

The background consists of several overlapping, curved, teal-colored shapes that create a sense of depth and movement. The colors range from a light, almost white teal to a darker, more saturated teal.

IMPLEMENTING CARE SYSTEMS IN SUBNATIONAL CONTEXTS IN LATIN AMERICA

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EXECUTIVE SUMMARY

Across Latin America, care has increasingly moved into national debates on gender equality, social protection, aging, disability, labor markets, and economic development. This shift reflects a growing recognition that care is an essential social infrastructure and not only a private household responsibility. Yet the experience of countries that have developed national care systems or care strategies shows that their implementation depends on partnerships between national and local stakeholders: National governments need to provide rights frameworks, financing commitments, service standards, and technical support, while local governments, community organizations, and other territorial actors shape priorities, adapt services, and make access real.

This paper reviews selected care system experiences in Uruguay, Chile, Colombia, Brazil, Mexico, Costa Rica, and Argentina. The cases show important advances, including stronger rights-based frameworks and expanded public recognition of unpaid care. At the same time, they reveal recurring risks: financing gaps, weak coordination mechanisms, uneven local capacity, fragile legal anchoring, reach gaps among marginalized groups, and persistent precariousness in paid care work.

The central argument is that care systems should be understood as social policy frameworks and multilevel territorial governance systems. The paper concludes with lessons and recommendations for subnational governments and advocates seeking to build and/or implement care policy, while also pushing for national enabling conditions for care that make territorial action equitable, financed, and sustainable.

INTRODUCTION

The global care crisis is a defining social and economic challenge of the 21st century. Aging populations, women's increased labor force participation, demographic transitions, migration, smaller households, gender gaps in unpaid care work, and persistent cross-sector gender inequalities have intensified pressures on households and exposed the limitations of care provision models that rely primarily on unpaid labor performed by women and girls.

Women in Latin America perform approximately 76.2% of the total hours of unpaid care work, and 47% of women outside the labor force cite care responsibilities as the main reason (ILO, 2024a, c). Unpaid care work remains one of the principal structural drivers of gender inequality in labor force participation, income, time poverty, and social protection.

Decades of feminist advocacy, care worker organizing, union engagement, academic research, community care practice, and multilateral support have been central to pushing nations to recognize and treat care as an important part of public policy. Their arguments draw on feminist economics, including Razavi's (2007) "care diamond" framework, which maps care provision across four institutional domains (families, markets, states, and communities), and on the International Labour Organization's (ILO's) 5R Framework for care: recognize, reduce, redistribute, reward, and represent care workers (Addati et al., 2018). Although national care systems may not always be fully rights-based in design or implementation, some countries now have or are in the process of developing national care systems, integrated care policies, and long-term care strategies. These efforts represent an important shift in how states conceptualize care, moving beyond a private household responsibility to a greater public policy issue connected to gender equality, social protection, labor markets, disability rights, aging, childhood development, and economic development.

Several Latin American countries have become important global references regarding care:

- Uruguay established the National Integrated Care System (Sistema Nacional Integrado de Cuidados—SNIC) through Law N.º 19.353 in 2015, becoming one of the first countries globally to institutionalize care as a coordinated public policy system.
- Colombia has expanded internationally recognized local care infrastructure models, such as Bogotá's Manzanas del Cuidado (referred to as "Care Blocks" in English), while creating a National Care System.
- Chile launched its Chile Cuida (Chile Cares) framework, which became formal national law in February 2026 (Law N.º 21.805).
- Costa Rica established the National Care and Support System (Sistema Nacional de Cuidados y Apoyos—SINCA) through legislation in 2022 (Law N.º 10.192).

- Mexico and Argentina have advanced national care policy frameworks, albeit through different trajectories.
- Brazil enacted its National Care Policy in December 2024 (Law N.º 15.069).

Yet while national care systems are increasingly discussed at the global and regional levels, implementation realities remain uneven. This is not the usual challenge of adapting a social protection program to local contexts because care infrastructure has long been undervalued and treated as women's or families' private responsibility; advocacy gains have often emerged as opportunities arise at the subnational level before national systems are ready to finance, regulate, or scale them; and many countries still lack adequate financing, data systems, and intergovernmental coordination mechanisms.

This creates a core policy challenge: **How can nationally articulated care rights and strategies be translated into territorial implementation without leaving care to local governments alone or reproducing existing inequalities across territories? Conversely, how can national strategies be informed by effective subnational implementation?**

This paper explores these questions through a review of selected national care systems and care policy approaches in Latin America. It argues that national care systems should be understood as multilevel territorial governance systems whose effectiveness depends heavily on the interplay between national and territorial initiatives. National commitment and resourcing are necessary, but local priority-setting, institutional capacity, community legitimacy, and political dynamics determine whether care systems reach those most affected by care inequalities.

METHODOLOGY AND SCOPE

This review is an illustrative case analysis that draws on publicly available policy documents, legal frameworks, comparative analyses, academic literature, and institutional reports related to national care systems and care strategies. It focuses primarily on Uruguay, Chile, Colombia, Brazil, Mexico, Costa Rica, and Argentina. These countries were selected using a convenience sample, and they are not the only examples of care policies or strategies in Latin America.

The objective is to provide an overview of select case studies to identify patterns, challenges, and recommendations regarding the implementation of care policies in territories. This paper is intended primarily for national and local policymakers and care advocates seeking to learn about what enables or undermines care system implementation across the region. It does not seek to provide exhaustive country profiles. Also, given the rapidly evolving nature of care policy development in the region, some initiatives remain incomplete or in transition at the time of writing.

Additionally, this paper focuses primarily on the governance, territorial adaptation, and institutional resilience of care systems rather than on their social or economic impacts. While the literature increasingly documents care policies' potential effects on labor-force participation, time use, and well-being, comparable outcome evaluations remain limited across the region, particularly for recently established systems. Future research should examine how different territorial implementation models influence outcomes for caregivers, care recipients, and care workers.

A limitation of this paper is that it does not systematically examine men's participation in caregiving, masculinities, or changes in household gender norms, nor does it analyze the extent to which care systems in the region directly target men in their national care policies or subnational implementation. While the redistribution of unpaid care responsibilities between women and men is an important component of gender-transformative care policies, a systematic analysis of men's or gender-diverse people's participation in care and changing household gender norms falls outside the scope of this review.

03

NATIONAL-SUBNATIONAL
CARE POLICY CHALLENGE

Although care systems are often framed as national projects, implementation is territorial. For this paper, subnational adaptation refers to the processes through which nationally articulated care rights, institutions, and policies are translated, modified, prioritized, and implemented within diverse territorial contexts. Subnational governments frequently play central roles in:

- **Service delivery;**
- **Infrastructure management;**
- **Community outreach;**
- **Labor market coordination;**
- **Beneficiary identification;**
- **Care workforce training;**
- **Transportation and mobility;**
- **Data collection; and**
- **Intersectoral coordination.**

However, territorial realities differ substantially within countries, and subnational contexts may vary according to:

- Fiscal capacity;
- Urbanization;
- Demographic composition;
- Existing care, health, and social protection infrastructure;
- Labor market structures;
- Prevalence of informality;
- Migration patterns;

- Digital connectivity; and
- The presence, capacity, and political strength of feminist movements, disability organizations, care worker groups, unions, community care networks, Indigenous and Afro-descendant authorities, and other local civil society actors.

As a result, national care systems often confront tensions among:

- Standardization and flexibility;
- Universal rights and territorial or population prioritization;
- Centralized coordination and local autonomy; and
- Technical design and political feasibility.

These tensions shape whether care systems become integrated and sustainable public infrastructures or fragmented pilot initiatives vulnerable to political change. From a feminist perspective, the tensions are not neutral, and decisions about which services are centralized, where institutional care is housed, which territories receive investments first, and other issues directly shape which women gain access to care support, how that support is framed in public discourse, and who is expected to provide care. A care system that is well designed on paper but reaches only the capital city or women in formal employment, or does not engage other actors to redistribute care, is not a transformative gender policy.

04

CORE LESSONS ON
INTEGRATING NATIONAL
FRAMEWORKS
AND SUBNATIONAL
IMPLEMENTATION

The cases reviewed in this paper point to several lessons about what enables or undermines the integration of national care policy with subnational and intersectional realities. The case studies for Uruguay, Chile, Colombia, Brazil, Mexico, Costa Rica, and Argentina are presented in Annex A; however, this section presents the lessons directly, together with key evidence from the case studies.

Care systems are inherently territorial, but territorial implementation requires enabling conditions.

Even where systems are nationally legislated or coordinated, implementation depends on municipalities, provinces, departments, local health and social protection systems, community organizations, and territorial political leadership. Existing welfare architectures, labor systems, and local political coalitions shape which forms of integration, financing, and coordination are feasible. At the same time, territorial implementation cannot be interpreted as a reason to shift responsibility downward. National governments remain essential for setting rights frameworks, financing commitments, data infrastructure, labor standards, and mechanisms for intergovernmental coordination.

The gap between national ambition and territorial reality can be an important barrier to care policy implementation. Some territories have strong public institutions, existing care infrastructure, organized caregiver networks, and fiscal resources. Others lack transportation, digital connectivity, trained care workers, or basic social service infrastructure.

If care systems assume uniform territorial readiness, they risk reinforcing inequality and overburdening already fragile institutions, especially in rural, conflict-affected, Indigenous, Afro-descendant, and peripheral urban territories.

In Uruguay, for example, service access and institutional capacity vary across departments even under the nationally coordinated SNIC, with implementation notably stronger in Montevideo than in rural interior departments (Estrades & Amabile, 2024; see Annex A.1). In Costa Rica, only three institutions nationwide (CONAPAM¹, CONAPDIS,² and the municipality of Heredia) had begun applying SINCA's standardized dependency assessment tool by the end of 2024, 3 years after the system's creation, illustrating how territorial rollout can lag national design even years after a system is legislated (Barquero Araya, 2025; see Annex A.6).

Coordination mechanisms are necessary across the national and subnational levels.

Care systems designed mainly at the national level cannot treat subnational implementation as an afterthought because that risks reproducing territorial inequality rather than reducing it. Actively planning for subnational implementation also brings resilience to national care systems by strengthening local governance and coordination mechanisms that can survive transitions at the national level. Similarly, care systems that originated at subnational levels and were used as models to expand into national care systems also require strategic planning around coordination mechanisms between subnational actors.

1 CONAPAM is the Spanish abbreviation for the Consejo Nacional de la Persona Adulta Mayor, or National Council for Older Persons.

2 CONAPDIS is the Spanish abbreviation for Consejo Nacional de Personas con Discapacidad, or National Council for Persons with Disabilities.

Mexico's pandemic response found that the absence of federal coordination mechanisms produced what one study calls “uncoordinated federalism,” with states filling gaps independently but with fragmented and inconsistent results, a pattern that is a real risk for care system implementation given how heavily Mexico's National Care Policy depends on state and municipal capacity (Cejudo, 2023; see Annex A.5)

Regardless of whether a bottom-up or top-down design has been used, effective implementation requires governance capacity to integrate services, connect caregivers and care recipients to the appropriate programs, and coordinate action across sectors and levels of government. Countries with stronger intergovernmental coordination mechanisms appear better positioned to maintain policy coherence, reduce fragmentation, and adapt implementation to diverse territorial realities.

Legal anchoring and public buy-in are preconditions for survival.

Uruguay's SNIC, established through national legislation in 2015, survived the 2020 change in government, although its gender-transformative ambition was weakened. Argentina's more ambitious executive-led care initiatives, including a dedicated ministry and interministerial coordination, were dismantled rapidly after the 2023 political transition because the comprehensive care system bill never became law. Legal anchoring does not guarantee effectiveness, but its absence can allow a system to disappear entirely. In Argentina, within months of taking office in December 2023, the Milei administration downgraded and then, by June 2024, shuttered the Ministry of Women, Genders, and Diversity entirely, dismissing roughly 500 of its 600 staff and cutting the national gender-based violence prevention budget by 89% between 2023

and 2024 (Jaureguy, 2024; Human Rights Watch, 2025; see Annex A.7).

Public buy-in also matters. Uruguay's SNIC emerged through sustained coalition-building among feminist movements, academia, unions, civil society organizations, international organizations, and state actors. Chilean caregiver research suggests that successful care systems must align with family realities and build trust in public services (Retamal-Retamal & Orellana, 2023). Feminist movements, disability organizations, caregiver advocates, unions, social workers, and local governments are essential to sustaining care as a public priority.

Financing gaps between national commitments and territorial needs undermine implementation.

None of the countries studied have fully resolved the financing architecture of their care systems. For example, Uruguay faces ongoing questions about fiscal sustainability. Mexico's National Care Policy was required to operate with existing resources, while direct care program spending declined despite the creation of a care budget annex. Brazil's plan relies heavily on pre-existing programs and implementation by fiscally unequal municipalities and states. Brazil's 2025–2027 budget of BRL 24.9 billion for its National Care Plan is heavily concentrated in a single pillar covering rights and support for those requiring care and unpaid caregivers; the remaining four pillars, including decent work for paid caregivers, together receive under 2% of total funds (Governo Federal do Brasil, 2025; see Annex A.4).

Recent regional financing discussions suggest growing recognition that care systems require dedicated and sustainable investment.

For example, the Sevilla Platform for Action included an accelerator for investments in comprehensive care policies and systems in Latin America and the Caribbean, promoted by Chile, Mexico, the Economic Commission for Latin America and the Caribbean (ECLAC), the Development Bank for Latin America and the Caribbean, and other partners, to help mobilize resources for care-system implementation. Chile also illustrates a more concrete financing partnership: Its 2025 World Bank Program-for-Results operation supports intersectoral social protection reforms, including implementation of Chile Cuida, care-service coverage targets, and municipal coordination tools. However, these examples remain emerging financing pathways rather than evidence that the region has resolved the structural financing gap (ECLAC, 2025c; UN, 2025).

Subnational implementation creates additional financing challenges around intergovernmental transfers, fiscal equalization, and uneven territorial resources. The territories with the greatest care needs often have the weakest fiscal bases. The financing challenge is not only the total amount of money available for care systems but also how resources are distributed across territories with unequal needs, infrastructure, and fiscal capacity. Brazil and Mexico illustrate this clearly because implementation depends heavily on states and municipalities with very different capacities, while Colombia and Costa Rica show how rural, ethnic, migrant, and lower-capacity territories may require additional support to make national care commitments meaningful in practice. Without explicit equalization mechanisms and recurrent funding for local implementation, national commitments to universal access are undermined precisely where they matter most.

Longstanding patterns of marginalization shape whom national and subnational implementation reaches.

National care systems are implemented in territories already shaped by longstanding inequalities related to race, ethnicity, disability, migration status, rurality, informality, income, and access to public infrastructure. These dynamics affect not only who needs care and who provides it but also which territories are prioritized, which services are available, how beneficiaries are identified, and whether communities trust or can access formal institutions.

Every country reviewed here documents significant gaps between formal care system design and the realities of unpaid, underpaid, and informally employed caregivers. In Mexico, 56% of women in informal employment have no practical access to the formal childcare system now being scaled through Education and Child Care Centers (Centros de Educación y Cuidado Infantil—CECI) (Ruiz & Pereznieto, 2022). In Costa Rica, Indigenous communities face compounded care burdens and labor exclusion, while the evidence suggests that SINCA does not consistently reach them with culturally appropriate approaches. In Colombia, reaching conflict-impacted and Indigenous and Afro-descendant territories remains an open, persistent challenge, despite testing alternative methods like care boats and buses. Uruguay's SNIC has prioritized care workforce professionalization through training and certification, but territorial disparities in workforce availability and the persistent feminization of care labor continue to limit its reach outside higher-capacity departments.

Workforce conditions are, therefore, central to the equity challenge. Care systems depend on qualified and stable care workers, yet workforce availability, access to training, wages, benefits, labor protections, and retention vary significantly across territories. In rural areas, marginalized communities, and informal labor markets, care provision often depends on unpaid, underpaid, migrant, community-based, or informally employed women workers. Without explicit workforce strategies, care systems may expand services while reproducing the same gendered, racialized, and classed inequalities they aim to address.

Additionally, not all caregivers and care recipients have the same access to services and resources provided through existing care systems. People caring for small children or for people with disabilities requiring intensive support may not be able to access care centers like the Bogotá Care Blocks despite the principle of simultaneity of services (Bustamante & Urrego, 2023). These barriers reflect structural features of how care systems tend to be designed: around formal employment, predetermined service hours, urban service infrastructure, and standardized national eligibility criteria.

Addressing these limitations requires deliberate design choices made from the outset, including territorial diagnostics before implementation, differentiated eligibility frameworks, and intercultural approaches to service design, territorial workforce assessments, localized training strategies, labor protections, and workforce retention policies. These are not afterthoughts because they shape whether national care commitments become meaningful for the caregivers, care workers, and care recipients who are most likely to be excluded from formal systems.

Integrated care systems require integrated information systems.

Many countries have improved their time-use data and recognition of unpaid care work, but territorial care information systems remain limited. Data systems are often fragmented across sectors and levels of government, and these systems may not support intersectional analysis of care needs, workforce conditions, service access, and system interoperability.

Chile's National Time Use Survey (Encuesta Nacional sobre Uso del Tiempo—ENUT) and Argentina's Federal Care Map show the value of data for visibility and planning, while Chile's Local Support and Care Network (RLAC in the Spanish acronym) evaluation shows that improved policy ambition can be undermined by weak digital reporting systems. Effective systems require interoperable data, shared indicators, territorial mapping, and investment in local data capacities. Costa Rica's CUIDAR.CR digital registry shows how early-stage this work often is in practice: As of December 2024, it had registered only 143 formal caregivers and 518 dependent persons nationally, a small fraction of the roughly 160,000 adults with functional dependency and 170,000 caregivers the system aims to reach (Barquero Araya, 2025; see Annex A.6).

Broad, federated coalitions are the most durable foundation for care systems.

Care systems are more resilient when they are owned by broad coalitions of feminist movements, disability organizations, unions, academic networks, Indigenous communities, local governments, caregiver organizations, and care workers rather than when these systems depend on a single administration or ministry.

In Argentina, although the state-based care infrastructure built between 2019 and 2023 was rapidly dismantled after the 2023 leadership transition, the National Women’s Meeting³ (a federal, province-spanning gathering held annually since 1986) has continued to provide a durable foundation on which future care-system recovery could be built (Grados, 2025; see Annex A.7).

These coalitions strengthen political legitimacy, territorial ownership, continuity, and implementation capacity. Subnational levels are often where these relationships are strongest, even when participation mechanisms are underinstitutionalized.

Participation should not be limited to consultation during policy design or public audits; it should extend into implementation monitoring, budgeting, evaluation, and adaptation planning. The question is not only whether a national government is committed to care but also whether coalitions of actors have the capacity and legitimacy to sustain care as a public priority through political change.

3 The gathering was historically called the “Encuentro Nacional de Mujeres” (“National Women’s Meeting”) but has since been renamed as the “Encuentro Plurinacional de Mujeres, Lesbianas, Travestis, Trans, Bisexuales, Intersexuales y No Binaries” (“Plurinational Meeting of Women, Lesbians, Transvestites, Trans People, Bisexuals, Intersex People, and Nonbinary People”).

05

RECOMMENDATIONS
FOR SUBNATIONAL
GOVERNMENTS AND
ADVOCATES

This section outlines recommendations specifically for municipal, departmental, and provincial governments in Latin America, as well as for the advocates, feminist organizations, and civil society actors who work alongside them. National governments remain essential actors in care policy, but subnational governments and movements are not merely implementers of national decisions. As this paper has shown, they have repeatedly been the source of policy innovation, the last line of defense against national rollback, and the actors closest to the women whose lives care policy is meant to improve.

1. **Recommendation 1: Use territorial data to make the local care burden visible and politically actionable.**

Argentina's Federal Care Map demonstrated that territorial data on care supply and demand can be a powerful planning and advocacy tool. Subnational governments that lack access to a national data infrastructure, or whose national infrastructure has been dismantled, can develop their own. These could include municipal or provincial time-use studies, participatory mapping of existing care services and gaps, and documentation of care burdens in specific communities—especially among Indigenous, Afro-descendant, rural, and informally employed women, who are often invisible in national statistics. Making the local care crisis visible in the language of municipal budgeting and development planning is often the necessary first step toward building political will for local investment in care.

2. **Recommendation 2: Leverage local systems to expand access to care services even where national efforts are lagging.**

Bogotá built one of the most internationally recognized care models in the region as a municipal initiative, years before Colombia had a national framework. Chile's municipal networks shaped national legislation that came afterward. Subnational governments should assess how their existing legal competencies, budgets, and service-delivery responsibilities can be used to expand care-related support, while documenting the financing, regulatory, and coordination gaps that require national action.

3. **Recommendation 3: Intentionally include diverse women's organizations, local caregivers, and people who require care in the design and implementation of care systems.**

This paper shows that standardized national eligibility criteria that are built around formal employment or urban service models, tend to exclude informally employed, rural, Indigenous, and Afro-descendant women specifically. Subnational governments have local knowledge that national systems often lack. Before adopting or implementing a national program, local governments should ask explicitly which women in their territory are least likely to be reached by its default design, and should adapt outreach, eligibility processes, and service locations accordingly rather than treating equity gaps as a problem for the national government to solve later.

4. **Recommendation 4: Diagnose where administrative processes exclude eligible caregivers, using data and direct consultation, and redesign eligibility procedures to close that gap and increase uptake.**

Research in Chile found that 41% of caregivers who failed to access services did so because of eligibility criteria they could not meet, often due to complicated administrative processes rather than genuine ineligibility (Retamal-Retamal & Orellana, 2023). Subnational governments should treat simplifying access, in plain language and in locally relevant languages where applicable, as a core part of program design, not an afterthought, and should assume that low uptake of a service may reflect access barriers rather than lack of need.

5. **Recommendation 5: Treat care workers' conditions as part of the system.**

Colombian research found that even an internationally celebrated model like Bogotá's Care Blocks reproduced precarious, informal labor conditions for some of the care workers it employed (Montoya-Robledo & Fernández-Gallego, 2026). A related issue arises in Mexico City's Transformation and Organization for Inclusion and Social Harmony Units (*Unidades de Transformación y Organización para la Inclusión y la Armonía Social* (Utopías)), where more than 1,600 operational participants are described as beneficiary service facilitators who receive economic support while carrying out activities related to care, education, inclusion, social well-being, and maintenance of public spaces, without a formal public employee relationship providing labor protections (Colin et al., 2024; El Universal, 2026).

The ILO (2024b) identifies the formalization of care jobs, adequate wages, reasonable working-time limits, occupational safety and health, social security, labor inspection, and freedom of association and representation as central elements of decent care work. It also states that public-sector care providers should lead by example. This guidance has been reinforced by Advisory Opinion OC-31/25 of the Inter-American Court of Human Rights (2025), which concluded that regardless of the sector in which they work, paid care workers have the same labor rights as other workers and that states should adopt special measures to guarantee just, equitable, and satisfactory working conditions because of care work's historical invisibility and undervaluation. The court specifically identified fair remuneration, employment stability, occupational safety, limits on working time, rest, social security, inspection, and access to remedies among the relevant protections. The 2025 Tlatelolco Commitment further calls on countries in the region to implement the ILO's 5R Framework, promote the professionalization of the care sector, and include trade unions, domestic workers' organizations, caregiver organizations, and care cooperatives in the design, implementation, and monitoring of care policies (ECLAC, 2025b).

Subnational governments expanding care services should set explicit labor standards, including wages, contracts, occupational safety protections, and social security coverage, for care workers from the outset rather than treating job creation in the care sector as automatically beneficial regardless of working conditions.

Categories such as “facilitator,” “beneficiary,” or “volunteer” should not be used to obscure relationships that, in practice, have the characteristics of regular paid employment or to transfer the costs and risks of service provision onto already marginalized people, often women and girls.

6. **Recommendation 6: Join intra-national, regional, and international learning exchanges.**

Subnational governments and regional municipal associations should invest in direct exchange with peer cities and provinces facing similar challenges, both within Latin America and beyond. International organizations, including ECLAC, the ILO, the Inter-American Development Bank, and UN Women, could facilitate this exchange. At the same time, models developed in very different welfare-state and political contexts, including outside Latin America, should be treated as a source of design ideas to be tested and adapted, not as templates to be adopted directly.

7. **Recommendation 7: Push for, and help design, fiscal equalization mechanisms.**

Subnational governments with the greatest care needs typically have the weakest fiscal capacity to address them. Local governments and regional associations should advocate not only for more care financing in general but also explicitly for fiscal equalization provisions within any national care financing framework because formula-based national funding without equity adjustments may reproduce existing territorial inequality rather than close it.

Territorial diagnostics, time-use data, care-needs mapping, and service-gap analyses can help local governments document why equal funding is not always equitable funding. These tools can also strengthen the case for national co-investment, fiscal equalization transfers, and dedicated support for territories where care needs are high and implementation capacity is weak.

8. **Recommendation 8: Build care into the local budget.**

Local governments should identify and tag care-related spending that is already happening but not currently counted as such because it is scattered across health, social assistance, public works, and transportation budgets. Chile’s pre-2026 experience shows that care services depend as much on transportation, digital access, and accessible infrastructure as on dedicated care programs, and this spending often exists already without being visible as care investment.

Local governments should also resist describing the relabeling or consolidation of existing budget lines as “new investment” even where this is politically convenient. This is precisely the pattern that Maske (2025) and others warn risks producing recognition without material change; a municipal care budget should be auditable and should distinguish clearly between new resources and reorganized existing ones.

Additionally, multiyear budget commitments, even modest ones, provide more genuine protection for care programs than larger single-year allocations, given how consistently this paper has shown that care infrastructure is vulnerable at the moment of political transition; a three-year capital plan for a single care center is more durable than an annual discretionary line that a new administration can simply not renew.

Local governments should track and publish what share of the local budget reaches relevant marginalized groups (e.g., informally employed, elderly, Indigenous, and Afro-descendant populations) specifically since national and local budgets alike tend to default toward urban, formally employed populations unless equity in reach is deliberately measured and reported, not only equity in total spending.

CONCLUSION

National care systems reflect a growing recognition that care is essential social infrastructure, central to gender equality, and foundational to economic and social well-being. Yet the long-term success of these systems depends not only on national legislation or policy ambition but also on these systems' ability to adapt across unequal territories, reach the caregivers (especially marginalized women) that standardized national design tends to miss, and survive institutional and political change. Care is ultimately provided, and care policy is ultimately experienced, in communities, municipalities, and households, not in national ministries.

The seven cases reviewed here show both real advances and recurring vulnerabilities. Argentina's experience since 2023 provides the starkest recent demonstration of what happens when care systems are built without durable legal anchoring or broad social coalitions; however, Colombia's system is also currently in a political and legislative limbo that will test the new system's survival. Uruguay's SNIC demonstrates the value of the opposite approach, while still showing that legal survival does not guarantee sustained feminist ambition. Across every case, the women most likely to be excluded from formal care systems (e.g., Indigenous, Afro-descendant, rural, and informally employed women) are also the women carrying the heaviest care burdens.

Future work on care policy in the region must treat care as a multilevel governance challenge requiring territorial adaptation, dedicated financing, institutional coordination, political resilience, and a clear, ongoing commitment to reaching the women that national design so often overlooks. This requires not only technical policy design but also sustained investment in the relationships, institutions, and coalitions capable of defending the right to care as a durable public commitment—including, and especially, at the subnational level. An important risk is creating expectations on localities to implement care systems without the consistent, dedicated resources to support them. However, when subnational contexts have the right investments, there are useful lessons learned for national policies and cross-subnational exchanges.

The evidence reviewed suggests that successful territorial implementation is a necessary, though not sufficient, condition for improving outcomes for caregivers and care recipients. However, comparable evidence regarding the long-term social, economic, and well-being impacts of Latin American care systems remains limited.

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ANNEX A:

COUNTRY CASE STUDIES

The reviewed countries demonstrate important advances in positioning care as a public policy issue linked to gender equality, labor markets, aging, disability, and economic development. At the same time, the cases reveal substantial variation in institutional design, territorial implementation, governance structures, financing arrangements, and levels of policy consolidation. A recurring finding across all cases is that care systems are ultimately implemented territorially, even if designed nationally.

A.1 Uruguay

Uruguay is widely considered the first country in Latin America to establish a comprehensive national care system. Created through Law N.º 19.353 in 2015, the National Integrated Care System (Sistema Nacional Integrado de Cuidados—SNIC) was designed as an interinstitutional system integrating services, regulation, workforce development, information management, and coordination across sectors.

The SNIC emerged from “an extensive social and political debate involving various societal actors including academics, civil society organizations and government officials” (Goyeneche et al., 2025, p.9). Sustained coalition-building, including with international institutions like the Economic Commission for Latin America and the Caribbean (ECLAC), the International Labour Organization (ILO), and UN Women, was vital to reframing care from a private household issue into a matter of public policy. The international organizations functioned as active members of this coalition instead of as neutral outside actors, and a national care forum in 2023 continued to bring together civil society, academia, and international cooperation partners around the SNIC’s development.

This system explicitly recognizes caregivers and care recipients as having the right to care and seeks to reduce fragmentation in the provision of care for children, persons with disabilities, and older adults in situations of dependency (Sternkopf, 2024; Mahon, 2024). The SNIC includes early childcare services, personal assistants for persons with severe dependency, telecare services, caregiver training initiatives, and support services for the older adults. It has also sought to professionalize care work through training programs, certification mechanisms, and labor regulation efforts to improve labor conditions within historically feminized and precarious sectors (Goyeneche et al., 2025; Matus-Lopez & Pedraza, 2016).

However, national time-use surveys continue to show persistent gender inequalities in unpaid care work. Uruguay's 2021 time-use survey found that families (and particularly women within the families) continue to be the primary providers of care despite the SNIC's existence and its explicitly transformative objective to address the gendered division of labor and redistribute care responsibilities among the state, families, communities, markets, men, and women. Similarly, Goyeneche et al. (2025) emphasize that the SNIC has only partially achieved the shift from family-based care toward a more collective organization of care, sometimes described in social-policy literature as “defamilialization.” In practice, this means reducing the automatic reliance on unpaid family care, particularly women's care work, by expanding public services, community supports, decent paid care work, and shared responsibility.

Following Uruguay's 2020 political transition, the SNIC remained legally and institutionally intact, but Mahon (2024) documents that during the Lacalle Pou government (2020–2025), the consultative committee established within the SNIC to provide ongoing civil society oversight was sidelined, and the system's original gender-transformative framing lost some political visibility.

Subnational Adaptation Findings

Although Uruguay's system is nationally coordinated, service access and institutional capacities vary across contexts, with stronger implementation in Montevideo and other higher-capacity departments. Uruguayan National Director for Territorial Planning Paola Florio noted in 2026, “Real transformations happen on the ground, and it is the local authorities, who are part of the national system, that in many cases develop and implement public policies directly affecting people's lives” (Pavlenko, 2026). Legal institutionalization through national legislation appears to have provided greater resilience than initiatives that depend on executive priorities, but it has not eliminated territorial inequalities. Estrades and Amábile (2024) note that despite a decade of SNIC, public coverage for adults over 65 years old and individuals with disabilities remains low (approximately 15%), while expanded coverage for children aged 0 to 3 has reached 57%, though the authors caution that much of this increase may reflect declining birth rates rather than expanded services. These figures may vary by department, with urban areas faring better than rural or semirural interior departments.

A.2 Chile

Chile has increasingly incorporated care into social protection and gender equality policy frameworks through initiatives such as Chile Cuida (Chile Cares) and debates shaped by evidence from Chile's national time-use survey (Encuesta Nacional sobre Uso del Tiempo—ENUT). What began as an executive-led policy initiative culminated in the February 2026 promulgation of Law N.º 21.805 (Ley Chile Cuida), which created the National Support and Care System (Sistema Nacional de Apoyos y Cuidados—SNAC) and established care as the fourth pillar of Chile's social protection system alongside health, education, and social security.

Research with unpaid caregivers in Chile's Santiago Metropolitan Region found strong support for recognizing care as a public responsibility: Approximately 75.9% of surveyed caregivers agreed that care should be recognized as a right, 75.6% viewed care as an essential social service, and 70.0% supported economic compensation for care work. At the same time, fewer than half of the surveyed caregivers agreed that care should be institutionalized through public social programs, reflecting both the cultural importance of family caregiving and concerns about the adequacy and accessibility of existing public services (Retamal-Retamal & Orellana, 2023). This ambivalence about the state's role in care provision highlights that legislative advancement does not automatically translate into social legitimacy or demand for formal services.

Law N.º 21.805 enshrines three dimensions of the right to care (the right to care, to be cared for, and to self-care) that apply to children and adolescents, older persons, persons with disabilities, persons with dependency, and care workers (both paid and unpaid), making care workers rights-holders within the system. From a feminist perspective, the explicit inclusion of unpaid caregivers as rights-holders represents an important normative advance, and Chile's conceptual framework explicitly cites Razavi's (2007) care diamond (Gobierno de Chile, 2024).

The law is coordinated jointly by the Ministry of Social Development and Family and the Ministry of Women and Gender Equity. The care budget grew from CLP 73 billion for 2023 to a projected CLP 151.5 billion for 2026 (El Mostrador Braga, 2026; Ossandón, 2026). Additionally, there is an explicit subnational implementation architecture with regional governance structures (Mesas Regionales de Cuidados, or Regional Care Boards).

Subnational Adaptation Findings

Chile's case is important because the 2026 legislation arrived after years of territorial implementation experience, making it a case where subnational learning preceded and shaped national legislation rather than being designed downward from it (ECLAC, 2025a). The RLAC coordinated local support services for households with members in situations of dependency, particularly older persons and persons with disabilities, through municipal networks and intersectoral referral systems.

A 2020 evaluation conducted by Chile's Budget Directory with the Ministry of Social Development and Family identified design and implementation issues in the RLAC's predecessor program: The unpaid principal caregiver was not sufficiently recognized as a target of intervention; municipalities struggled with delays, staff turnover, and meeting coverage commitments; accountability mechanisms were weak; and information systems could not generate key performance indicators because the data often remained in physical case files (Dirección de Presupuestos de Chile & Ministerio de Desarrollo Social y Familia, 2020). These findings show that financing growth and territorial reach do not necessarily move at the same pace.

Before the new law, Retamal-Retamal and Orellana (2023) identified failure to meet eligibility criteria for social programs as one of the most common concrete barriers to service access, reported by 41% of surveyed caregivers. Additional barriers included lack of information regarding available services, fragmented programmatic offerings, and unequal territorial availability of support infrastructure. They emphasize that territorial investments beyond social programming are needed for effective care policy implementation, including transportation, digital access, healthcare infrastructure, and geographically accessible services with trained personnel (Retamal-Retamal & Orellana, 2023).

The 2026 law created an explicit subnational governance architecture that addresses some of these gaps through the Mesas Regionales de Cuidados (Regional Care Boards) and gradual municipal planning (El Mostrador Braga, 2026). Implementing regulations were required to be issued within six months of the law's publication, meaning territorial implementation was still in an early stage at the time of writing (Ministerio de Desarrollo Social y Familia, 2026).

Also, World Bank engagement in Chile has focused on financing as well as on delivery systems, municipal intervention models, and integration with the broader social protection architecture. A World Bank (2025) Program-for-Results document identifies that the program will include several actions to consolidate and expand the SNAC, including designing a SNAC management system, expanding care support for people with disabilities, consolidating a budget to "put all care support programs under a single budget line," establishing new indicators to identify households with dependents and caregivers, and establishing new monitoring mechanisms to identify "the number of women who provide care receiving respite care services, and the number of people with dependency accessing care services outside of their family care (including by disability and/or age)." The program "will also certify competencies and skills to many female caregivers and care sector workers based on the identification of competency needs, improving not only the quality of care, but their labor force prospects" (World Bank, 2025).

The Chile case suggests that development-bank partnerships can help strengthen the technical architecture of national-to-local implementation, but they cannot substitute for domestic political ownership, recurrent financing, and territorial governance capacity.

A.3 Colombia

Colombia has emerged as an important recent example of care system development in Latin America, building on local innovations while developing the National Care System (Sistema Nacional de Cuidado—SNC). Bogotá’s Sistema Distrital de Cuidado (District Care System), launched in 2020, implements a spatial strategy concentrating public services for leisure and culture, education, psychosocial support, and employment within a targeted 20-minute walkable radius in urban neighborhoods. This strategy is called *Manzanas del Cuidado* (referred to as “Care Blocks” in English). By the end of 2025, 26 Care Blocks were operating across the city, in addition to two mobile care buses providing transitory services in rural communities, and the government had set a target of establishing 31 Care Blocks by 2028 (Secretaría Distrital de la Mujer, 2026; El Tiempo, 2025).

The Care Blocks model establishment and expansion depended on feminist economists and advocates who held positions inside city government (Alvarez Rivadulla et al., 2024). This is an important and fragile dynamic: Individual feminist actors occupying key institutional roles can produce real policy innovation, but such innovation is vulnerable when those individuals leave office or when political administrations change. While recognizing the Care Blocks as innovative, Montoya-Robledo and Fernández-Gallego (2026) find that the model simultaneously reproduces the feminization, precarization, and commodification of care work since care workers employed within the Care Blocks often lack labor protections and are paid informally. This finding is an important caution around reproducing precarious conditions for the paid caregivers that systems hire to support unpaid caregivers.

At the departmental level, Antioquia’s Secretariat for Women led one of the earliest subnational care diagnostics in the country, developing a Departmental Care Plan between 2020 and 2023 whose qualitative methodology later informed the national territorial diagnostic tools used across the Red Territorial del Cuidado (Territorial Care Network).

At the national level, Colombia institutionalized recognition of unpaid care work through Law 1413 of 2010, which mandated the inclusion of the care economy in national accounts (Satellite Account on the Economy of Care). With Oxfam, Colombia also developed a tool to simulate individuals' contribution to their households and the country through their unpaid domestic and care work.⁴

Additionally, Colombia undertook an extensive public consultation process that actively included Indigenous and Afro-Colombian communities. This process identified three priority lines, each with different action items: 1) institutional response to guarantee the rights of caregivers; 2) strengthening of community care organizations and their own organizational processes for care; and 3) cultural change toward a caring society.

Colombia's approach is also distinguished by how centrally it places *cuidado comunitario* (community care), understood as care developed by territorially rooted, popular, and self-managed organizations that operate through solidarity-based cooperation. This includes practices such as community soup kitchens and dining halls, collective work groups in rural areas, women's organizations that care for neighbors' children so others can work, traditional midwifery, and Indigenous and Afro-descendant ancestral care practices (Ministerio de Igualdad y Equidad, 2025b, 2026).

Colombia made recognizing and strengthening community and collective care organizations the first specific objective of CONPES 4143,⁵ ahead even of recognizing individual caregivers' rights, a choice the Ministry of Equality and Equity describes as a deliberate political decision to treat care as not only an individual or family practice but also a collective and territorial one. In practice, this has translated into concrete instruments: The *alianzas público-populares* (public-popular partnerships), regulated by Decree 874 of 2024, created a new legal mechanism for formalizing relationships between the state and community, an explicit alternative to conventional public-private partnership models. Additionally, the ministry's *Comunidades del Cuidado* (Care Communities) strategy reported strengthening 239 community care organizations across 24 departments and 84 municipalities between 2024 and 2026 (Ministerio de Igualdad y Equidad, 2025b, 2026).

Colombia's leadership during the 2026 Community of Latin American and Caribbean States (CELAC)–Africa High-Level Forum in Bogotá, held under the theme “Connected by Care,” also highlighted the growing role of South–South cooperation in care policy.

4 The simulator is available at <https://sitios.dane.gov.co/SimuladorTDCNR/>.

5 CONPES (Consejo Nacional de Política Económica y Social, or National Council for Economic and Social Policy in English) is Colombia's principal national policy instrument, used to establish government priorities and coordinate public action across sectors. CONPES 4143 (2025) establishes the National Care Policy, providing the framework for the National Care System and recognizing care as a right for both caregivers and those requiring care.

The forum created opportunities for dialogue among governments, civil society organizations, and experts from Latin America, the Caribbean, and Africa on shared challenges related to care, social inclusion, and territorial inequalities. While the discussions extended beyond care systems, the forum emphasized the potential of horizontal policy exchange and reinforced the value of South–South learning as an emerging source of innovation in care policy and practice.

However, the SNC is facing political and administrative risks: Following the Constitutional Court’s decision that the creation of the Ministry of Equality and Equity did not follow appropriate protocols and is therefore ‘unenforceable’, the government issued a package of decrees in June 2026 initiating the ministry’s liquidation, redistributing functions, and establishing a revised governance framework for the National Care System. Although the SNC has not formally disappeared, the administrative transition creates uncertainty on institutional capacity, staffing, financing, and continuity of territorial implementation. Certain feminist actors holding key state positions played an important role in advancing the SNC. This created opportunities for rapid innovation but also raised continuity risks where institutional processes remained closely associated with particular officials or administrations (Alvarez Rivadulla et al., 2024).

Subnational Adaptation Findings

Colombia demonstrates several important dynamics. First, territorial innovation can precede national scaling, and Colombia’s approach emerged significantly from municipal experimentation, feminist advocacy, and territorial policy innovation. Bogotá’s Care Blocks functioned as neighborhood hubs offering integrated services and became politically visible because they offered a concrete, easily communicated model of what care infrastructure could look like while using mostly pre-existing services. Although evidence of their benefits is limited and/or mostly anecdotal, their popularity led to replicating the model across diverse Colombian territories and visits from local government representatives internationally. However, the Ministry of Equality and Equity recognized that replicating this model in diverse territories, including conflict-affected areas and Indigenous and Afro-descendant communities, would promote a one-size-fits-all approach that disregarded territorial specificities.

As such, an extensive consultation process was used, and the Ministry created a composite index where municipalities could be organized into quintiles based on:

- An index of pressures on the social fabric, calculated based on the number of victims of the armed conflict based on the national registry and socio-environmental conflicts identified by civil society;
- A Care Needs Pressure Index based on the portion of the population requiring care (children and adolescents under 14, people with disabilities, people requiring palliative care, and people over 80 years old);

- The rate of women without independent, formal income, considering women over 14 years old who are enrolled as beneficiaries in the contributory health insurance system or enrolled in the subsidized health plan;
- A National Planning Department Governance Index measuring the institutional and organizational capacity of cities; and
- The presence of ethnic territories (Ministerio de Igualdad y Equidad, 2025a).

By mid-2025, the Red Territorial del Cuidado (the technical assistance strategy of the Ministry of Equality and Equity) had supported 77 territorial entities across Colombia in designing or implementing their own territorial care systems, spanning all 32 departments, 26 capital cities, and six priority municipalities. Cali, Villavicencio, Manizales, Popayán, Cúcuta, Cumbal, and Valle del Cauca illustrate the diversity of approaches, from full district-level systems to narrower intersectoral commissions created by decree. This variation reflects differences in fiscal capacity, institutional experience, local care needs, and political will.

Colombia highlights the importance of territorial diversity, which creates substantial implementation complexity where implementation conditions differ significantly. This example shows that local initiatives and priorities can guide the development of national care frameworks, but also that national investment, coordination, and legal bases are fundamental, even in highly unequal subnational contexts. Political continuity remains a central challenge, and the Colombian example illustrates the vulnerability that care systems have at the national and subnational levels to administrative restructuring, elections and political transitions, and changing governmental priorities.

A.4 Brazil

Brazil has historically addressed care through fragmented sectoral policies connected to social assistance, public health, early childhood development, disability policy, labor protections, and poverty reduction programs rather than through a unified national care system. In December 2024, Brazil enacted Law N.º 15,069, establishing the National Care Policy (Política Nacional de Cuidados—PNaC), developed by an Interministerial Working Group on Care that included more than 20 federal ministries, international organizations (e.g., ECLAC, UN Women, ILO, and the United Nations Children’s Fund). PNaC is coordinated jointly through the Ministry of Development and Social Assistance, Family, and Fight Against Hunger and the Ministry of Women.

Guimarães (2024) identifies three overlapping crises that produced the conditions for Brazil’s care policy: an economic crisis beginning in 2014, a political crisis culminating in the 2016 presidential impeachment and a subsequent rollback of social welfare policy from 2017 onward, and the COVID-19 public health crisis beginning in 2020. Guimarães and Pinheiro (2023) describe care work in Brazil through three “types”: *profissão* (profession, meaning paid and at least somewhat formalized work), *obrigação* (obligation, meaning unpaid family care understood as a moral duty), and *ajuda* (solidarity or help, meaning unpaid community-based care typically performed by women in conditions of extreme poverty, disproportionately Black women). This typology captures the social complexity of care in Brazil and the ways care is shaped by gender, race, class, and informality.

Care inequalities in Brazil are deeply racialized. The reliance on Black women’s unpaid and underpaid care labor is rooted in Brazil’s history of enslavement and the continued concentration of Black women in domestic and care work after abolition. Women account for 75% of Brazil’s care sector workforce, Black women represent 45% of that workforce, and domestic workers make up roughly one quarter of all care workers (Latina Republic, 2026). Brazil also has the largest single domestic worker labor market documented in this review, with 7 million of the 52 million domestic workers counted globally by the ILO in 2018 working in Brazil (Maske, 2025).

The PNaC defines care broadly as the daily work necessary to sustain life, the workforce, society, and the economy. It applies a principle of progressive universalism that prioritizes children and adolescents, older adults, people with disabilities, and paid and unpaid care workers before extending to the general public. Law N.º 15,069 also includes antiracism as one of its core principles.

In July 2025, the federal government issued Decree 12,562, formally regulating the National Care Plan (known as *Brasil que Cuida*) around five pillars: rights and policies for those requiring care and unpaid caregivers; balancing paid work, education, and family care; decent work for domestic workers and paid caregivers; recognition and cultural transformation around care; and governance of the plan.

However, the 2025–2027 budget of BRL 24.9 billion is heavily concentrated in the first pillar, while pillars 2 to 5 account for under 2% of the total (Governo Federal do Brasil, 2025). Much of the first pillar also draws on pre-existing programs rather than entirely new appropriations. This supports skepticism in literature like Maske (2025), which raises a necessary question: Will this law will be effectively implemented, or will it be “swallowed by the social abyss that has historically prevented universal social policies from materializing in Brazil”?⁶

Subnational Adaptation Findings

Brazil illustrates the complexity of adapting care policy in a highly decentralized and unequal federal system. States and municipalities already play central roles in administering social assistance, health systems, and education services through decentralized governance arrangements such as the Unified Health System (Sistema Único de Saúde—SUS) and the Unified Social Assistance System (Sistema Único de Assistência Social—SUAS). Implementation of the PNaC will depend heavily on municipal administrative capacity, state-level coordination, territorial financing arrangements, and integration across existing systems.

Territorial disparities are especially significant in rural regions, Amazonian territories, peripheral urban communities, and historically marginalized Afro-Brazilian and Indigenous populations. Research has also identified gaps affecting Indigenous persons with disabilities, who may fall in the gaps between Indigenous health policy and disability health policy, illustrating how national care systems can reproduce exclusion if territorial, ethnic, disability, and accessibility dimensions are not explicitly integrated (Garcia, 2025; Santos, 2025).

Civil society and third-sector organizations will likely play an important role in PNaC implementation, and the plan acknowledges a role for civil society as partners, including through training strategies for public servants and service providers under pillar 5. However, the institutional weight of that role—for example, whether civil society holds formal voting or oversight authority within the plan’s governance bodies—is not fully clear at this point. Brazil therefore shows that decentralized governance structures alone do not guarantee integrated care systems; effective implementation requires intergovernmental coordination, sustainable financing, shared policy frameworks, and territorial implementation capacity.

6 Original text: “Não obstante, é de se questionar se estas políticas serão realmente efetivadas, ou se serão tragadas, novamente, no abismo social brasileiro que as impede de materializar o seu caráter universal, visto que as políticas sociais do cuidado são diversas vezes impossibilitadas de se concretizarem em razão de estruturas governamentais deficitárias e da desigualdade social estrutural que se expressa no país e na América Latina (Guimarães; Hirata, 2021). Ademais, para uma construção da sociedade de cuidados, como disposto na Política Nacional de Cuidados, é indispensável que ocorra uma também transformação ou efetiva reorganização da divisão sexual do trabalho na forma como ela se encontra instituída” (Maske, 2025, p. e-61534).

A.5 Mexico

According to the 2022 national care-system survey, 77.8% of Mexican households include someone who requires care; more than 75% of caregivers are women; and 86.9% of principal caregivers (those responsible for care even when others help) are women (Instituto Nacional de Estadística y Geografía, 2022).

Mexico's demographic transition also creates additional pressures: The proportion of adults aged 60 and older is projected to rise from 12.4% in 2024 to over 20% by 2040 (Consejo Nacional de Población, 2024). It's estimated that the working-age population will stop outnumbering dependents (the demographic dividend) by 2030. Unlike Uruguay, which built its care system before its demographic peak, Mexico continues to rely heavily on families (predominantly women) as the default providers of elder care in the absence of coordinated, regulated, or publicly funded alternatives (López-Ortega, 2024).

In 2020, Mexico's Chamber of Deputies approved a constitutional reform recognizing the right to dignified care; as of mid-2026, this reform remains pending in the Senate, though Mexico City moved ahead independently in May 2026, when its local congress unanimously approved a constitutional reform recognizing the right to care and creating a Sistema Público de Cuidados (Public Care System) at the city level (Centro de Investigación Económica y Presupuestaria, 2025; Arochi, 2026). In March 2024, a reform to the Ley General de Desarrollo Social (General Social Development Law) formally defined care work and established a National Care Policy but required it to operate using existing resources. The Center for Economic and Budgetary Research found that while the 2026 federal budget proposal created a cross-cutting care annex (Annex 31) totaling MXN 466.7 billion, programs with direct care objectives actually declined by 18.6% compared to 2025 (Centro de Investigación Económica y Presupuestaria, 2025).

The Sheinbaum administration (2024–2030 [projected]) has designated the National Care System as Commitment #55 of its government plan. The flagship initiative is the construction of 1,000 Education and Child Care Centers (Centros de Educación y Cuidado Infantil—CECI) by 2030, managed by the Mexican Social Security Institute (Instituto Mexicano del Seguro Social—IMSS). The CECI model shifts from the previous privatized system (where 90% of childcare was contracted to private providers) to direct public provision, with IMSS constructing and operating its own facilities.

Mexico's federal structure has been shaped by feminist movements, civil society organizations, academic networks, INMUJERES (Instituto Nacional de las Mujeres, or National Institute of Women), El Colegio de México, and feminist economist networks aligned with ECLAC (Mahon, 2024). However, Mahon also documents how the previous López Obrador administration canceled the childcare center program for poor working women's children, replacing it with cash transfers worth less than the cost of the care those centers provided, and made significant cuts to INMUJERES's operating budget. The justification for canceling the program was an effort to decrease corruption associated with service providers.

However, the change in strategy exacerbated the shortage of childcare centers given the growing demand from working families, and it appears that the closure of daycare centers had a negative impact on the quality of the centers that remained open (Myers & Vargas, 2023). This reinforced the image of public programs being poor-quality programs for the poor instead of combating a major source of resistance to public services among families.

Mexico hosted the XVI Regional Conference on Women in Latin America and the Caribbean in 2025, organized jointly by ECLAC, INMUJERES, El Colegio de México, and UN Women. The resulting Tlatelolco Commitment built upon the Buenos Aires Commitment (2022) establishing a regional transition toward a “society of care” and the Quito Consensus (2007) recognizing the right to care (Maske, 2025).

Subnational Adaptation Findings

Mexico’s federal structure has major implications for territorial implementation, including substantial variation across states, uneven social service infrastructure, large urban-rural disparities, and differing political priorities across local governments. Research on Mexico’s pandemic response found that the absence of federal coordination mechanisms led to “uncoordinated federalism”: States filled gaps independently, but with fragmented and inconsistent results, a pattern that is a risk for care system implementation, too (Cejudo, 2023).

The CECI program’s current targeting criterion (municipalities with formal employment growth) reflects a broader tension in Mexico’s care system design (IMSS, 2025c). With 56% of women in informal employment, access to IMSS-linked childcare is unavailable to the majority of working women. Rural areas, southern states, Indigenous communities, and agricultural regions (where care burdens are typically highest and public infrastructure weakest) risk being left out. According to IMSS data, of an estimated 3 million agricultural day workers, only 700,000 (approximately 23%) have social security coverage (IMSS, 2025a).

A pilot CECI for agricultural day workers in San Quintín, Baja California, represented a deliberate effort to reach beyond the formal sector, but it remains an isolated case (IMSS, 2025b). Notably, the Ministry for Women, established in 2025, has stated it will begin implementing the national Public Care System with agricultural day laborers and *maquila* (assembly plant) workers in Ciudad Juárez, a further signal of federal intent to reach beyond the formal sector, though such efforts remain nascent and geographically concentrated (ECLAC, 2025a).

Additionally, the 2022 national care-system survey found that 53.2% of respondents believe childcare is a family responsibility, and 21.4% reported that children were mistreated in public childcare centers (Instituto Nacional de Estadística y Geografía, 2022). These findings reflect cultural and trust barriers that any care system expansion must address intentionally.

The Mexican case underscores that constitutional and legal advances alone are insufficient without implementation financing, intergovernmental coordination mechanisms, social legitimacy, and local institutional capacity. The cancellation of the previous childcare program demonstrates how quickly care systems can be dismantled. The CECI program's dependence on IMSS administrative structures and a presidential commitment, without constitutional anchoring or durable cross-party legislative support, raises concerns about long-term resilience. The absence of a constitutionally enshrined right to care (still pending Senate approval) and lack of a clear budget legislative framework further underscore the institutional fragility of the emerging system.

Mexico's case reinforces a lesson visible across the reviewed countries: Legal entrenchment, durable financing, and broad social coalitions (beyond presidential commitments alone) are what make care systems survive political transitions.

A.6 Costa Rica

Costa Rica became the second country in the region to formally establish a national care system (and the first middle-income country) when its National Care and Support System was established through executive decree in 2021 and national legislation in 2022 (Chaverri-Carvajal & Matus-López, 2021). Costa Rica's care policy is anchored in the Política Nacional de Cuidados 2021–2031 (National Care Policy 2021–2031), with the Sistema Nacional de Cuidados y Apoyos (SINCA) formally established through Law N.º 10.192.

Costa Rica's eight Indigenous Peoples live across 24 recognized Indigenous territories, covering almost 7% of the national territory. The International Work Group for Indigenous Affairs (2026) documents that state institutions have systematically failed to implement the 1977 Indigenous Law in these territories, which continue to experience persistent land invasion and a lack of culturally appropriate state services.

Within this context, SINCA is a multi-institutional system coordinated through the Interinstitutional Technical Commission (Comisión Técnica Interinstitucional—CTI), led by the Joint Social Welfare Institute (Instituto Mixto de Ayuda Social—IMAS). It includes a standardized dependency assessment instrument (baremo), a services catalog, and a georeferencing and monitoring system for tracking care supply across territories. In June 2025, the Inter-American Development Bank approved a loan of over \$200 million to strengthen SINCA, targeting approximately 160,000 adults with functional dependency and 170,000 caregivers (approximately 140,000 unpaid and 30,000 paid).

This was signed in November 2025 and includes implementation of the CUIDAR.CR digital platform for registering and crediting formal and informal caregivers to improve their employability and contribute to care workforce professionalization (Inter-American Development Bank, 2025).

Subnational Adaptation Findings

Costa Rica's broader territorial inequality provides important context for understanding the conditions under which SINCA must operate. The Atlas de Desarrollo Humano Cantonal (Cantonal Human Development Atlas) has consistently found significant and persistent gaps in human development, poverty, and gender inequality across the country's 84 cantons, with the most acute disadvantages concentrated in border, coastal, and rural cantons, particularly in the Huetar Norte, Huetar Caribe, and Brunca planning regions (Universidad de Costa Rica, 2020; Sánchez, 2023).

SINCA is intentionally structured to include subnational representation: Decree N.º 44242 and N.º 44243 (issued in 2023 and 2024 respectively) formalized the multi-institutional CTI structure by creating the Secretaría Técnica de Cuidados (Technical Secretariat for Care) and delimiting institutional responsibilities and coordination mechanisms (Esquivel, 2025). However, subnational implementation is limited in scale relative to documented need: As of December 2024, the system had completed 5,677 baremo dependency assessments nationally, identifying 3,289 people in situations of severe dependency, and 3,089 unpaid caregivers were receiving the IMAS care monthly subsidy (transferencias por cuidados). The CUIDAR.CR digital platform had registered only 143 formal caregivers and 518 dependent persons as of December 2024, indicating that this workforce-recognition tool was still in an early stage of adoption.

Barquero Araya (2025) also states that SINCA “does not have a budget assigned for its execution” (p.4). The unit responsible for SINCA's technical implementation from 2023 to 2024 reported a recurring work overload due to issues of persistent understaffing (Barquero Araya, 2025). As such, by the end of 2024, only CONAPAM,⁷ CONAPDIS,⁸ and the municipality of Heredia had also begun applying the baremo to new and existing service users (Esquivel, 2025; Barquero Araya, 2025). Heredia piloted a teleasistencia (or remote care service) service delivery model for older adults that was developed with technical and financial support from IMAS and the Inter-American Development Bank, and this model is possible due to Costa Rica's relatively strong broadband and internet connectivity. IMAS had begun separate, earlier-stage coordination with the municipalities of San José and Cartago to explore extending the teleasistencia model in 2025, and staff in San José's Gestión Social (Social Management) office had already received baremo training in anticipation (Barquero Araya, 2025).

7 CONAPAM is the Spanish abbreviation for the Consejo Nacional de la Persona Adulta Mayor, or National Council for Older Persons.

8 CONAPDIS is the Spanish abbreviation for Consejo Nacional de Personas con Discapacidad, or National Council for Persons with Disabilities.

In December 2023, IMAS adopted an intercultural model for service provision in Indigenous territories developed in consultation with Indigenous Peoples and experts, which was organized around four areas: territorial access, dignified treatment, promotion and recognition, and interinstitutional coordination. According to the government, prior institutional practice in Indigenous territories suffered from “non-application of regulations and a lack of translation procedures” (Barquero Araya, 2025, p.7).

A notable territorial model is Casas de la Alegría (Houses of Joy), seasonal childcare centers for coffee-harvest workers, many of whom are Indigenous Ngäbe and Buglé families traveling from Panama. These centers started in 2014 and have grown to include 41 centers across the Brunca, Los Santos, and Western Valley regions during harvest season. The program is coordinated jointly by IMAS, the Ministry of Health through the Centros de Educación y Nutrición & Centros Infantiles de Atención Integral (CEN-CINAI), the Caja Costarricense de Seguro Social (CCSS), the Ministry of Labor and Social Security, the National Coffee Institute (Instituto del Café de Costa Rica—ICAFFE), the National Fund for Coffee Sustainability (FONASCAFÉ), REDCUDI, the National Child Welfare Agency (PANI), the United Nations Children’s Fund, coffee cooperatives, and private coffee farms, illustrating a multisectoral, public-private-civil society model for reaching a target population that the formal SINCA architecture does not appear to reach through its standard institutional channels. This represents a deliberate effort to extend care infrastructure to informal agricultural workers (González, 2025; Instituto del Café de Costa Rica, 2022). This seasonal cross-border flow situates Casas de la Alegría within the regional care migration corridors ECLAC documents, in which Costa Rica is among the principal destination countries for migrant women, many of whom enter feminized and informal care work (ECLAC, 2025a).

Worker safety was identified as a challenge to implementing baremo field visits, with some regions identified as “*zonas de peligrosidad*” (“danger zones”), and insecurity led IMAS to establish a protocol for protecting staff in June 2024.

A.7 Argentina

Argentina presents one of the most instructive (and sobering) cases in the Latin American care policy landscape. Under the Frente de Todos administration (2019–2023), it advanced rapidly toward institutionalizing care. Since December 2023, under President Javier Milei, nearly all of that infrastructure has been dismantled, making Argentina a stark case study in political vulnerability and the necessity of legal anchoring for care systems.

Advances Under Frente de Todos (2019-2023)

Created in 2019, the Ministry of Women, Genders, and Diversity was Argentina’s first national ministry coordinating gender equality and care policies. Key initiatives included:

- The Federal Care Map (Mapa Federal del Cuidado), developed in partnership with ECLAC, was an interactive web portal geolocating care spaces and training opportunities, designed explicitly to serve national and subnational governments as a tool for evidence-based, territorially situated care policy planning.
- Care Parliaments (Parlamentos del Cuidado) were multi-stakeholder forums held across Argentina with social organizations, provincial and municipal governments, trade unions, and community care networks around two central questions: “How do we care today?” and “How do we want to care and be cared for tomorrow?” These generated territorial evidence on care gaps and priorities across provinces.
- A comprehensive care system (Sistema Integral de Cuidados) bill was submitted to the National Congress in May 2022, drafted jointly by the Ministry of Women, Genders, and Diversity and the Ministry of Labor. However, the bill did not advance beyond the committee stage.

Advances Under Frente de Todos (2019-2023)

Within days of taking office in December 2023, the Milei administration downgraded the Ministry of Women, Genders, and Diversity to an undersecretariat of the Ministry of Human Capital. By June 2024, it had been completely shuttered, eliminating the gender equality infrastructure that had existed since the creation of the National Women’s Council in 1992, with approximately 500 of 600 staff dismissed (Jaureguy, 2024). In February 2024, the government declared its intention to prohibit “anything related to gender perspective” within the national administration (Quiroga, 2024).

Prieto (2025) finds that while the Frente de Todos made advances in care policies without structural transformation, under Milei there is a clear regression “consistent with austerity policies, but with the novelty of an ideological reaction to gender institutionality.”⁹ The national budget for gender-based violence prevention and response fell 89% between 2023 and 2024, and the Acompañar economic-support program collapsed from over 100,000 recipients in 2023 to 434 in 2024 (Human Rights Watch, 2025). The Mapa de las Políticas Sociales en la Argentina (Social Policy Map for Argentina) records the largest social-spending cut since 2002 (Fundar & Instituto Universitario CIAS, 2025).

Subnational Adaptation Findings

Argentina’s Federal Care Map and Care Parliaments were built as subnational planning tools, but the literature does not yet include systematic evaluations of how provincial governments translated these national tools into subnational care policies before the 2023 transition.

Community care organized through the popular economy (neighborhood-based care networks sustained by women in informal work) survived changes in national government because it is embedded in civil society rather than state structures (Hopp & Bonelli, 2025).¹⁰ Women-led organizations continue to provide childcare and other services in neighborhoods historically excluded from formal labor markets and social protection, and have articulated care as a trade union issue (Hopp & Bonelli, 2025). However, this infrastructure remains vulnerable because many broader social programs that supported it were also dismantled or defunded.

Argentina’s feminist movement has an explicitly federal structure connecting groups across all provinces through the National Women’s Meeting (held annually since 1986), which exists independently from government institutions and represents a durable subnational foundation for future care system recovery due to its existence outside of formal government institutions (Grados, 2025). Argentina illustrates the lesson that legal entrenchment, legislative anchoring, and broad social coalitions support care system survival during political transitions. It also demonstrates how federal governance structures can enable subnational resistance to national rollback, even as they create fragmentation risks when coordination is withdrawn.

9 Original text: “en línea con las políticas de austeridad, pero con la novedad de la reacción ideológica a la institucionalidad de género” (Prieto, 2025).

10 As an example, there was a November 2023 gathering titled (translated into English) “Who Cares for Those Who Care” and a Feminist Trade Union Assembly in May 2024 organized by the Union of Workers of the Popular Economy.