with severe and moderate dependency, the proposal involves a personal assistant for activities both inside the home and outside it. The pilot project means that the system could offer a personal assistant for a specified number of hours per week, to take over some of the care generally provided by the family. The actual number of hours per week would need to be defined according to criteria that arise from the application of tools to value the degree of dependency; and it will be up to the disabled person and his or her family, according to the division of responsibility, to choose the days and activities for which the service will be used. In this case, it could be applicable both for assistance/care tasks in the home and for activities outside it, accompaniment to places of work or study, health care or leisure.

A tele-assistance service is also proposed, which will be determined by the application of the instrument to assess the degree of dependency; and priority will be given to those persons who live alone, or who spend several hours of the day at home alone. It is particularly applicable to adults and older adults in situations of dependency owing to disability.

5. Dependent older adults

The implementation of a care policy for older adults in Uruguay necessarily involves a universal approach, although with a gradual process of entry into the system according to the dependency levels of the older adults in question.

Two lines of action are stressed in the short term: enhance the quality of services targeting dependent older adults who live in long-stay institutions; and provide support services for dependent older adults (and their caregivers) who live in their own homes.

The SNC proposes to work with persons who are currently responsible for care tasks within homes or in institutions, whether paid or not. Both paid and unpaid tasks are highly feminized: over 95% of the persons identified as paid caregivers are women (Aguirre, 2010), and women do more than twice the number of hours per week of unpaid work in the homes.

The main proposals for each of the dependent population groups targeted by the National Care System are summarized below.

TABLE 3
MAIN PROPOSALS FOR DEPENDENT POPULATION GROUPS

Scope of action	Proposals
	1. Proposals for persons with disabilities
Within the home	<ul style="list-style-type: none"> - Design and implement a National Home-Based Care Programme. - Design and implement incentives for volunteer experience. - Design and implement a Tele-Assistance Programme. - Design and implement a National Technical Support Programme.
Outside the home	<ul style="list-style-type: none"> - Design day centres with extended working hours, with the corresponding regulations and quality certification. - Design the creation of new centres to cover demand. - Design the inclusion of persons that provide care and services in the centres. - Design the corresponding regulation for the residential centres and quality certification of existing services. - Design and implement long-stay centres (prioritizing persons without family). - Design the gradual creation of sheltered housing to promote adult autonomy. - Design the gradual creation of curatorial services for all age groups.

Table 3 (concluded)

Scope of action	Proposals
2. Proposals for early childhood	
Within the home	<ul style="list-style-type: none"> - Design and implement a National Home-Based Care Programme. - Implement extended maternity and paternity leave, and equality between male and female workers in the public, private, and self-employed sectors, and also for taxpayers in the simplified regime. - Design and implement the extension of paternity and maternity leave (breast-feeding and care). - Consider paternity leave of one month after birth. - Consider half-time paternity work with respect to children of between two and six months of age. - Consider parental leave periods when children are sick.
Outside the home	<ul style="list-style-type: none"> - Design and implement subsidies (vouchers) for care in private centres. - Design and implement centres in firms —promotion measures for their opening. - Consider the expansion of public day-care centres for children between one and three years of age for the whole population.
Actions targeted on persons living in situations of poverty and those who are poverty-vulnerable (250,000 households)	
	<ul style="list-style-type: none"> - Design and implement a National Household Care Programme. - Design and implement the expansion of the CAIF system providing day care for children between one and three years of age. - Design and implement the strengthening and increased coverage of public care centres for children from birth to one year old.
Actions targeted on persons living in situations of indigence and those who are vulnerable to indigence (30,000 households)	
	<ul style="list-style-type: none"> - Design and implement a National Household Care Programme. - Design and implement places for inclusion in company-based care centres. - Implement meeting rooms (expansion of coverage) for preparation for childbirth.
3. Proposals for older adults	
For persons living in long-stay institutions	<ul style="list-style-type: none"> - Design a regulatory framework for care services outside the home (up-to-date analysis of the present and future realities of Law No. 17.066). - Design and implement intervention protocols, creation of minimum service standards, public-private subsidy aimed at improving service quality. - Design changes in referral strategies. - Design and implement regional care referral centres.
For persons living in a private home	<ul style="list-style-type: none"> - Design a regulatory framework for care services within the home (regulation of companion services). - Design and implement a law regulating leave periods for direct family relations to care for dependent persons. - Design and implement a National Household Care Programme. - Design and implement a programme to rebuild and adapt homes to take account of situations of dependency. - Design and implement a Tele-Assistance Programme. - Design and implement a Sheltered Housing Programme. - Implement day-care centres.

Source: Information extracted from the document “Hacia un modelo solidario de cuidados. Propuesta para la construcción del Sistema Nacional de Cuidados” (Inter-agency Working Group, CNPS, 2012).

V. Conclusions: challenges in constructing the care society in the region

Today, the topic of care is indisputably gaining a place on the region's public agenda, as the focus of analysis shifts from the private domain of families to the public sphere of policies. This positioning process, which has progressed to varying degrees according to the country being analysed, is based on the inclusion of the gender and rights perspective in the care system.

Key milestones in this process were the information obtained from time-use surveys, which revealed the gender injustices present in the distribution of the care burden, analyses of the social organization of care and demographic and family changes, together with more integrated views of social-protection systems.

Care policies are a work in progress; and, like any other public policy, they need to take account of multiple interests that manifest themselves in the different stages of the production cycle, according to the national reality and context. In a situation characterized by multiple interests, actors, resources, objectives and rights, it is nonetheless possible to highlight a number of elements in terms of lessons learned and main challenges in the processes analysed.

Firstly, it should be noted that the current social organization of care suffers from a major imbalance between the four domains of access to welfare: families, the State, the market and civil society. This social organization of care is based mainly on the unpaid work that women do in the home, and is highly stratified.

Secondly, based on the situations described and analysed in this document, the need arises for public policies to recognize, reduce and redistribute the work of care giving and foster change in the current sexual division of labour. There are two key redistribution mechanisms in this context: the first aims to affect the division of unpaid care work within households, in other words between women and men, so that the latter increase their share of domestic chores and care tasks. A second mechanism targets the division between the institutions and main care actors, because nearly all of the responsibility is currently delegated to the families. In both mechanisms, major State intervention is needed in terms of policies and programmes to alleviate the burden that currently falls on women in their households.

The countries that have been analysed in this document display initiatives in both directions, with different emphases.

Thirdly, the different components of the social policy network need to be integrated and mutually strengthened, so as to enhance care provision and promote an intersection between gender equality policies, those of co-responsibility and those promoting the rights of dependent persons (children, older adults, persons with disabilities). On this point, a critical analysis of welfare and social-policy regimes from the gender perspective is very useful for specifying some of the programmes and policies that are relevant in this framework. The design of care policies has a major potential impact on equity in the income distribution; on equity between men and women; on fostering processes of demographic change; on the sexual division of labour and on the care deficit at the family level; and on the labour market.

Fourthly, a specific challenge concerns the actual moment of designing and formulating policies and the inclusion of the gender and rights perspective from the outset. Policy design is important — among other reasons, for the creation of synergies between the objectives related to co-responsibility and specific objectives of the sectors that require care. It is also decisive for achieving more homogeneous access to quality services for all people, irrespective of the social sector to which they belong, and to guarantee the sustainability of the different programmes in time.

In our countries, social inequalities are closely linked to the unequal provision of family and social care, forming a genuine vicious circle: families that have more resources have greater access to quality care, but also have fewer household members to care for. In contrast, those with fewer means to gain access to market-based care services, but larger care burdens, accumulate disadvantages owing to the heavier burden of domestic family tasks, difficulties in accessing public services, and the need to make use of informal female care-givers.

Fifthly, there is the notion of the care system as a regional challenge. Overall, a care system involves rethinking sector-based public policies with their own institutional framework, financing, governing bodies and regulation, provision of services, and redefining services and attributions which in some cases were envisaged exclusively as part of specific “sectors” —education, health, etc. being clear examples. Care systems aim not only to generate a public policy towards dependency but also to encourage cultural change: the change of the sexual division of labour in the framework of current models which are family based, toward solidarity-based and co-responsibility models.

It is important to construct a common discourse around the topic of care; and, as noted above, this constitutes the initial stage of the process. To that end, conceptual and information-producing contributions are crucial. In the conceptual domain, the main contribution that has made it possible to reveal gender injustices in care are time-use surveys and studies on the social organization of care, principally child care.

Lastly, if we now analyse the current critical challenges to be resolved when implementing integrated care systems or policies, we find that the first is universality. The targeting-universality dichotomy is one of the greatest tensions in the current design of policies. Care policies should not be considered as either targeted or social-inclusion policies exclusively. The experiences analysed show that while universality is put forward as a proposal at the level of discourse, targeting is generally imposed when implementation actually takes place. The second challenge concerns the tension between the development of policies that are gender-fair, promote a better balance in care and encourage women’s incorporation into labour market, and the approach that prioritizes social investment in childhood health, targeting the least-favoured sectors. This tension also ultimately represents a struggle between the rights of children and the rights of women. It has been present in all of the processes analysed and is generally one of the greatest impediments to progress on care policies with a gender and rights perspective.

Thirdly, there is a quality challenge in terms of developing care policies: quality in the services to be supplied, and quality of jobs in the care sector, upholding the labour rights of male and female workers, with adequate pay.

The fourth challenge is intersectoral articulation and coordination in providing public services, so that they operate on a comprehensive basis, engaging the different sectors related to the subject: childhood, social security, health and education, among others.

The fifth challenge concerns the inclusion and mainstreaming of gender in the design, formulation and implementation of these policies and their systems. On this point, the hierarchical level of the gender mechanism and the possibility of negotiating budgets and actions are crucial.

Lastly, mention should be made of the domains of action needed in care-policy formulation processes, which are important for gradually and progressively moving towards care-policy formulation and the objective of promoting care as a social responsibility. The available spaces and mechanisms encompass a wide spectrum of possible options, including the following:

- Expand the coverage and supply of care, by developing new care services. The State has a central role to play in the organization of this for the care of children, older adults and persons with disabilities.
- Guarantee quality services for all, setting minimum standards. The State has the role of regulating and supervising the services provided, and promoting integrated services.
- Adapt the supply of services to the needs of workers of both sexes with family responsibilities, through actions that facilitate time management.
- Promote quality jobs for persons who work in the care sector, based on the supply of public care services and labour market regulation.
- Provide special attention to the occupational segregation associated with paid work in care services, which affects wage gaps and the fact that these occupations are closely associated with situations of vulnerability and poverty.
- Improve labour regulations in the field of care services —particularly, but not only, domestic service. Uruguay and Costa Rica have started to bring the rights of female domestic workers partially or totally in line with those of the rest of the employed population, and to establish effective mechanisms to control and supervise compliance with the regulations.
- Recognize the important contribution women make in the form of unpaid care provision, through the corresponding social-protection, equality and redistributive policies.
- Further develop mechanisms for enforcing the right to care, in conformity with the international human rights instruments ratified by each country, and the rights enshrined in national constitutions.

BOX 6
RATIONALES FOR CARE POLICIES

The challenges identified in this analysis show clearly that there are good reasons for developing public care-provision policies:

- *For equality*: promoting equal rights, responsibilities and possibilities for men and women; this is not possible if women are responsible for caring for dependent persons.
- *Because women are citizens before they are mothers*: for that reason, unlike men, they are educated to develop a personal life project, independently of their maternity.
- *Because total work time should be equalized* between men and women in society, since women currently work longer hours than men (total paid and unpaid work time) and they earn less than men.
- *Because it is a right*: Care is an individual entitlement. Persons have the right to be cared for, to provide care, and also to reject caregiving as only their daily possibility.
- *For the economic development of the countries*: Freeing up time spent on care tasks means giving women time to engage in productive activities that contribute to their countries' economic development.
- *To facilitate women's labour market participation*: Releasing women from caregiving tasks makes it easier for them to participate in the labour market.
- *For the better development of children*: In the case of child care, it has been shown that preschool education is essential for full childhood development.
- *Because it reduces poverty*: It has also been shown that women contribute to poverty reduction through their paid work; for that reason, they can no longer bear exclusive responsibility for care tasks in their homes.
- *Because it corrects time poverty*, which is a type of poverty that weighs particularly heavily on women.

Source: Prepared by the author on the basis of studies conducted by the Division for Gender Affairs of ECLAC.

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