

# **Towards construction of comprehensive care systems in Latin America and the Caribbean:**

ELEMENTS FOR  
IMPLEMENTATION



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**TOWARDS CONSTRUCTION OF COMPREHENSIVE CARE SYSTEMS IN LATIN AMERICA AND THE CARIBBEAN: ELEMENTS FOR THEIR IMPLEMENTATION.**

Study prepared jointly by the Regional Office for the Americas and the Caribbean of the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and the Economic Commission for Latin America and the Caribbean (ECLAC)

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Authors of the study: **Julio Bango** and **Patricia Cossani**, consultants for the Regional Office for the Americas and the Caribbean of UN Women, with the collaboration of **Viviana Piñeiro**.

General coordination: **María Noel Vaeza**, Regional Director for the Americas and the Caribbean of UN Women, **Alicia Bárcena**, Executive Secretary of ECLAC, **Cecilia Alemany**, Deputy Regional Director for the Americas and the Caribbean of UN Women, and **Ana Gúezmes**, Director of the Division for Gender Affairs of ECLAC.

Study coordination: **Raquel Coello**, Regional Economic Empowerment Specialist, and **Beatriz García** Specialist in Economic Empowerment of UN Women and **Lucía Scuro**, Social Affairs Officer of the Division for Gender Affairs of ECLAC.

Editing and content revision: **Constanza Narancio**, Communication Advisor of the Regional Office for the Americas and the Caribbean of UN Women.

Editorial design: **Emicel Guillén**, Consultant for UN Women.

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# **Towards construction of comprehensive care systems in Latin America and the Caribbean:**

## **ELEMENTS FOR IMPLEMENTATION**

Prepared by Julio Bango and Patricia Cossani



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# Foreword

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The Latin American and Caribbean region is experiencing an unprecedented economic and social crisis. The effects of the coronavirus disease (COVID-19) pandemic have spread to all spheres of human life, hurting economies, changing the way we interact, and causing extensive societal changes. The crisis has highlighted and exacerbated structural gaps, deepening pre-existing inequalities and exposing the vulnerabilities of political, economic, and social protection systems. The onset of the crisis magnified the structural challenges of gender inequality, reversing much of the progress made in recent decades. In particular, the pandemic has highlighted the vital role that care plays in the functioning of our economies and societies, hence why its current organization is unsustainable and unfair.

Owing to the sexual division of labour, care work is highly feminized, whether paid or unpaid. Even before the pandemic, women in the region dedicated three times as much time as men on unpaid care work. This situation was aggravated by a rise in demand for care and a decline in the supply of services caused by the lockdowns and physical distancing measures adopted to curb the crisis. As a result, women have faced even greater barriers to full participation in opportunities for paid work, which has had the added effect of increasing their exclusion from various spheres of public life. Furthermore, in order to balance the care tasks assigned to them and income-generating work, women have increased their participation in part-time work and informal economic activities.

The centrality of care has been progressively, albeit unevenly, incorporated into public

agendas in the region through the contributions of the feminist economy and years of tireless work by women's and feminist organizations and movements to draw attention to the key role of societal reorganization of care in shaping more equal and inclusive societies. In the framework of the Regional Conference on Women in Latin America and the Caribbean, which has been meeting for more than 40 years, the member States of ECLAC adopted the Regional Gender Agenda, to safeguard the rights of women, advance their autonomy, and lay the foundations for societies with equality. Over the last 15 years, governments have adopted a number of agreements that are essential for designing and implementing care policies. The agreements reaffirm the principles of universality and progressivity in access to quality care services, the importance of co-responsibility between men and women, and among the State, the market, communities, and families, as well as the importance of promoting the financial sustainability of public care policies aimed at achieving gender equality.

In short, the Regional Gender Agenda provides a robust framework of agreements adopted by the governments of Latin America and the Caribbean aimed at guaranteeing women's human rights, preventing setbacks, and advancing towards women's autonomy and substantive equality. Several countries in the region have in turn implemented programmes and policies to move towards the recognition, redistribution, and reduction of care work at the national and local levels. These advances have gradually shaped a situation in which care has ceased to be a women's issue or an issue that can be resolved on its own

and is now seen as an issue that society must address, for ethical reasons, and in the interest of justice and survival.

The sixtieth meeting of the Presiding Officers of the Regional Conference on Women in Latin America and the Caribbean was held in February 2021. During the meeting, a special regional consultation session was held, in conjunction with the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), in preparation for sixty-fifth session of the Commission on the Status of Women. The participating governments discussed the central role of care for a transformative recovery focused on the sustainability of life and the importance of pursuing a regional compact. The initiative was bolstered in the framework of the Generation Equality Forum held in Mexico City from 29–31 March 2021 and in Paris from 30 June–2 July 2021, at which the National Institute for Women of Mexico and UN Women championed the creation of the Global Alliance for Care, a collective multisectoral initiative in which governments, the private sector, international and philanthropic institutions, and civil society organizations can participate and make specific commitments to advancing the care work agenda at the global level. The Alliance, of which ECLAC is a member, seeks to foster, among other things, creation and

strengthening of care systems, transformation of gender roles and acceleration of equitable economic recovery in the aftermath of the COVID-19 pandemic, through specific commitments and actions on care.

Given the urgency of the situation, a change in the development model is needed, putting care and sustainability of life at the centre. The creation of comprehensive care systems as a fundamental pillar of social protection entails moving towards a structural and comprehensive proposal that guarantees the rights of people who require care, as well as the rights of caregivers. The creation of comprehensive care systems, in addition to representing progress on rights and a vital achievement in terms of gender equality and the empowerment of women, is also an essential contribution to well-being and a key sector for a transformative recovery with equality and sustainability.

In this regard, UN Women and ECLAC hope that this publication will be a contribution to knowledge and reflection to move forward with implementation of comprehensive care systems and a transition to a care society that prioritizes the sustainability of life, placing it at the centre of policies that support the pursuit of the 2030 Agenda for Sustainable Development.

**MARÍA NOEL VAEZA**  
Regional Director for the Americas  
and the Caribbean, UN Women

**ALICIA BÁRCENA**  
Executive Secretary  
ECLAC



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INTRODUCTION

This document has been conceived to serve as a guiding framework for those involved in the development of comprehensive national Care Systems as a pillar of social protection in the countries of the region. We believe that these systems should be designed from a human rights perspective, with particular emphasis on mainstreaming the gender perspective to achieve care models co-responsible between the State, the market, the community, and families, and between men and women.

Although there is a section dedicated to conceptual aspects in Chapter 2, we have not gone into depth, given that UN Women, ECLAC, and other agencies of the United Nations System have already elaborated on them. We did feel it was appropriate to highlight those things that we believe distinguish the approach we are promoting with its respective road map.

Chapters 3 and 4 are the core chapters. These chapters develop what we call “the what” and “the how” of Care Systems. Chapter 3 begins by distinguishing between care programs policies, and Care Systems, which we believe is essential for policymakers to understand the systemic, comprehensive, and national nature of their development. This chapter discusses the policy targets, the principles that should guide the construction of the system and its components.

Chapter 4 covers the core aspects of implementation, proposing a new management model and a corresponding institutional design. It identifies a possible political governance scheme and offers elements for the construction of intersectoral management for each of the system’s components. The idea is to show that the structure of systems does not only involve the implementation of services to satisfy needs but that other components define the possibility of moving towards a new social organization of care, in which gender co-responsibility must be an essential element.

We also show how, in terms of management by components, many substantive actions can be carried out that are not limited to budget availability. We attempt to present a series of aspects that may enable the establishment of differential roadmaps according to each country’s starting point but having as a goal a shared vision of the system to be designed. This chapter also discusses the importance of processes that ensure the participation of the actors involved in care policies and their relevance for the social sustainability of the system.

The chapter closes with considerations on financing alternatives for Care Systems and a series of recommendations for the road map to be adapted by each country.

Lastly, Chapter 5 emphasizes the positive externalities of implementing Care Systems and their contribution to the sustainability of well-being. The creation of comprehensive national Care Systems and their impact on the advancement of rights, their contribution to gender equality and women’s economic autonomy, their dynamism in the economy and their respective economic returns, as well as their contribution to development, undoubtedly evidences the need for the region to make progress in this regard. Through this publication, we hope to make an essential contribution to achieving this goal.

02

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CARE AS A PILLAR  
OF WELFARE AND  
A DRIVING FORCE FOR  
RECOVERY IN THE FACE  
OF THE COVID-19 CRISIS

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## 2.1. What do we talk about when we talk about care?

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Care activities regenerate people's physical and emotional well-being on a daily and generational basis. It includes the daily tasks of managing and sustaining life, such as the maintenance of domestic spaces and goods, the care of bodies, the education/training of people, the maintenance of social relations, or the psychological support of family members.<sup>1</sup> It, therefore, refers to a wide range of aspects that include health care, home care, care for dependents and caregivers, and self-care. It is work which, in terms of quantity, measured in physical units of time, slightly exceeds the total paid work of men and women. In contrast, in terms of quality, it has fundamental characteristics for maintaining the conditions of sustainability of the system as a whole.<sup>2</sup>

Care, therefore, runs through the lives of all people. And all people, at all stages of life, require care. However, based on this broad definition, it is important to narrow the concept down establishing the specific work of care systems, policies, and services, distinguishing them from health care or education and prioritizing among the target populations those dependent on care from third parties or those who provide care. The purpose of outlining this border is not to create a sealed compartment with the rest of

social protection policies, but the opposite: defining a field of action for care policies must enable them to interact among one another.

On the other hand, it is essential to note that in recent years, the use of the term "care" has given rise to critical reflection by organizations working in the field of persons with disabilities, insofar as its definition may eventually lead to the implementation of welfare policies, which consider the person with a disability not as a person with the right to an independent life but as a passive subject in need of assistance. For this reason, and in line with the definitions adopted by the United Nations Convention on the Rights of Persons with Disabilities, the term "care" includes a reference to assistance and/or support services. A similar situation occurs when we speak of care, support, or assistance to dependent older persons, a concept that necessarily includes the promotion of autonomy as a priority in the inevitable process of aging. In the case of children, the concept of care is linked strongly to education, and it is understood that they go hand in hand. It is a matter of having quality time for the care of children, prioritizing adequate child development.

The concept of care has a double dimension: care is a right to which people should have

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1 UN Women & ECLAC. (2020). *Care in Latin America and the Caribbean in times of COVID-19. Towards Comprehensive Systems to Strengthen Response and Recovery*.

2 Picchio, A. (2001). *Un enfoque macroeconómico «ampliado» de las condiciones de vida*, University of Barcelona, cited in UN Women (2018). *Recognition, Redistribution, and Reducing of Care Work: Inspiring practices in Latin America and the Caribbean*.

access, but the act of caring is also a function that some people perform, which is key to society's reproduction. Therefore, from a rights-based perspective, care policies can guarantee the right to receive and provide care under conditions of quality and equality.

In short, it is important that the precise definition of these concepts be agreed upon by consensus in each country in order to establish the parameters that will guide the design and implementation of care policy.

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## 2.2. What is the current organization of care in Latin America, and what is its basis?

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In recent years, Latin American and Caribbean countries have progressed in the recognition of unpaid domestic work and care work. This is evidenced by the effort of having time-use surveys and the incorporation of satellite accounts that quantify unpaid work in the framework of national accounts in the region's countries.

Historically, the region's protection systems were built on the sexual division of labor that culturally prescribed roles associated with gender: the so-called "breadwinner" model, in which men generate economic income for families and women are responsible for caring for children and people in need in the home.

According to data from the Gender Equality Observatory for Latin America and the Caribbean of the Economic Commission for

Latin America and the Caribbean (ECLAC)<sup>3</sup>, even before the crisis caused by the COVID-19 pandemic, women in the region spent more than three times as much time on unpaid work as men. It was also confirmed that in households with children, women were more overburdened with care work (with the usual consequences for their incorporation into the labor market).

Evidence also indicates that the main obstacle to women's full participation in the labor market is the time devoted to unpaid domestic work and care work. According to ECLAC's data, around 60% of women in households with children under the age of 15 say that they do not participate in the labor market because they have family responsibilities. In contrast, in households without children in the same age group, this figure is close to 18%.<sup>4</sup>

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3 Economic Commission for Latin America and the Caribbean (ECLAC). [COVID-19 Observatory in Latin America and the Caribbean](#).

4 Economic Commission for Latin America and the Caribbean (ECLAC), [Social Panorama of Latin America](#), 2020 (LC/PUB.2021/2-P/Rev.1), Santiago, 2021.

On the other hand, the incorporation of men and women into the labor market often requires the commodification of domestic and care work in the home so that the work previously done by women in an unpaid manner is replaced by the paid work of other women.

Given the sexual division of labor, paid and unpaid care work is highly feminized. In Latin America and the Caribbean, as of 2019, around 13 million people were engaged in paid domestic work, 91.5% of them women, many of them Afro-descendants, indigenous and/or migrants.<sup>5</sup>

This sector tends to be subject to high levels of precariousness; its wages are among the lowest of all paid workers, and its levels of informality are exceptionally high (76% of women employed in this sector do not have social security coverage).<sup>6</sup> In addition, we need

to consider that 51.6% of migrants in Latin America are women, and more than a third of them are engaged in paid domestic work (35.3%)<sup>7</sup>, forming part of what has come to be known as “global care chains.”<sup>8</sup> According to data compiled by ECLAC, the economic contribution of women’s unpaid work ranges from 15.9% to 25.3% of GDP, with women accounting for nearly 75% of this figure.<sup>9</sup>

From a comprehensive and gender-sensitive perspective, the design of Care Systems must promote the modification of the traditional sexual division of labor, enshrining the right to care and the right to be cared in conditions of quality and equality, prioritizing child development, the right to a dignified life for older people and the right to independent living for people with disabilities, and making it compatible with women’s right to autonomy and their full political, economic and social participation.

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5 *Ibid*, p. 211

6 Valenzuela, M. E., Scuro, M. L. & Vaca Trigo, I. “Desigualdad, crisis de los cuidados y migración del trabajo doméstico remunerado en América Latina”, Gender Affairs series, No. 158 (LC/TS.2020/179), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC), 2020. Page 85.

7 International Labour Organization (ILO). *Labour migration in Latin America and the Caribbean. Diagnosis, Strategy, and ILO’s in the Work Region*. Lima, Regional Office for Latin America and the Caribbean, 2016.

8 *Ibid*, p. 213

9 Economic Commission for Latin America and the Caribbean (ECLAC). *Social Panorama of Latin America, 2020* (LC/PUB.2021/2-P/Rev.1), Santiago, 2021.

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## 2.3. Why is it necessary to take steps towards a new organization of care?

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### 2.3.1. Care Systems as a fundamental pillar of well-being

The welfare regimes or social protection systems in our region were built on three pillars: health, education, and social security. Depending on the country, each has its own characteristics and unequal degrees of development in terms of coverage and quality of benefits.<sup>10</sup>

As well as health, education, and social security requirements, there is a fourth element, care, which, in addition to fulfilling a relevant social function, is a need that arises throughout our lives. First, because all people, at all times of their lives, require care. But, additionally, depending on age, health, or personal circumstances, there are situations in which we rely on care from third parties. For example, during childhood, children require care to acquire their autonomy. Later in adulthood, care from third parties may be necessary in the face of a disability that may become permanent or worsen, especially in old age. Care, therefore, accompanies the life cycle of individuals and is a factor in personal development and a key component in the reproduction of society.

The creation of national Care Systems, in that sense, is a direct response to the unequal distribution of domestic work and care work between men and women and to the care deficit that countries are facing, which has led to what has come to be known as the “care crisis.” This **care crisis** is a result of demographic factors. In Latin American countries, life expectancy has lengthened because of improvements in science and health systems, so that the population requiring care is also on the rise. On the other hand, the female activity rate has also increased since the 1990s.<sup>11</sup> These two phenomena combined leave a balance of more people to care for and fewer people available to do so, making it essential to have public care policies. Over the last few decades, feminist movements have placed this issue on the public agenda, calling on political actors to implement public care policies.

Therefore, it is necessary for countries to complement classic social protection with the care axis and for States to act urgently

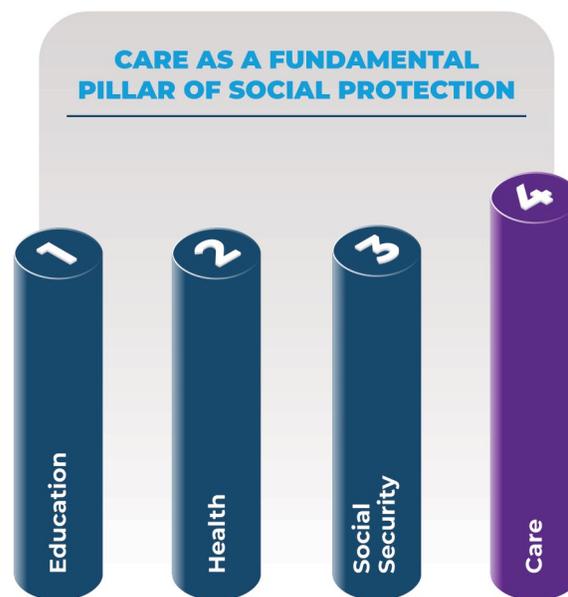
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10 UN Women & ECLAC. (2020). *Care in Latin America and the Caribbean During the COVID-19. Towards Comprehensive Systems to Strengthen Response and Recovery.*

11 *Ibid*

to recognize, redistribute and reduce unpaid care work.<sup>12</sup>

The creation and consolidation of this new pillar of social protection based on care does not exempt the need to continue strengthening the other pillars, each in itself and with the others. Moreover, the existence of the care pillar provides an opportunity to increase the efficiency of the other welfare pillars and, thus, strengthen Latin American social protection systems. This is because care, as an axis of social protection, in addition to having its own purposes, contributes at the same time to responding to situations related to the other pillars, which cannot be addressed without the articulation and coordination of different actions.



Source: Authors' elaboration

### 2.3.2. Care Systems are fundamental to face the challenge of overcoming poverty and reducing inequalities successfully

The current social organization of care, which is fundamentally centered on women, within the home, and in an unpaid manner, also disproportionately affects the poorest women. This situation is mainly present for lower-income women (quintile 1), the women struggling with the so-called “sticky-floor”, who spend an average of 45 hours a week on unpaid work, compared with women with “glass ceilings” (quintile 5), who spend 33 hours a week.<sup>13</sup>

This generates a vicious circle between care, poverty, inequality, and scarcity<sup>14</sup> since those in the worst economic situation are less able to hire part of the care services in a paid manner on the market, having to do this work themselves. In turn, the more they perform care work, the more difficulties they face overcoming poverty because time poverty limits opportunities to enter the labor market, a particularly serious situation for women heading single-parent households. In fact, according to ECLAC, the highest rates of extreme poverty in the countries of the

12 UN Women. (2018). *Recognition, Redistribution, and Reducing of Care Work: Inspiring practices in Latin America and the Caribbean*.

13 ONU Mujeres. (2017). *El Progreso de las Mujeres en América Latina y el Caribe 2017*. Simple regional average calculated from data from the latest national time-use surveys, available from CEPALSTAT. Accessed December 2016.

14 Coello Cremades, R. (2013). *Como trabajar la Economía de los cuidados en la cooperación para el desarrollo. Aportes desde la construcción colectiva*. Agencia Andaluza de Cooperación Internacional al Desarrollo (AACID) Junta de Andalucía. Sevilla.

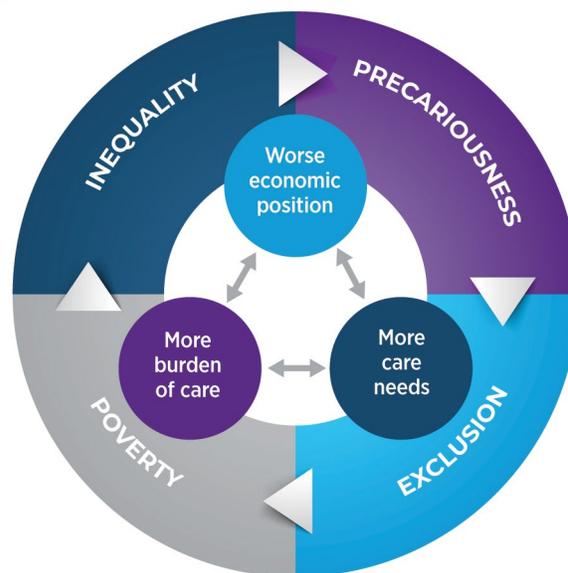
region are found in single-parent households, 85% of which are headed by women who are responsible for children and adolescents. "This undermines the chances that the children and the adults in charge of them will lead a full life."<sup>15</sup>

Another element that contributes to the vicious cycle between care, poverty, inequality, and precariousness is the fact that care work is sometimes the only employment option for many women living in poverty. However, to the extent that this work is often poorly paid and is carried out in precarious conditions without labor rights and, therefore, without social protection, it does not enable people to escape poverty, and at the same time affects the future income of those working in the sector because of the lack of social security and pension rights.

Therefore, although it may sometimes be understood that the construction of Care Systems should be a task to be considered after the objectives of overcoming poverty and reducing inequalities have been successfully addressed, in reality this is a fundamental task for achieving them and should be conceived as the development of one more vector—along with policies on employment, health, education, housing, etc.—in a successful strategy for achieving results.

In short, the countries of the region that wish to meet the challenges of reducing poverty and inequality in all its forms must invest as a priority in the development of Care Systems, from a human rights perspective with an emphasis on gender, intersectionality, and interculturality.

## VICIOUS CYCLE: CARE-POVERTY, INEQUALITY-EXCLUSION-PRECARIOUSNESS



Source: Adapted from Coello Cremades, R. (2013). *How to work the Economy of care in development cooperation. Contributions from collective construction*. AACID

In the framework of the Regional Conference on Women in Latin America and the Caribbean, the governments of the region recognize care as a human right of individuals. The Montevideo Strategy<sup>16</sup> urges governments to encourage the adoption of care policies and promote co-responsibility between women and men that contribute to women's autonomy and a fair social organization of care.

This commitment was ratified at the XIV Regional Conference on Women in Latin America and the Caribbean, held in January 2020 in Santiago, Chile, through the Santiago Commitment,<sup>17</sup> which explicitly mentions

15 Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America*, 2020 (LC/PUB.2021/2-P/Rev.1), Santiago, 2021.

16 Economic Commission for Latin America and the Caribbean (ECLAC). *Montevideo Strategy for Implementation of the Regional Gender Agenda within the Sustainable Development Framework by 2030*.

17 Economic Commission for Latin America and the Caribbean (ECLAC). *Santiago Commitment*. Santiago. 2020.

the need to “implement gender-sensitive countercyclical policies, in order to mitigate the impact of economic crises and recessions on women’s lives and promote regulatory

frameworks and policies to galvanize the economy in key sectors, including the care economy.”

### 2.3.3. Care as a driver of socio-economic recovery in COVID-19 times

The current economic and social crisis in the region caused by the COVID-19 pandemic has deepened the crisis in the current social organization of care. In all countries, the impact of the closure of educational centers and care services, where women have seen their burden of care in the home increase due to confinement, has been noted.<sup>18</sup> The overburden of care for families—and within them, for women—has led to a greater perception of paid work, which is reflected in specific studies conducted in recent months by various countries in the region.<sup>19</sup> In this regard, a comparative analysis of the rapid assessment surveys conducted by UN Women on the differential effects of COVID-19 on men and women in Chile, Colombia, and Mexico indicated that more women than men saw an increase in childcare work and performed other tasks in greater proportion than men, with a gap of 3.5 percentage points between women and men, having increased by 44% for women, compared to 40% for men.<sup>20</sup>

The COVID-19 crisis has also made the care deficit more visible to citizens, which is an opportunity to raise the need and relevance of advancing public policies and Care Systems.

Faced with this situation, the different national States—and in some cases at the provincial, district, or municipal level—have begun to develop actions that attempt to address this deficit and modify the current unjust and unequal social organization of care. Several countries in the region have incorporated specific actions in their immediate response to the crisis.<sup>21</sup> Some have gone further and are moving towards creating comprehensive Care Systems or promoting longer-term policies and programs.

From a rights-based approach, this requires addressing the challenge of simultaneously guaranteeing the right to care for all persons who require it, with the right to care in conditions of quality and equality.

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18 UN Women & ECLAC. (2020). *Care in Latin America and the Caribbean During the COVID-19. Towards Comprehensive Systems to Strengthen Response and Recovery*.

19 Economic Commission for Latin America and the Caribbean (ECLAC). *Social Panorama of Latin America*. 2020. Box V.1 “Data collection care during the pandemic” - p.204-205.

20 ONU Mujeres (2021). *Efectos diferenciados por género de COVID-19 en el desarrollo sostenible. Análisis comparativo de las encuestas de evaluación rápida de género en Chile, Colombia y México*.

21 According to data from the gender tab of the COVID-19 Observatory in Latin America and the Caribbean, promoted by ECLAC with the support of UN Women, as of 31 August, a total of 14 countries had implemented 41 measures. [See details](#)

### 2.3.4. The economic and social returns of investing in Care Systems: the triple dividend

Investment in Care Systems not only breaks the vicious circle of poverty and exclusion but can also be transformed into a virtuous circle that generates economic and social returns<sup>22</sup> through the so-called triple dividend of care investment.<sup>23</sup>

First, investment in Care Systems contributes directly to people's well-being, especially if the quality of community, public and private care services are regulated and monitored. Studies<sup>24</sup> show that preschool education and childcare can improve children's physical and cognitive development, especially for those from impoverished backgrounds, with lasting effects even into adulthood, through, for example, employment and income prospects.

Second, if linked to labor policies, investment in Care Systems can, directly and indirectly, create quality jobs. Quality employment also means a return of income for the State through tax and social security contributions.

Third, investment in Care Systems facilitates people's participation in the labor force, which has a particular impact on women. As noted above, time spent on unpaid domestic and care work is currently the main obstacle to women's full participation in the labor<sup>25</sup> market. Care services are therefore essential for those in paid work who are in high demand for care, whether it be childcare, care for the sick or the elderly, to remain in or return to work. For them to be effective, services must not only be safe and of high quality but must also be compatible with the needs of working people in terms of location and opening hours.<sup>26</sup> The incorporation of women into the labor market will allow an increase in family income that will improve the quality of life of households and activate the economy through the greater capacity for consumption and savings, again generating a return via State taxes.

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22 ECLAC. (2021). *The economic autonomy of women in a sustainable recovery with equality*. Special Report N°9 COVID-19. 10 February 2021.

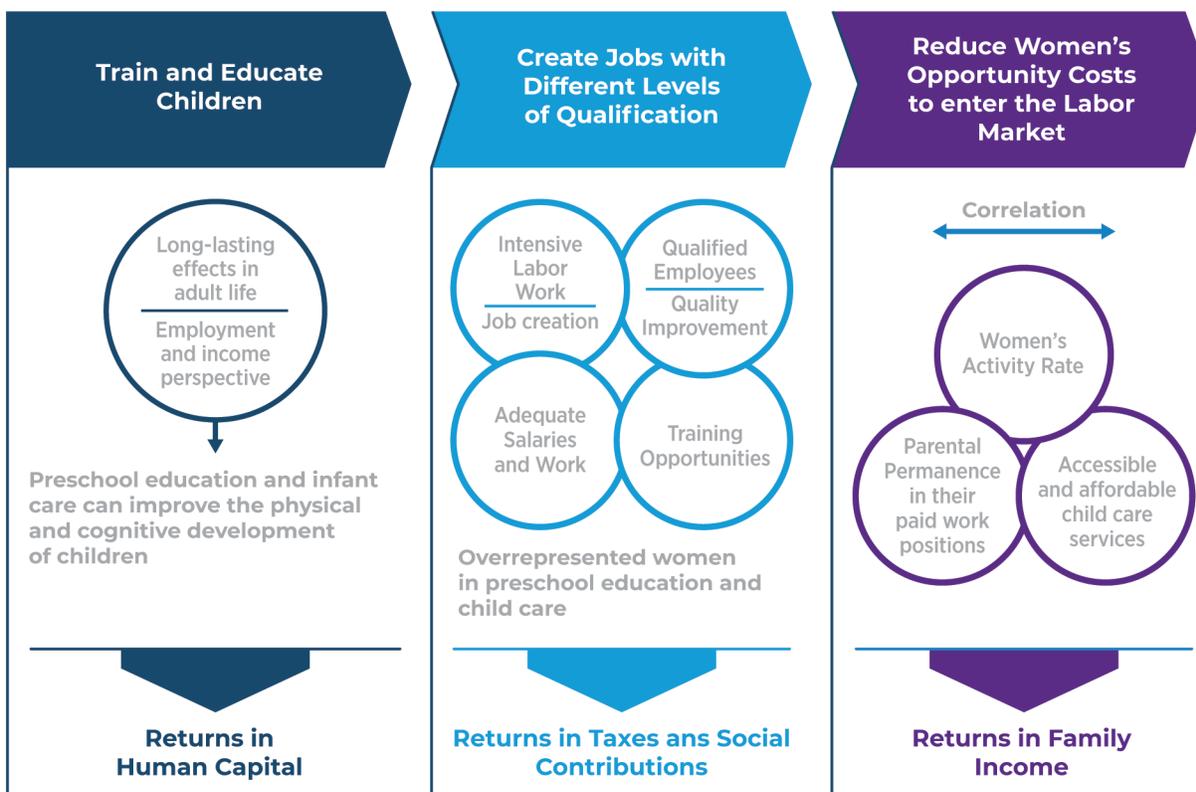
23 UN Women. (2015). *Gender Equality, Child Development and Job Creation: How to Reap the 'Triple Dividend' from Early Childhood Education and Care Services*. Policy Brief No. 2.

24 Yoshikawa, H., & Kabay, S. (2015). The Evidence Base on Early Childhood Care and Education in Global Contexts, UNESCO, Paris; Pianta et al. (2009), "The Effects of Preschool Education: What We Know, How Public Policy Is or Is Not Aligned with the Evidence Base, and What We Need to Know", *Psychological Science in the Public Interest*, Vol.10, No. 2, pp. 49-88; J. Schweinhart et al. (2005). Lifetime Effects: The High/Scope Perry Preschool Study Through Age 40.

25 Economic Commission for Latin America and the Caribbean (ECLAC). *Social Panorama of Latin America*. 2020. Box V.1 "Data collection care during the pandemic" - p.204-205.

26 UN Women. (2015). *Gender Equality, Child Development and Job Creation: How to Reap the 'Triple Dividend' from Early Childhood Education and Care Services*. Policy Brief No. 2.

## ECONOMIC AND SOCIAL RETURNS OF INVESTMENTS IN CARE SYSTEMS: THE TRIPLE DIVIDEND



Source: Authors' own elaboration, adapted from UN Women (2015). *Gender Equality, Child Development and Job Creation: How to Reap the 'Triple Dividend' from Early Childhood Education And Care Services*.

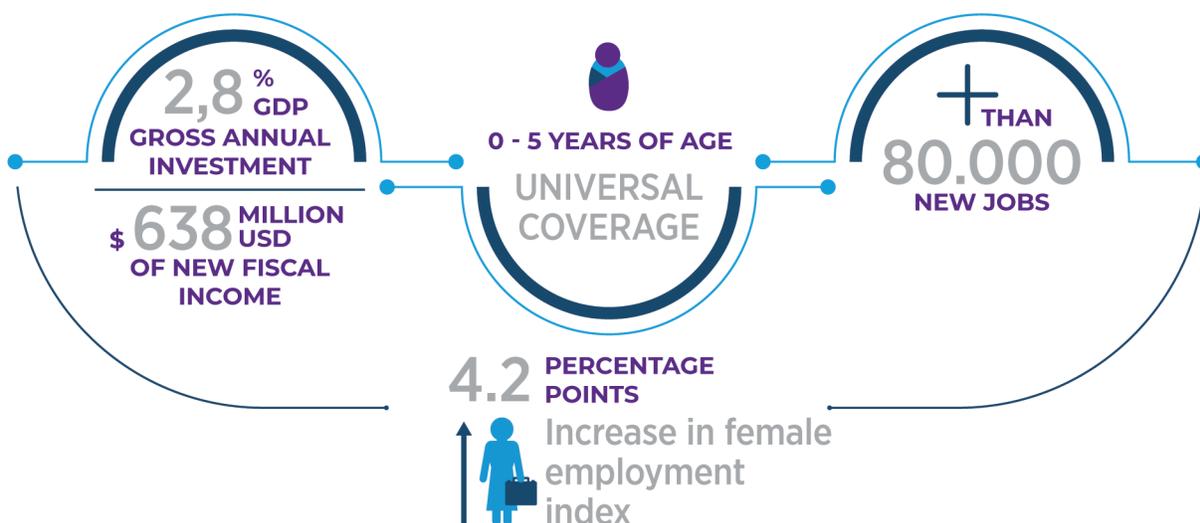
For example, in 2018, Uruguay estimated the annual fiscal cost of public investment in universal early childhood services. Results showed that a gross annual investment of 2.8% of GDP would not only result in universal coverage of early childhood care and education for all girls and boys, aged 0 to 5, but would also create more than 80,000

new jobs and, thereby, increase employment among women by 4.2 percentage points. These new jobs would generate new tax and social security revenues of up to 638 million U.S. dollars. A less ambitious projection requiring only 2.2 % of GDP could serve as a stepping stone to universal coverage.<sup>27</sup>

27 De Henau, J., Budlender, D., Filgueira, F., Ilkharacan, I., Kim, K., & Mantero, R. (2018). *Universal childcare in South Africa, Turkey and Uruguay. A comparative analysis of costs, short-term employment effects and fiscal revenue*. The estimates for Uruguay were made by Fernando Filgueira and Rafael Mantero. The methodology was based on the calculation of indicators based on key variables such as the number of places in childcare centers, the weekly opening hours and per year, the educator/pupil ratio, the working time of professionals, their level of remuneration and qualifications, and infrastructure costs.

## ANNUAL FISCAL COST OF INVESTING IN UNIVERSAL EARLY CHILDHOOD SERVICES

Uruguay, 2018



Source: Adapted from De Henau et al (2018). *Investing in Free Universal Childcare in South Africa, Turkey and Uruguay: A Comparative Analysis of Costs, Short-Term Employment Effects and Fiscal Revenue*.

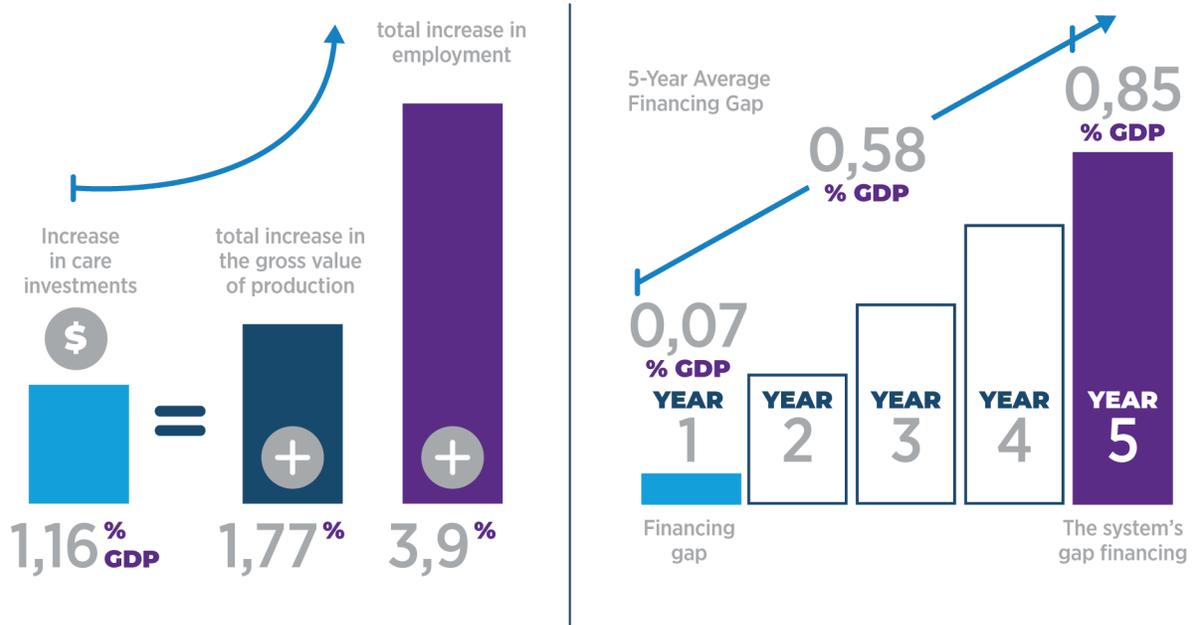
In Mexico, using this same methodology, the total annual costs, returns on investment, potential effects on employment, the economy, and additional tax revenues of a universal, free, and quality childcare system for children under six years of age were estimated. According to these calculations, an additional investment of 1.16% of GDP in the childcare system would lead to a total increase in the average annual gross value of production of 1.77% and a total increase in

employment, averaging 3.9% of the employed population in 2019. The study considers different scenarios in each year with different levels of coverage that progressively increase each year (for a total of 5 years). On average, the financing gap would be 0.58% of GDP. In the first year, this gap is 0.07% of GDP, and by the fifth year—when the desired coverage is achieved—the financing gap of the system would be equal to 0.85% of GDP.<sup>28</sup>

28 UN Women & ECLAC. (2020). *Costs, Returns, and Effects of a Universal, Free, and Quality Child Care System in Mexico*.

## COSTS, RETURNS, AND EFFECTS OF A UNIVERSAL, FREE, AND QUALITY CHILD CARE SYSTEM

Mexico, 2019



Source: UN Women and ECLAC (2020). *Costs, Returns, and Effects of a Universal, Free, and Quality Child Care System in Mexico*.

# 03

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WHAT ELEMENTS  
CONSTITUTE  
A COMPREHENSIVE  
CARE SYSTEM?

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## 3.1. What do we mean when we talk about Comprehensive Care Systems?

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A Comprehensive Care System can be defined as a set of policies aimed at implementing a new social organization of care with the purpose of caring for, assisting and supporting people who require it, as well as recognizing, reducing and redistributing care work—which today is mostly performed by women—from a human rights, gender, intersectional, and intercultural perspective. These policies must be implemented based on inter-institutional coordination from a people-centered approach. The State is the guarantor of access to the right to care, based on a model of social co-responsibility—with civil society, the private sector, and families—and gender. The implementation of the system implies intersectoral management for the gradual development of its components—services, regulations, training, information and knowledge management, and communication for the promotion of cultural change—that considers cultural and territorial diversity.

Explaining the aspects that make up a Care System—from its very definition onwards—is not a mere theoretical exercise. On the contrary, the choices made regarding the definition, principles, and components that

make up the system will determine the care policy's direction and the type of implementation it will have. Therefore, it is essential to clarify these choices, as they will result from the set of policy decisions made by the authorities per each country's processes.

Although it is desirable for countries to take more significant steps towards implementing Care Systems, many of them have services, programs and/or policies in place with their own characteristics. Transforming these actions in a way that allows for progress in the consolidation of systems involves an exercise in the design, redesign and coordination of public policy that implies, for example, in the case of older persons and persons with disabilities, moving towards a social and health care model, or in the case of childcare, linking it with education policies.

This design or redesign of policies—from a rights-based approach—must also include a gender perspective, since policies must pursue the dual objective of tending to, and guaranteeing care and redistributing the unpaid care work carried out primarily and to a greater extent by women.

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## 3.2. What is the difference between programs, policies, and Care Systems?

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The care deficit is a reality globally and throughout Latin America and the Caribbean, in particular, which has led to the implementation of various types of government responses, in some cases limited to specific populations. In some cases it is focused on the most vulnerable people, with varying degrees of formalization and scope.

To understand the heterogeneity of care situations in the region, it is necessary to distinguish between *care programs, policies, and systems*.

Practically all of the region's countries have **programs** that provide some type of care services. Undoubtedly, the most widespread are early childhood services, which target children living in poverty and/or vulnerability. The main objective of these programs is, in itself, child development. In some cases, there is a redistribution of care by freeing up the time of many women, who are mainly responsible for caregiving. In contrast, programs designed to provide care services for older persons and persons with disabilities are much less widespread in the region, and the existing supply is almost exclusively private, which means that not everyone who needs care has access to it.

**Care policies** are defined as a series of programs designed to meet the needs and ensure the exercise of the rights of a given population.

For these care policies to become a **system**, it is also necessary to develop a **governance model** that includes **interinstitutional coordination**—at national and territorial levels—among all the institutions that implement actions aimed at providing care for different target populations as a way of making efficient use of the capacities installed at the State and social levels, thus developing a management model that tends to move “*from the logic of services to the logic of people.*”

The creation of a system that, while addressing the needs of the population, operates on the need to move towards the recognition, reduction, and redistribution of unpaid care work, requires the articulation of policies aimed at all target populations, including those who require greater care—children, older persons, and persons with disabilities—but also those who provide care (both paid and unpaid). To achieve this, it is desirable to deploy its actions around five components:

- The services (public and/or private) provided;
- The regulations that are established (service and labor);
- The training of caregivers;
- Actions to generate and manage data, information, and public knowledge on care;

- Communication actions aimed at disseminating rights and promoting cultural change.

Depending on each country's starting point, it is necessary to establish a "road map" that allows the system to be developed progressively.

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## 3.3. Target populations

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Care permeates the lives of all people, and all people require care as a key aspect of the production and reproduction of life. As mentioned above, care can be defined differently, involving other actors and spheres, and these definitions can be more or less restrictive. However, to implement a public care policy or a Comprehensive Care System, it is necessary to define the policy's target populations in terms of its goals.

For this reason, the implementation of a care policy, from a systemic perspective, that seeks to alter the current social organization of care from a gender perspective should incorporate as target populations *all* people who may require care, assistance and/or support that must be provided by third parties throughout their lives, and all people who perform care tasks—both paid and unpaid. The design of policies based on a model such as this one, which addresses the needs of individuals and families, will contribute to families' care strategies.

From this perspective, the following will be considered target populations of the Care Systems:

- **Children**, to contribute to their development through attention and care.
- **People in a position of dependency** (temporary or permanent), who for reasons of aging, illness or disability, require care, assistance and/or support to carry out basic, advanced, or instrumental daily life activities.
- **Care workers** (paid and unpaid).

Regarding people who perform paid care work—whether at home or in diverse institutional settings—the aim is to enhance the value of their work, generating career training that, while ensuring the quality of the care they provide, will enable them to consolidate their integration in the labor market and achieve decent working conditions.

Unpaid caregivers, mostly women, have the right to free time, to have life projects free of violence, and to achieve economic autonomy that allows them to participate socially and politically in society. To achieve these objectives, it is necessary to have a system that not only reduces the burden of care, but also recognizes and redistributes it.

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## 3.4. Guiding principles for the creation of Comprehensive Care Systems

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### 3.4.1. Care as a right

Conceiving care as a right implies incorporating a **rights-based approach** to guide the construction of care actions, policies, and systems. In short, —and based on successive international instruments<sup>1</sup> signed by the countries of the region—, the idea **is to conceive all policy targets as active subjects of rights and not as passive beneficiaries of a policy**. Therefore, it implies that these people, who are subjects of rights, must have a voice in the design, implementation, and evaluation of care policies, with social participation and the creation of mechanisms for enforceability

being the main tools for this purpose. Likewise, action plans must be committed so that people, through successive accountability, can evaluate the progress of the policy. These action plans can also be used to ensure the principle of progressivity and non-regression on the part of the State as guarantor of the right to care. Lastly, the **principle of equality and non-discrimination should be incorporated**. Although all people should have equal opportunities to exercise their rights, situations of discrimination and inequality should be properly addressed.

### 3.4.2. Universality

A universal policy is usually understood as one that guarantees access to all persons who have a given right. The access dimension is undoubtedly relevant, but the concept of universality should not be restricted to access alone but should also include its **quality**. When the challenge of advancing towards universality in care policy arises, it is necessary to consider that **it is just as important for everyone to have access to the**

**right to care as it is for all care services to be of equal quality**. The issue of universal quality is crucial to ensure that public policies do not generate stratified services such as “State services of uncertain quality for economically vulnerable people” and “private services for those who can afford to pay for quality.”

In other occasions, the concept of universality— in its dimension of access to services—is defined

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1 Mainly: Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Inter-American Convention on Protecting the Human Rights of Older Persons, International Convention on the Rights of Persons with Disabilities, International Convention on the Rights of the Child, Regional Conferences on Women and Regional Conferences on Social Development of ECLAC, Conventions 156 and 189 of the International Labour Organization.

in opposition to the concept of *targeting*. The opposition between universality/targeting makes sense to distinguish the strategic orientation of public policy.

When universality is the strategic orientation, then social policies are understood as the provision of rights that reach all people. Once

### 3.4.3. Co-responsibility

The notion of co-responsibility has two dimensions: *social co-responsibility* and *gender co-responsibility* in care.

Defining **social co-responsibility** as one of the guiding principles of public policy implies that such policy is the result of a combination of efforts among all actors in society that can be well-being providers: the State (at the federal, provincial, or municipal level), the market, families, and the community. Businesses can play an important role in social co-responsibility in care, from advancing measures and permits for reconciliation with gender co-responsibility to being part of virtuous alliances to implement care services. Similarly, not all well-being providers bear the same responsibility. The State has a key role to play in guaranteeing the right to care as a universal right, both in terms of access and the quality of services, so that access is not conditioned by people's ability to purchase goods on the market.

The concept of **gender co-responsibility** refers to the promotion of gender equality to transform the unfair sexual division of labor that causes women to lose opportunities to participate in society and develop their life

the strategic orientation has been defined, the concept of targeting has a place, but as a *methodological resource* to ensure the effectiveness and efficiency of the actions, to establish priorities in access within the framework of universal policies, and to make policies specific to the characteristics of the territories.

projects because they have additional unpaid work time that is not recognized as such, and that generates inequities in the use of time compared to men. This inequality is structural and has consequences not only for women's individual possibilities of achieving economic autonomy and personal development but also has implications for the functioning of society, which loses women's contribution to wealth creation, politics, culture, and other issues. Therefore, one of the objectives of care policy must be to promote sharing responsibility for care between men and women.

The incorporation of men in caregiving has positive effects on social well-being because it improves bonds within the family (couple relationships, parent-child bonds) and can reduce violence by promoting changes in the predominant model of masculinity. This requires the "establishment of mechanisms—curricular, communication, awareness-raising and training—for the construction of a masculinity capable of caring for and being cared for, that is, of attending to the needs of others, in contrast to a violent masculinity focused on the use of force to dominate other people."<sup>2</sup>

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2 Martínez, J., Salvador, S. (2016). Política de Corresponsabilidad Social de los Cuidados de El Salvador. Documento Base.

### 3.4.4. Promotion of autonomy

Care Systems must assure that people are capable of formulating and fulfilling their life plans in a framework of interrelation with other people. Autonomy has a relational component because people need others to carry out a life plan. Even those who have significant levels of autonomy require the recognition of other people with whom they coexist and live in society.

Therefore, the aim is not merely to promote individual autonomy, but to understand that

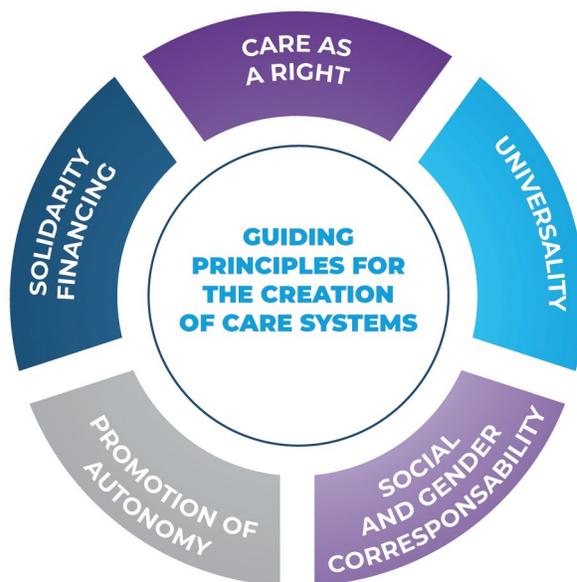
the conquest of personal autonomy means the possibility of having the capacity to be protagonists and agents of transformation in the community and society.

The promotion of autonomy has an individual objective concerning people's self-determination, which refers to the capacity of people to decide for themselves their life projects and the conditions in which they access care, assistance, and support policies.

### 3.4.5. Solidarity in financing

Solidarity in the financing of Care Systems implies designing instruments that consider families' ability to pay to facilitate universal access to policies.

To this end, it is desirable to establish progressive schemes involving a timetable for access to services based on criteria for each case, which would imply developing a financing model based on solidarity from a socio-economic and intergenerational point of view.



Source: Authors' own elaboration

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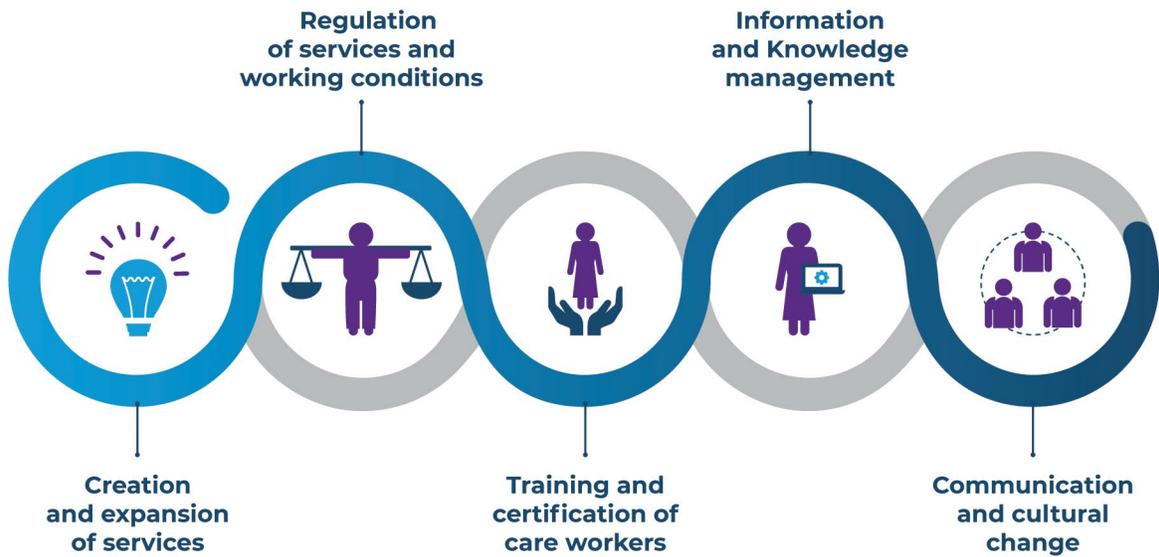
## 3.5. The components of Comprehensive Care Systems

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The creation and/or articulation of public care policies from a systemic vision that complies with the principles proposed from a rights and gender perspective implies the development of each of the components in a process of coordination and institutional articulation. The five components of the Comprehensive Care Systems are presented below:

- The **creation and expansion of services** aimed at the different target populations with a diverse offer in terms of both modalities and schedules, with progressive coverage and tending towards universality in terms of both access and quality. These services can be provided through home care, institutional day-care, or residential care services (known as long-term care) and remote care services, such as telecare. It is possible to incorporate subsidies for the payment of the above-mentioned care services. In addition, there are co-responsibility programs, associated with time policies through leave and leave of absence. Lastly, there are programs to promote autonomy and prevent and reduce situations of dependency, as well as programs for timely stimulation in the case of children.
- The **regulation** component includes two main dimensions: the first refers to the **regulation of services**—both public and private—, with the incorporation of a human rights approach with emphasis on the gender perspective and territorial equity. Work must be done to deconstruct the idea that there are different categories of services depending on who they are intended for and, on the contrary, to generate services of universal access and quality. The second dimension of this component is the **regulation of workers' working conditions**, the possibility of building a collective, formalizing the task, and improving the working conditions of the care sector.
- **Training for paid care workers** that allows them to guarantee quality care and at the same time strengthen their careers with decent employment conditions and exercising the right to self-care. This implies the development of courses at different levels and with specializations by population and type of services. It is also necessary to validate previously completed studies and certify labor competencies.
- **Information and knowledge management** that allows for the comprehensiveness of the systems and the possibility of making political decisions in an adequate manner, based on quality information. This includes the collection of statistical data on satellite accounts and time-use, which also allows for measuring the impact on the reduction and redistribution of unpaid care work.
- **Communication to promote cultural change** so that men and women share equally the task of care-giving duties in times that will continue to be shared within the family and betting on social co-responsibility, where all actors in society, the State, the market, the community, and families are responsible for supporting it.

## FIVE COMPONENTES OF COMPREHENSIVE CARE SYSTEMS



Source: Authors' own elaboration

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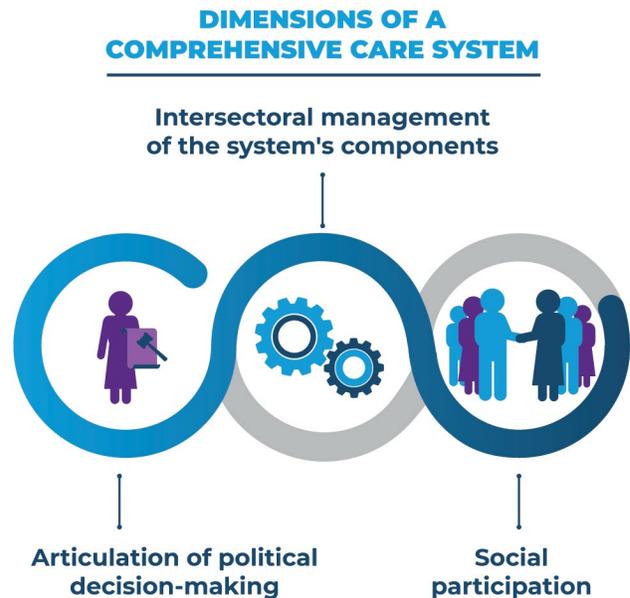
IMPLEMENTATION DYNAMICS  
OF COMPREHENSIVE  
CARE SYSTEMS: ELEMENTS  
TOWARDS A ROADMAP

The construction of a Care System cannot have a single dynamic. Each country has its own economic and social situation, cultural identities, and differential institutional legacies; and it also has a particular organization of care that stems from the previous dimensions.

For this reason, the following guidelines, which are related to the “how”—that is, how to progressively advance towards the implementation of comprehensive Care Systems— attempt to propose a set of elements to be considered, which will have to pass through the sieve of the political decisions of those in power and as a result of a process of open dialogue with the different actors in society.

The gradual construction of a system of care should prioritize the definition and implementation of a policy management model based on a systemic logic. To this end, it is necessary to consolidate an institutional architecture and a dynamic of implementation that starts from the construction of systemic devices and encourages logics of management that privilege interinstitutional articulation.

Implementing a Care System suggests the implementation of various simultaneous processes of articulation, management, and promotion of social participation at the levels of political decision-making, sectors, and territory. For analytical purposes, three spheres or dimensions should be distinguished: **the sphere (or dimension) of the articulation of political decision-making; the sphere or dimension of intersectoral management of the components of the system; and the sphere or dimension of social participation**, which includes both the participation associated with the management of all the actors making up the system within the framework of the principle of social co-responsibility and community participation in the territorial sphere.



Source: Authors' own elaboration

This implementation dynamic applies to any level of government or administration. It applies both to the construction of Comprehensive Care Systems and the creation of local care plans at subnational levels—district, provincial—and at the municipal and municipal levels. Of course, the institutional competencies vary at each level and, in some cases, may depend on the transfer of resources from the central government or may be subjected to national or federal regulations. However, the aim is to apply a management logic that, as mentioned above, can be based on the inter-institutional coordination of all the agencies with competence in the area of care at each level, the management of all the components—within the framework of the competencies established by the legal system— and the construction of instruments

that promote participation associated with the management of the private sector and civil society organizations, considering the diversities and specificities of each territory.

The aspects of the implementation of Care Systems considered most relevant for each of the three dimensions are developed below and illustrated with examples of experiences that follow the proposed logic.

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## 4.1. Political governance of the System: The interinstitutional articulation of the political decision to move “from the logic of services to the logic of people”

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### 4.1.1. Construction of the legal-normative framework

First, the construction of a legal-normative framework for the Care System through the establishment of national laws is a vital point for enshrining the right to care and to care for people in conditions of quality and equality. The legal framework is also a central element in establishing an institutional architecture that underpins the political governance of the system based on interinstitutional articulation. Similarly, when developing systems at the subnational level, it will be essential to establish the institutional framework through the corresponding legal instruments.

Thus, a legal framework that meets these objectives should establish, as appropriate, the rights holders, definitions, principles, and

components; and the institutional framework of the Care System, with its functions and powers and oversight mechanisms; as well as the establishment of jurisdictional authorities at the national/federal, district/provincial, and municipal levels.

The experience in our region shows that the processes that lead to the development of a “framework” law on care can be diverse. In some cases, the drafting and enactment of a law may result from a process of social dialogue that runs parallel to the authorities’ process of building the System. In other cases, the legislative initiative—also the result of a process of dialogue—may precede a government’s decision to create a Care System and may be an incentive to put the issue on the agenda.

## 4.1.2. Institution building for governance

The construction of an institutional framework that ensures the political governance of the System must be based on inter-institutional coordination that places people's rights at the center and that it also makes effective and efficient use of the capacities installed in the State and in society.

It is, therefore, important to distinguish between what is meant here by "coordination" and "articulation" of a public policy. The **coordination of a policy** implies a process in which the parties involved in its implementation (for example, provincial or district ministries or secretariats) establish joint actions based on their sectoral mandates (education, health, employment, etc.) and their corresponding competencies. They converge in a coordination space where plans are shared, and common elements are identified as means to join efforts and work more effectively in achieving the objectives and management goals previously defined for each sector.

In contrast, a **policy articulation model** involves a process in which a space for discussion and collective decision-making is created around a problem or issue to be solved (for example, how to solve the social deficit in early childhood care). Objectives and goals are defined to solve the problem, and responsibilities are assigned for implementation based on the mandates and sectoral competencies of each agency. In other words, the objectives are not predefined by sector but result from collective political discussions and decision-making. This is the management mode that focuses on people's situations and, from there, structures the execution of services and the other components of the system.

Under the premise of moving "*from the logic of services to the logic of people,*" the

implementation of care policies must respond to the different situations and needs of the people to be cared for, the paid and unpaid caregivers and their families.

To make this logic of political decision-making viable, one possible option is to create a national/federal, subnational, or municipal interinstitutional care board, council or roundtable, made up of the ministries or State secretariats, provinces, districts or municipalities that could bare responsibility for the implementation of care policies in each case. Regardless of the particular configurations they take on in each country, it is understood that there are bodies, such as the social authority (ministries of social development or similar), the machinery for the advancement of women and gender equality, the ministries of finance, health, labor, education, as well as the authorities for children and social security (and their counterparts at the subnational and local levels), whose integration is necessary.

This board, bureau, or council would be responsible for making policy decisions with the initial and essential task of defining an *action plan* based on objectives and targets for each of the defined target populations and each of the components of the system. It would also have the function of identifying budgetary requirements and preparing a collective proposal for budget allocation to the executive branch. The future articulation capacity of the system's members is at stake in these two issues.

On the other hand, a critical element is to have a body in charge of coordinating the System, establishing the interfaces between the bodies responsible for implementation in each case, and following up on the decisions of the political decision-making body.

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## 4.2. Intersectoral management of the components of Comprehensive Care Systems

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### 4.2.1. The construction of intersectorality as a principle of management by components

The construction of intersectorality for the management of the system's components implies establishing links between two or more member agencies, not only for the implementation of care services for the different populations, but also for the coordinated management of the other components of the system, giving priority to the agency that in each case has competence in the matter in question.

Intersectoral management presupposes the construction of permanent working groups—or system commissions—with representatives of the bodies that make up or will make up the System. This is the level at which the political decisions of the governance body are operationalized and where conceptual

agreements are advanced, and planning is carried out for the implementation of the previously decided action plan. This allows for the articulated implementation of all the components of the system to be set in motion.

In each case, the implementation of the actions will be led by the respective competent bodies. The coordinated management of the system's components makes it possible to structure solutions that are better adapted to people's realities. This is a win-win scheme for the agencies involved in care policy, since they participate in the construction and implementation of more efficient solutions and have better conditions for successfully fulfilling their own sectoral mandates.

### 4.2.2. Aspects to consider in the implementation processes of the system's components

The development of a Care System will undoubtedly have different starting points in terms of services, regulations, human resources training strategies, etc. This will depend not only on policy options but also on the opportunities and restrictions that the countries have. However, there is a wide range of possibilities for starting with the implementation of Care Systems

in their different components. Beyond the specificities of each country, the process of intersectoral implementation of the System's components will require a set of actions to organize the implementation.

The following is a set of **possible actions to be developed in terms of intersectoral management of the system's components**

that, without claiming to be exhaustive, attempts to show the multiplicity of actions that can be developed.

## Services

- Establish which services will be considered care services by developing a typology.
- Identify existing services once the target populations have been defined. These services constitute the “baseline” of the future system.
- Conduct geo-reference studies of the potential demand and supply of existing services.
- Identify possible alliances and collaborations of the public sector with other key actors to supply services, such as the private sector and the community.
- Make a preliminary estimate of the services’ unit costs.
- Design new care services, assistance, and support services required to complement existing ones.
- Elaborate coverage expansion scenarios for the different services based on possible gaps between supply and demand, using progressive access schemes that combine different variables (age, location, vulnerability, dependency levels, etc.).
- Conduct a previous evaluation that allows projecting the financing requirements in different scenarios, but also projecting the impacts in terms of job creation, increase in tax revenue and gross value of production, among others.

- Redesign pre-existing services from a systemic point of view that ensures the mainstreaming of the rights and gender perspective approach.

- Create tools for monitoring and evaluating the services’ impact.

## Regulation

In the area pertaining regulation of services:

- Establish a “baseline” of existing regulations for different services.

- Advance in a regulatory framework that allows for the evaluation of the quality of services and establishes the requirements to reach the standards that are defined.

- Establish standard criteria among the institutions that carry out audits on which indicators will be evaluated (whether of the technical team, the infrastructure, or the work in relation to the users and their families).

- In the case of the services to be created, establish supervision schemes that include control and sanction mechanisms for non-compliance with requirements.

- Develop instruments to strengthen technical and financial capacities that contribute to improving the quality of services.

- Conduct evaluations on the impact of services on the quality of life of users.

- Promote the implementation of work-life balance measures with gender co-responsibility in workplaces (public and private).

- Extend parental and exclusive leave for men for childbirth or other caregiving tasks.

- Promote gender and care clauses in collective bargaining agreements.

In terms of the regulation of working conditions, based on ILO<sup>1</sup> recommendations to complement the 3R approach (recognizing, reducing, and redistributing unpaid care work) with actions to *reward* and *represent* paid care work (the 5R), it is considered necessary to make progress in the following areas:

- Regulating working conditions and wages in the care sector by creating safe working environments (including domestic workers).
- Generate regulations for migrant women workers.
- Promote freedom of association, social dialogue, and the right to collective bargaining in the sector.
- Promote alliances between care sector trade unions and civil society organizations representing the interests of target populations (including those of unpaid women caregivers).

## Training

- Define the labor profile of care workers as a way of beginning to establish the limits of the care occupation to then generate training trajectories.
- To design a competency-based training curriculum that allows for the implementation of the axes of the training strategy.
- To build the teaching profiles that guarantee the inclusion of the public health and socio-

educational models necessary for the development of training in care.

- Design training courses for trainers from a rights-based approach and a gender perspective.
- Define requirements for the qualification of private training entities and/or public institutions that can provide training.
- Establish the institutional framework for the management of the training strategy that includes the development of:
  - Courses (different levels and modalities by level of dependence or by area in which the task is developed).
  - Validation of previous training.
  - Certification of labor competencies.

## Information and knowledge management

- Create a National Care Registry. This may include different modules that account for the System's users, authorized training entities, care service providers and persons authorized to work, among others.
- Develop platforms that collect information on supply and demand for care services.
- Follow up on the action plan and its budget.
- Rely on reports that provide information on the services' coverage.
- Create, together with academia, a knowledge agenda necessary for the implementation of Care Systems.

1 OIT (2019). *El Trabajo de Cuidados y los Trabajadores del Cuidado para un Futuro con Trabajo Decente*.

- Contribute to the articulation of academic networks of care.
- Generate gender equality indicators to incorporate into service quality measurements.
- Promote a knowledge agenda on care and gender.
- Continue data collection on the use of time and social perceptions of care within families, in order to evaluate the impact of the system on the distribution of unpaid work.

## Communication

- Develop awareness-raising campaigns on the right to care and on social and gender co-responsibility.
- Conduct training on care from a gender perspective for political, social, and institutional actors involved.
- Awareness-raising at a local level on social and gender co-responsibility in care.

**With all these elements, it will be possible to make decisions that will allow us to advance in a gradual implementation, but with the final construction of the system as a goal.**

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## 4.3. Social participation: partnerships for management and community participation in the implementation and monitoring of the system

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### 4.3.1. Partnerships for management

As already stated, establishing that the Care System is the result of co-responsibility between the State, the market, families, and the community allows us to think about policies that allow us to move *from “a State that cares” to “a society that cares.”* This requires the promotion and implementation of institutionalized spaces for dialogue where

all social actors converge civil society organizations—including feminist organizations, people with disabilities, the elderly, and children (among others), trade unions and business organizations, and the academic sector.

In the case of social organizations, it is important to incorporate organizations

representing all the populations in the System. A commitment should be made to the accurate monitoring of the system's progress. Social actors have a leading role in analyzing the system's progress, discussing approaches and proposing initiatives, and not merely being recipients of information. An essential tool in this sense could be the construction of social observatories.

From the system's design, the implementation, monitoring, and review of the policies that comprise it by the actors involved, this process of participation will result in the construction of a basis for sustainability that can transcend the political, economic, and social situation. In this sense, the inclusion as part of the institutional framework of an advisory and consultative body made up of representatives of the groups of the society involved in the System's development may be strategic for its strengthening and sustainability over time. This body can have a propositional, advisory, and consultative character, constituting a

platform from which to ensure the voice of society in decision-making.

The participation of the actors involved in the Care System can also include—within the framework of the principle of social co-responsibility—their involvement in the management and implementation of the system's different components. For example, building partnerships with the private sector for the management of care services that creatively develop public-private co-financing mechanisms is a necessary step towards universal coverage for people in need of care. Likewise, the coordination of public-private efforts to promote instruments that reconcile work and family life is of great importance.

In addition, it is of great importance that the design of care policies at all levels include the participation of civil society and academic organizations, taking advantage of their knowledge and practices, as well as their proximity to the needs of the people who would be the subjects of the policy.

### **4.3.2. Community participation as a territorial key for the implementation and monitoring of the care policy**

The territorial articulation of care policies is an essential element of the implementation process. When we refer to territory, we are not referring exclusively to the geographical location where public policies are implemented. It is based on a relational concept of territory, understood as the set of social relations that coexist in a given time and space among local actors—political, social, and institutional—who manage the implementation of the policy and provide feedback to the centrally designed policy. Thanks to this process, public policy design incorporates specificities that are not detectable when action plans are created at the central level. After this process, the central level must discuss and incorporate

those aspects that are considered for the design of public policy on care.

To strengthen this virtuous circle, it is necessary to develop institutional spaces for dialogue that include social participation at the local level, where political, institutional, and social actors can contribute to the Care System model from the management of the territory. These institutional spaces will generate synergies and coordinate actions to develop each of the components of the care policy at the local level.

The care policies implemented at the local level must also be articulated with the general policy. The construction at the local level of

the different policies, services, or actions that promote the right to care cannot be self-referenced but must be in constant dialogue with central planning and seek synergies with other territories according to their competencies. This does not preclude the possibility of first moving forward with the implementation of public policies at the local level—as it happens in several countries in the region—if the conditions, policies, and resources to do so are in place. However, it is essential to maintain a strategic vision to contribute, from the specificity of the territory to the objective of strengthening Care Systems as a fourth pillar of social protection and thus contribute to a fairer and more sustainable social reorganization of care.

Therefore, in order for the territorial work to have political relevance beyond **implementation, not to be a testimonial space**, and to contribute to the comprehensiveness of the system, there must be specific articulation and coordination mechanisms between national and local levels that include the different territories.

In addition, as was the case at the national level, it is essential that, through the various inter-institutional coordination mechanisms, the implementation of care plans at the local level be designed and coordinated. The development of such plans is an opportunity to:

- transfer the power of initiative to local actors, which implies that they can make decisions within a general framework, having the margin of action to involve their own resources, defining the role of each of the local actors and the prioritizations that they believe are pertinent in accordance with the distribution of competencies in each country;
- integrate the specificities of the territory with the central level, which implies the inclusion

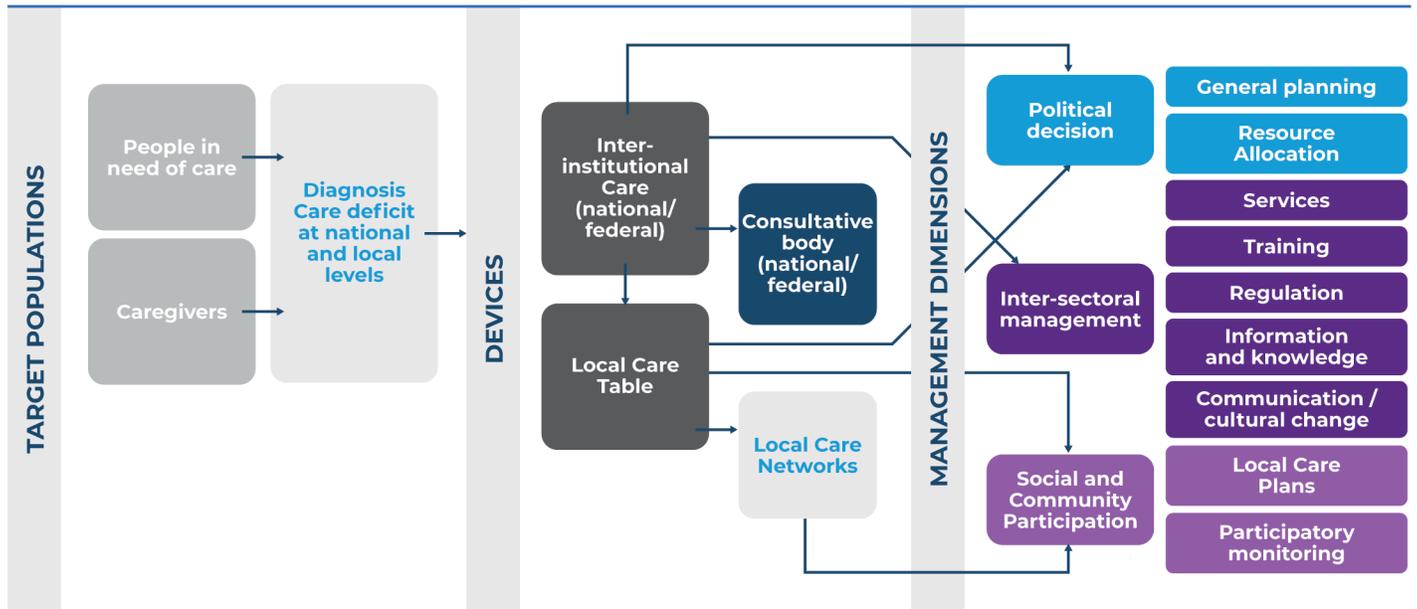
of local aspects in each of the stages of the policy, with special emphasis on the lessons learned from the implementation processes. Given the strategic centrality and agreement on the objectives and design of the policy, each territory must collectively build the articulation and coordination of resources in a co-responsible manner among all institutional, political, and social actors;

- carry out an adequate management of expectations regarding the actions that can be taken to solve the problems posed, taking into account the available resources and the competencies of the institutions that will carry out the process of implementing local care policies;
- incorporate community assets in the designing of plans. Thus, for example, a very important complementarity can be established between geo-referenced mappings of supply and demand for care, and participatory diagnoses that serve the dual purpose of conceptualizing and raising awareness of the need and the right to care to collectively establish the dimensions of the problem and the characteristics of the actions to be taken;
- develop monitoring instruments that are also participatory, specifically in the case of the deployment of services; territorial monitoring commissions could be implemented to monitor specific services that accompany their implementation and operation, involving users and their families;
- install service mechanisms that allow for a permanent dialogue with citizens regarding access to the system and its progress. It is necessary to generate a permanent and open channel of communication. To develop this element, it is important to have institutional areas of proximity that implement

decentralized face-to-face, telephone, and virtual communication channels that can be efficiently responsible for citizen service. This must be accompanied by the

construction of information systems or the adoption of existing systems and ongoing training to enable quality service.

### DYNAMICS OF THE IMPLEMENTATION OF PUBLIC CARE POLICIES



Source: Authors' own elaboration

## 4.4. Can care be sustainable in the medium term?

### The issue of budgeting and financing Care Systems

Based on the definition of the target populations that will be part of the future Care System and the programmatic objectives and goals set for each component, it is necessary to size the investment amounts required to

put it into operation, which must be added to the investment currently allocated to existing care services or a specific line of the rest of the components, which will constitute the budgetary baseline.

It is also important to be able to carry out a prospective analysis to identify the economic returns that would be generated by its implementation in the short and medium-term, as well as the effects on employment and the formalization of care workers.<sup>2</sup>

The inclusion of these aspects in the discussion on the budget for Care Systems is critical, especially in the dialogue with the economic authority, always bearing in mind that investment in care is an intelligent investment, with high economic and social returns, which in addition to generating a triple dividend, contributes to the reduction of gender gaps, as well as contributing to the reduction of poverty and inequality. The financing modalities are varied and can be combined with each other. In turn, different modalities may be adopted depending on the goals and objectives set and the stage of the System's construction.

- A first modality is financing through the contribution of resources from the **national/federal budget**, by which the systems are financed through State revenues.

The State's budgetary contribution is a basic condition for any financing strategy, since it is the investment of resources that enables the State to fulfill its function of guaranteeing the right of access to care for the people who require it.

This model has the advantage that it can be installed quickly and without resistance from society (because it does not necessarily involve creating a new tax), but it has the disadvantage

that it does not directly finance the system and is, therefore, subject to changes in political orientation and the economic cycles of each country. On the other hand, it seems rather challenging to meet the total demand for care through this mechanism.

- An alternative modality is that of **individual insurance** through which people take out insurance against the risk of being in a situation of dependency. Care services are provided only to those who have taken out the insurance, which excludes those who are unable to take out insurance because of their socio-economic status. The advantage of this model lies in the flexibility and possibilities offered by the insurance modalities, but it is based on an unequal construction in a policy that aims to be universal in terms of access and quality.
- **Care funds** could be a solidarity-based financing alternative based on social security contributions or taxes directly associated with this fund. From a progressive standpoint, one possibility is to establish contributions from workers who pay social security contributions or to create a tax that is earmarked for this fund. Having a fund can avoid subsequent problems of dismantling the policy in the event of a change of government, but it does raise the difficulties faced by countries with high rates of informality, especially among women, in the event that the contribution comes exclusively from social security.

It is important to note that financing models are not mutually exclusive, and models can

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2 In this regard, see: "Methodology for Estimating the Economic Costs and Impacts of Care Services in Latin America and the Caribbean. Analysis and Simulation of the Economic Costs and Effects on Output, Employment and Tax Revenues in the Implementation of Universal Care Services for Early Childhood, Infancy and Dependent Persons." Julio Bango - Luis Miguel Galíndez, Karina Caballero, Jorge Campanella. UN Women, (document pending publication).

be designed according to the political and economic conditions of each country using any or all of them. In turn, whichever model

is used, state financing mechanisms may be combined with co-payment and State subsidy schemes.

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## 4.5. Final recommendations

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The construction of Comprehensive Care Systems is a long process that requires multiple political wills, and the articulation of varied actors and levels of management. However, it should be understood as a gradual process where the important thing is to start the journey and make it progress over time. By way of synthesis, some final recommendations that can guide the process are included below:

- 1.** It is essential at the local level to carry out awareness-raising actions on the right to care and the social and gender co-responsibility, mobilizing not only society as a whole around the need for a Comprehensive Care System but also local actors from sectors directly involved in care policies, civil society, academics, companies, and workers in the sector.
- 2.** Through adequate management of expectations, advance in diagnoses of needs and possible solutions to the care deficits of a specific territory, considering its characteristics and the different starting points.
- 3.** Generate spaces for institutional articulation between local actors with strong political coordination and high-level representation that allows for programmatic agreements to be made and implemented. The complexity of this institutional structure will be a consequence of the levels of decentralization and scale of each territory.
- 4.** Encourage among the institutional actors involved a shared vision of what a Care System entails.
- 5.** To carry out an in-depth analysis based on each of the components of the System that will make it possible to establish, per the competencies of the different local spheres of government, the economic resources, and the scale of the territorial dimension, achievable programmatic goals that will be reflected in the preparation of the local care plans.
- 6.** Generate instruments to empower civil society organizations by transferring resources and initiative capacity to solve care deficits at a community level.
- 7.** Encourage agreements with the academic sector at the territorial level that enhance the generation of knowledge on care, becoming a factor that helps place the issue on the public agenda.
- 8.** Establish a permanent dialogue with the national/federal level that contributes to the construction of a Comprehensive Care System that is sensitive to the territory and that, in turn, this anchoring at the national level gives sustainability to all the local care actions or policies that are developed.

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CONCLUSION

Investing in Care Systems can create the conditions for the economic autonomy of thousands of women who see their unpaid care work burden alleviated and of many others who enter the formal labor market carrying out paid care work. At the same time, creating a service economy based on care will boost local economies by improving family incomes. Finally, in the medium term, it could have an impact on the formalization and professionalization of paid care workers, increasing their labor skills, income, and productivity.

The relevance of addressing the current care crisis has been recognized in the 2030 Agenda for Sustainable Development themselves, formulating its Goal 5.4. in terms of "Recognize and value unpaid care and domestic work through the provision of public services, infrastructure, and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate."<sup>1</sup>

At the Regional Conference on Women in Latin America and the Caribbean, the region's governments recognized care as a human right, highlighting the key social function that care plays in the production and reproduction of life and the well-being of societies. In this regard, the Montevideo Strategy urges governments to promote the adoption of policies on care and the promotion of co-responsibility between women and men that contribute to women's autonomy and a fair social organization of care. This commitment

was recently ratified at the XIV Regional Conference on Women in Latin America and the Caribbean, held in January 2020 in Santiago, Chile, through the Santiago Commitment, which explicitly mentions the need to implement countercyclical policies sensitive to gender inequalities to mitigate the effects of economic crises and recessions on women's lives, and to promote regulatory frameworks and policies that stimulate the economy in key sectors, including the care economy.<sup>2</sup>

In short, investing in care can contribute to generating a positive multiplier effect on output, employment, and tax revenues and incorporating a positive bias towards female employment. The commitment to the construction of comprehensive national Care Systems is therefore not only desirable, but necessary and possible, generating multiple benefits that can be summarized as follows:

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- 1 United Nations. *Sustainable Development Goals. Goal 5: Achieve Gender Equality and Empower All Women and Girls.*
  - 2 UN Women & ECLAC (2020). *Care in Latin America and the Caribbean During the COVID-19. Towards Comprehensive Systems to Strengthen Response and Recovery.*

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## 5.1. The progress in rights

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The States' promotion of care policies entails the inclusion of a new right in the welfare matrix: the right of all people to care and not to care, as well as their right to be cared for in conditions of quality and equality. This right implies that care is not provided solely by

family members and that those who require it will have services and alternatives so that it is not an exclusive responsibility. It does not limit the development opportunities of those who do it with little recognition and without remuneration.

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## 5.2. Elimination of social inequalities and the achievement of gender equality

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The inclusion of the right to care as part of the welfare matrix and promoting social and gender co-responsibility for care creates the conditions for changing the sexual division of labor. It recognizes that care responsibilities are not exclusively women's, thus helping to eliminate one of the structural causes of

gender inequalities. Time poverty, derived from the current overload of unpaid work for which women are responsible, limits their opportunities to participate on equal terms in paid work, training, the political sphere, or decision-making spaces at all levels, among others.

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## 5.3. The care economy as a dynamic sector of the economy/economic returns

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The recognition and valorization of unpaid care work have made it possible to measure its weight in terms of wealth generation in countries and its relevance in the economic structure. Investment in care policies in the form of services and regulations helps to increase activity rates, particularly among women, by eliminating the main structural barrier that women face in accessing the labor market. Investment in care is also a net generator of employment. This contributes

to increasing household disposable income, boosting consumption, and increasing State revenues through taxes and contributions to social security systems. For its part, legislation, regulation, and oversight of quality employment in the care economy improve working conditions in the sector and improve retirement conditions (pension systems). This promotes income distribution throughout the life cycle.

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## 5.4. Contribution to the sustainable development

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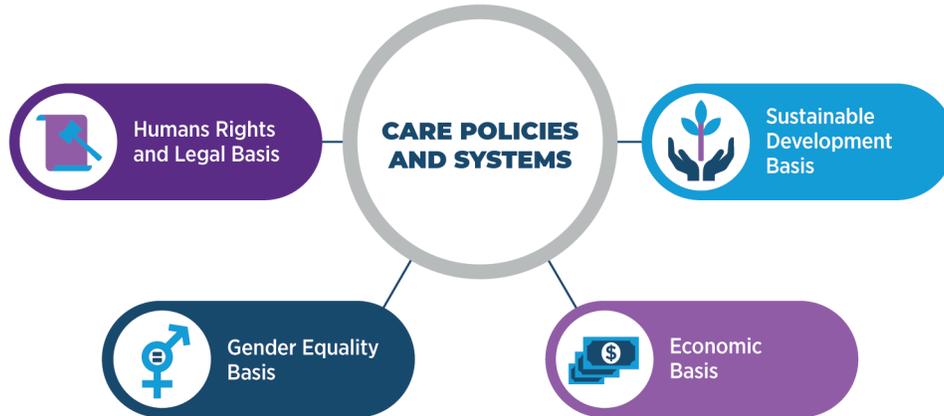
In an end-of-the-demographic-dividend scenario<sup>3</sup> in the region, the high proportion of older people in relation to the number of active people will require greater investment in health and social security in order to ensure the well-being of the population. It will be essential for all those who can work to be able to do so and for them to do so at productivity levels that will generate the wealth needed

to finance well-being. On the one hand, care policies are an essential instrument for encouraging greater participation by women in the labor market, contributing their full potential and generating a return to society for the resources invested in education systems. Furthermore, investing in early childhood care is key to ensuring that girls and boys have an adequate development,

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<sup>3</sup> Period during which the percentage of the working and productive age population is more than double of the dependent population.

achieve good education levels at school age and—in addition to being educated as critical citizens—obtain the required levels of qualification and thus gain access to highly productive jobs in the future.



Source: Adapted from UN Women and ECLAC (2020) *Care in Latin America and the Caribbean during the Covid-19. Towards Comprehensive Systems to Strengthen Response and Recovery*

# ANNEX

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## COMPREHENSIVE CARE POLICIES AND SYSTEMS IN LATIN AMERICA: SOME ADVANCES IN THE REGION

In the region, care has gradually entered the public agenda. In the last year, this process has been bolstered by the crisis generated by COVID-19. As noted above, although there is significant heterogeneity, many countries in the region have made progress in policies aimed at recognizing, reducing, and redistributing care. These processes have originated not only at the national or federal level, but in several countries the first steps in this agenda have been taken at the local, district, or municipal level, generating experiences that can undoubtedly become the foundation for the future generation of systems at the national level.



## In Argentina

**IN 2020 BEGAN THE DESIGN STAGE OF A FEDERAL CARE SYSTEM**

Under the coordination of the **Ministry for Women, Gender, and Diversity**, an interministerial roundtable on care policies was formed, comprising **14 AGENCIES OF THE EXECUTIVE BRANCH** to work on the design of the future system



In this framework, a drafting commission was also formed to **draft a bill for a comprehensive care system**

The aim is to generate a **fairer social organization of care**, which enshrines care as a right and social function and contributes to its recognition, reduction, and redistribution among the different care actors<sup>2</sup>

**STATE FAMILY**

**MARKET COMMUNITY**

Argentina is one of the examples in the region in which various state institutions (at the federal, provincial, and municipal levels) carry out various care actions.



## In Chile

the **Ministry of Social Development** has set up a Social Protection System consisting of three subsystems:

### CHILE CRECE CONTIGO<sup>3</sup> (Chile Grows with You)

As of 2021, the program is aimed at **"accompanying, protecting, and comprehensively supporting all children and their families...** providing children with expedite access to services and benefits that meet their needs and support their development at every stage of their growth". The subsystem is comprised of actions by diverse public bodies.

### CHILE CUIDA<sup>4</sup> (Chile Cares)

Since 2015, has also been implementing a subsystem of support and care that aids **people in situations of dependency, their caregivers, their homes, and their support network**. It is implemented through the municipalities and these, in turn, through local care networks. Visits are made to homes with the aim of facilitating access by dependent and people with disabilities to the community network of services provided by the State (technical aids, guidance, home care, and home adaptations).

### CHILE OPORTUNIDADES Y SEGURIDADES

Aimed at **families living in extreme poverty**.



## In Mexico

At the end of 2020, at the federal level, the **Chamber of Deputies<sup>9</sup> approved a reform** (to be ratified by the Senate) **that raises the right to care to constitutional rank and establishes the State's obligation to promote co-responsibility between men and women**, modifying articles 4 and 73 of the Constitution.

### THE SAME BILL ALSO CALLS FOR THE CREATION OF A CARE SYSTEM



#### AT THE FEDERAL LEVEL

A parliamentary initiative is underway to promote a **LAW TO CREATE A CARE SYSTEM** which **UN Women** and **ECLAC** are accompanying



#### AT THE LOCAL LEVEL

Mexico City approved a reform of its Political Constitution which recognizes the right to care and establishes that **"every person has the right to care services that support their life and provides the material and symbolic elements to live in society throughout their life"**.

**"The authorities shall establish a care system that provides universal, accessible, relevant, sufficient, and quality public services and that also develops public policies.** Mexico City's Constitution considers that the system will give priority attention to people in a situation of dependency due to illness, disability, life cycle, especially childhood and old age, and to those who, in an unpaid manner, oversee their care".

## In Colombia

**AT THE NATIONAL LEVEL, IMPORTANT STEPS HAVE BEEN TAKEN SINCE 2014 IN THE DEVELOPMENT OF A NATIONAL CARE SYSTEM**



The **Intersectoral Commission for the Economy of Care**, with the leadership of the **National Planning Department**, has worked on the construction of the institutional and technical bases of the

**National System of Care (SINACU)** through which the definition of the target population, the responsible axes, the approaches and the principles of the system are proposed.

### ➔ AT THE LOCAL LEVEL STANDS OUT:

The implementation of the **District Care System of Bogota**, which articulates existing and new programs and services to meet care demands in a co-responsible manner between the District, the Nation, the private sector, communities, and households since 2020.



The **"Manzanas de Cuidado"** (Care Blocks) are one of the ways in which the District Care System operates in the territory. They are areas that concentrate on existing and new care services.



Their objective is to **offer services close to the homes of those who care and those who require care** and provide them simultaneously: while those who care have access to training or respite, those who require care are in spaces of well-being and capacity building.



The **"Care Blocks"** are a new form of land-use planning in Bogota, which **puts the needs of caregivers at the center of urban planning**.<sup>5</sup>

## In Dominican Republic



In 2018, the Social Policy Coordination Cabinet (Gabinete de Coordinación de Políticas Sociales, GCPS) promoted a project presented at a **"CONSULTATIVE MEETING FOR THE CONSTRUCTION OF THE NATIONAL CARE SYSTEM IN THE DOMINICAN REPUBLIC: GUIDELINES AND SCENARIOS FOR A MORE EGALITARIAN SOCIAL PROTECTION."**<sup>11</sup>

The new administration that began in 2020 has confirmed its commitment to this agenda and has recently presented a care component within the **Supérate Program** that constitutes a pilot program towards the future implementation of a care system.

### THE PILOT AIMS

- ➔ To promote the first interinstitutional and intersectoral agreements to strengthen the public care network
- ➔ To support households, especially those with the highest levels of poverty, family burden, and demand for care services<sup>12</sup>



## In Costa Rica

**SINCE 2010, THE NATIONAL CHILD CARE AND DEVELOPMENT NETWORK<sup>6</sup> (ESTABLISHED BY LAW IN 2014)**

Has aimed to establish a public, universal, and solidarity-funded development and childcare system with universal access, which articulates different modalities of public and private provision of services for

**CHILDREN FROM 0 TO 6 YEARS OF AGE**

### THE PROGRAM ALSO SEEKS:

- To promote social co-responsibility, articulate different actors, alternatives, and development, and childcare services



Under the leadership of the **Joint Institute of Social Assistance**, the country recently approved the **National Care Policy 2021-2031**,<sup>7</sup> to implement a system of care for people in a situation of dependency (elderly, disabled or chronically ill people who need support and care to carry out their daily activities).

## In Panama

### MAY 2019

The **Public Policy Roundtable** was formed in Panama to define the comprehensive care system.<sup>9</sup>

### MAY 2020

In the framework of the Gender Parity Initiative promoted by the Ministry of Social Development, a series of measures for economic recovery with a gender perspective<sup>10</sup> were presented, including:

- installing the National Care Table for the definition of the comprehensive care system
- Guaranteeing the labor rights of paid care work
- Stimulating co-responsibility in the home between men and women



**IT IS CURRENTLY WORKING WITH THE ASSISTANCE OF UN WOMEN ON THE DESIGN OF A ROADMAP FOR THE SYSTEM'S IMPLEMENTATION**

## In Paraguay

**AN INTERINSTITUTIONAL GROUP FOR THE PROMOTION OF CARE POLICY** (Grupo Interinstitucional Impulsor de la Política de Cuidados, GIPC) **WAS ESTABLISHED IN 2016**



The GIPC is now made up of

### 11 STATE INSTITUTIONS

and has an initial roadmap to design, adopt and implement a national care policy.

## In Uruguay

**THE NATIONAL INTEGRATED CARE SYSTEM<sup>13</sup>** (Sistema Nacional Integrado de Cuidados, SNIC) **WAS THE FIRST SYSTEM CREATED IN THE REGION**

It was established in 2015, after a long process driven by civil society and academia, through the approval of Law 19.353



### ITS OBJECTIVE IS

To promote a co-responsible model that involves families, the State, the community, and the market in providing care to those who require it



The law that creates the system establishes care as a universal right, and the policy has gender equality as a cross-cutting theme

### THE SYSTEMIC APPROACH IS BASED ON:

- 1 The definition of the policy's target populations
  - **CHILDREN UP TO THE AGE OF 12**
  - **DEPENDENT OLDER PERSONS AND PERSONS WITH DISABILITIES**
  - **CAREGIVERS** both paid and unpaid
- 2 The articulation of five components:
  - **CARE SERVICES THEMSELVES**
  - **TRAINING FOR CAREGIVERS**
  - **REGULATION** (of services and labor)
  - **GENERATION OF INFORMATION AND KNOWLEDGE**
  - **COMMUNICATION**

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