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Care Across the Life Cycle: Building Care Systems in Latin America and the Caribbean

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Care Across the Life Cycle: Building Care Systems in Latin America and the Caribbean

This note presents the definition, relevance, and objectives of a care system from the perspective of both care recipients and providers. It also outlines a menu of care interventions for targeted populations throughout people's life cycle and highlights policy areas where the Inter-American Development Bank (IDB) can support the sector throughout Latin America and the Caribbean.

The note is organized as follows. After an introduction, Section 2 discusses the objectives, institutional organization, and financing of care systems. Section 3 analyzes the subsystems that provide care services for children, people with disabilities, and older people with care needs, describing key interventions or policies where IDB can help countries in the region strengthen their care system activities. Finally, Section 4 presents programs and policies focused on caregivers and the IDB's work in this area.

1 Introduction

Care encompasses a variety of activities to ensure people's physical, mental, and emotional well-being, including healthcare, household chores, support for dependents and caregivers, and self-care practices. **Care can be offered by public or private providers (institutional or community-based, formal, or informal), or by individuals (family members or hired caregivers). A care system** is an umbrella that organizes policies, programs, and the provision of care services. Historically, care has been seen as a private matter, primarily a responsibility of households and the women within them. Consequently, the state took on the role of assisting families rather than being a provider or regulator within the care system (ECLAC and UN Women, 2020). Today, it is widely recognized that care needs to be understood from a broader perspective, acknowledged as a public issue, and guaranteed as a right. This approach encompasses different population groups that need care, such as infants and toddlers, school-aged children, people with disabilities, older people with care needs, and unpaid or paid caregivers.

Care systems must also be designed to consider the needs and wellbeing of care providers (paid or unpaid), rather than just those who need care.

Providing care requires significant amount of labor, and the emotional and psychological wellbeing of caregivers is crucial for delivering quality care.[1] A care system's design should be adapted to the sector's workforce, which is predominantly female and includes people providing unpaid care within their own families and communities. In addition to designing and supplying care services, a care system must simultaneously regulate and supervise care, train human resources, and manage knowledge and information, as well as take communication actions to promote social and gender co-responsibility in care, all in a synchronized way.

Investing in a care system yields substantial benefits. First, care services increase recipients' quality of life. For instance, they can uphold people's dignity through personalized care tailored to individual needs, promote autonomy in decision-making, and foster emotional well-being. They support the autonomy of older people with care needs. At the same time, they reduce the burden on unpaid caregivers, who are usually family members, contributing to their emotional wellbeing.

Second, some care services like early childhood development services advance sustainable development and economic growth in significant ways (Berlinski and Schady 2015). A range of research and evidence supports this claim. For instance, experiences in the first years of life—when the human brain grows the fastest and is most malleable—affect outcomes such as school performance, physical and mental health, employment, and criminal behavior (Shonkoff and Phillips 2000; Berlinski and Schady 2015). Each person's life path and ability to reach their potential are affected by the interaction between their genetic endowment and their experiences in their environment, particularly in childhood (Manski 2011; Barth, Papageorge, and Thom 2018).

Third, expanded access to care services can increase female labor force participation. For example, existing evidence suggests that increasing access to childcare boosts employment among women, especially when baseline levels are low (IDB, forthcoming;[2] Hojman and Lopez-Boo 2022; Attanasio, et al. 2022).

Fourth, investing in care can create quality jobs and generate a virtuous cycle with multiplier effects on the economy. When accompanied by legislation, regulation, and oversight of quality employment in the care economy, this investment

[1] Care quality is generally defined as the degree to which services increase the likelihood of desired outcomes in care recipients.

[2] IDB, forthcoming. Expanding Opportunities - Policies for Gender Equality and LGBTQ+ Inclusion in Latin America and the Caribbean. *Development in The America (DIA).*

improves working conditions and access to social security. Estimates for Argentina suggest that the investment needed in order to improve care service the coverage and quality could be as much as 5% of GDP but would generate over 1 million direct jobs (ILO, 2022).[3]

Unpaid care work has historically been unequally distributed within families and communities and has been almost exclusively the responsibility of women. Women bear a disproportionate share of the burden of care activities, both within households and in the broader community.[4] Time spent on unpaid care is time they do not have for other activities such as work, study, or leisure. This affects the opportunities for women and girls to participate in economic, social, and political spheres, as well as the potential involvement of men and boys in caregiving. On an individual level, women sacrifice opportunities for professional growth and participation in activities beyond their homes. At the family level, this decision about how to distribute care responsibilities impacts labor incomes and may lead to poverty in the growing number of female-headed households in the region. On both the family and community levels, it reinforces traditional gender roles and influences bargaining power, particularly when care is undervalued. Societally, it redirects talent away from other productive activities. Efforts to reduce and redistribute care responsibilities contribute to a more equitable society, where all genders have equal opportunities to participate in all aspects of life.

[3] 240,000 among teachers and support staff; 226,000 among medical, obstetric, nursing, and other healthcare personnel; 550,000 home caregivers or caregivers in residential care settings.

[4] If valued at minimum wages, the hours spent on unpaid care worldwide would represent 9% of global GDP, or US$ 11 trillion per year. Among OECD countries, the estimate is 15% of GDP (Addati, Cattaneo, and Valarino, 2018; OECD, 2021).

2 The objectives, institutional organization, and financing of a care system

Objectives of a care system

Among other objectives, a care system should:

i. Promote the provision of care services throughout people's life cycle, through care subsystems for:

   a. Infants and toddlers;

   b. School-age children, in hours when their families cannot provide care due to work, study, or other responsibilities;

   c. People with disabilities with high support needs (personal assistance);

   d. Older people with care needs (long-term care).

ii. Ensure proper training for care providers.

iii. Ensure that all care providers (public and private) meet quality standards.

iv. Determine eligibility and targeting criteria for subsidized services.

v. Define the policy framework (national care policy).

vi. Develop governance structures for horizontal coordination (across sectors such as health, education, social development, and others) and vertical coordination (across levels of government—national, state, and municipal governments).

vii. Ensure financing for the system (resource generation, pooling, allocation, and procurement), channeling investments to sectors and geographical areas with unmet care needs.

viii. Foster an appreciation of care, redistribute care responsibilities, and change social norms to promote a culture of shared responsibility for care.

ix. Promote decent work for paid caregivers.

x. Adapt labor legislation to the care needs of families and society.

Policy and institutional framework

A care system's policy and institutional framework is the set of rules, regulations, and organizational structures that guide and govern the provision of care services and resources to support caregiving. While the specifics can vary across countries and regions, key components typically include:

i. **Legal and regulatory framework:** Laws and regulations that define the rights and responsibilities of both service providers and care recipients.

ii. **Standards and guidelines:** Licensing, standards, and guidelines for the quality of care; caregiver qualifications that include pre-service and in-service training (which may involve licensing, certification, or accreditation processes); expected outcomes for care recipients; safety; and ethical considerations. Standards cover facilities and infrastructure and other structural aspects of care: spaces, sanitation, staff-to-child ratios, supervision ratios, equipment, etc. Each care subsystem defines specific protocols for different types of care services and care facilities.

iii. **Funding mechanisms:** The financial structure supporting the care system, including funding sources, reimbursement mechanisms, and budget allocations for different types of care.

iv. Institutional structures: The organizational setup of entities involved in providing care services, including horizontal and vertical coordination.

v. **Eligibility criteria for care recipients:** conditional on budgetary constraints. The main eligibility criteria are age of users, degree of dependency (complementary to age), socioeconomic vulnerability, and spatial and geographical considerations (UN women, 2022), as well as

equity-based eligibility for subsidies, including, for instance, subsidized care services or differential pricing schemes.

vi. Information systems: Mechanisms for collecting, managing, and sharing information within the care system, which can include electronic records, data reporting systems, and communication channels. This aspect also includes monitoring and evaluation process, including quality improvement efforts.

Intersectoral nature of care. Care policies are inherently intersectoral and require coordination among various government actors. These actors include the ministries of social development, education, and health, which are often responsible for providing care services; ministries of labor, which oversee regulations, quality of work, training, caregiver certification, and labor policies such as maternal and parental leaves and flexible work arrangements to help families fulfill their care needs; ministries of finance, which are responsible for financing the care infrastructure and the provision of care services; and ministries of women's affairs, which promote cultural change and advocate for recognizing the value of care and redistributing care responsibilities as part of the discussion around equality in economic opportunities.

Financing

Key policy decisions when designing care systems include how to finance them, the relative importance of subsidies and copayments, and how to target subsidies. In Latin America and the Caribbean, the cost of financing a long-term care system with 35% coverage is projected to triple from 2020 to 2050, increasing from 0.27% to 0.77% of GDP (Fabiani et al., 2022). Creating the fiscal space to invest in care infrastructure and service provision (either directly or through third-party contracts) is a policy decision that requires hard-to-build political support. In the

absence of fiscal space for universal free access, subsidized or free care programs should prioritize those with the highest care needs who, absent the service, would receive the lowest quality of care due to either negligence, poverty, or community-level factors such as conflict or violence.

When examining models for financing comprehensive care policies and systems, it is important to clearly define the starting point based on the country's definition of care. This starting point encompasses current actions, budget allocations, and existing institutional frameworks. The challenge is to combine these established programs and policies into a coherent system with progressive implementation phases and financial stability. To craft financing models for regional care systems, counties must thoroughly explore a range of alternatives for diversifying resource streams. This entails striking a balance between social insurance, allocations from general revenues, targeted taxes, and direct contributions from families (CEPAL, 2022).

Financing sources can be classified as ex ante or ex post (Costa-Font, Courbage, and Swartz, 2015; Medellín et al., 2018). Ex ante mechanisms are financing that occurs before the need for care arises. Insurance is one example. Ex post mechanisms refer to financing that occurs once the need for care has arisen. Examples include public spending and out-of-pocket expenses by families.

An analysis of the long-term care funding sources of a group of 23 OECD countries shows that ex post sources (taxes, out-of-pocket expenses, and others) surpass ex ante sources (social insurance and private insurance). Taxes are the most widely used form of public financing. All countries in the sample use them, and they account for 52% of funding on average. However, a large number of countries also use

social insurance, and a considerable group use a balance between social insurance and taxes (Medellín et al., 2018).

Private insurance is incipient in all countries. This can be explained by the inherent difficulties of long-term care that make it complicated to develop an insurance market with products that are both profitable for insurers and attractive to users (Barr, 2010). These difficulties include high uncertainty about how much care required in the distant future will be worth, in addition to market failures like moral hazard and adverse selection. Out-of-pocket expenses are considerable in some countries. Importantly, in-kind contributions made by families through informal care are not included in private insurance schemes.

3 Subsystems for providing care services

Early Childhood

Objective and target population. Early childhood services offer center-based care to children zero to three years old. These services foster early childhood development (i.e., cognitive, socioemotional, motor, and language skills), but their effectiveness depends on service quality and the relative quality of alternative care options. Childcare services also aim to facilitate maternal employment.

Services. Childcare centers provide care, nutrition, opportunities to learn though play, and—sometimes—healthcare services. Countries offer childcare through various modalities, including the community modality (Colombia and Peru), the institutional modality (Argentina, Brazil, Chile, and Mexico), and a mixture of both modalities (Ecuador). Access to center-based programs varies by socioeconomic status: children in poorer households or from rural areas attend these services less than children in wealthier homes or urban areas, respectively. While these gaps are mainly driven by supply restrictions, demand-side factors also play a role, since families

consider many variables when deciding on care arrangements, including affordability, location, and hours of operation (IDB, forthcoming [5]).

Governments are the main providers of center-based programs and use different models, including institutional settings (e.g., the IMSS in Mexico offers services only to children of formally employed workers), community-based models (e.g., in Central America and the Andean Region), and subsidizing childcare fees (e.g., in Mexico) (IDB, forthcoming[6]). Alternatively, the governments of some countries, like Chile, mandate large firms to provide childcare services (Prada et al. 2015). In other countries, the private sector contributes by providing subsidized or unsubsidized programs. For example, civil society actors in Argentina, Colombia, and Mexico reach a large number of children in urban settings, while in Uruguay and Brazil, the private sector builds and operates childcare centers (IDB, 2024). However, the private sector's scope is limited, and the countries in the region need to design and implement regulations and standards for private-sector involvement in childcare.[7]

Human resources. Paid caregivers do not need to be professionals, but they do need training, support (mentoring), and encouragement. ECD working conditions are suboptimal in LAC: ECD staff get paid less and have lower qualification requirements than primary school teachers, face short contract terms, and lack recognition. This leads to frequent staff turnover and training investment losses. Beyond improving these conditions, offering in-service, ongoing, coaching-based training and professional development programs for ECD workforce on daily planning, effective interactions, and strategies to support children's learning is an important step toward better process quality (IDB, 2024).

[5] IDB, forthcoming. Expanding Opportunities - Policies for Gender Equality and LGBTQ+ Inclusion in Latin America and the Caribbean. *Development in The America (DIA)*

[6] IDB, forthcoming. Expanding Opportunities - Policies for Gender Equality and LGBTQ+ Inclusion in Latin America and the Caribbean. *Development in The America (DIA).*

[7] Despite efforts to expand access, childcare enrollment rates are 1% to 5% in Central American countries, Paraguay, and Peru, and are only between 30% and 40% in a few countries (Brazil and Uruguay).

Setting and supervising quality standards. The effectiveness of center-based ECD services depends on the quality, especially their process *quality*—which is the *quality* of the interactions between caregivers/adults and children. High-quality interactions are engaging, warm, frequent, rich in language, and responsive to children's needs. Other factors known as *structural quality*—which includes group size, content, materials, workforce characteristics, and security—contribute to child-wellbeing and safety, but they are not enough to improve child development. Quality ECD services can close the gap in ECD levels between more disadvantaged children and others by offering higher quality interactions than care at home does, along with learning opportunities, safe spaces, and nutritious meals, or by improving the home environment. To ensure quality, services must have certain minimum characteristics (as established in the standards used in Panama [MIDES, 2017], for example), have pre-established outcome targets, and, importantly, enforce mechanisms to ensure that such targets are achieved.

Financing. In Latin America and the Caribbean, funding for ECD is insufficient to ensure sustainable and high-quality services and volatile due to changes in government administrations (Berlinski and Schady, 2015).[8] Public-private collaborations have seen small, yet the growing use of these partnerships in ECD has potential for managing limited public finances, mobilizing additional resources, and tackling budget-related rigidities and restrictions (IDB, 2024).

The IDB's work on ECD. The IDB has financed operations and technical assistance activities to expand coverage, enhance quality, strengthen institutions, and evaluate childcare programs. Specifically, through loan operations, the IDB has supported initiatives to expand ECD services without sacrificing quality. These initiatives include built new centers, improved infrastructure, invested in equipment and learning materials, trained the workforce, and evaluated impact (in Argentina, Brazil, Ecuador, Nicaragua, Panama, Uruguay). Some of these operations involve developing quality standards for care and supervision systems (Argentina, Brazil, Nicaragua, Panama), while other efforts support the design of curriculum and methodological guides and the development of information systems (Ecuador, and Panama).

[8] The annual cost per child of providing ECD services varies in the region. For example, the cost of center-based services was $1,612 in Argentina (2017) and $2,798 (2018) in Uruguay.

Through technical cooperations, the IDB has supported efforts to (i) measure childcare centers' service quality, employing short and easy-to-use checklist-type tools (Argentina, Brazil, Mexico, and Uruguay), and ECD outcomes (Argentina, Ecuador, Panama); (ii) develop and use hybrid, in-service caregivers training strategies (Colombia, Jamaica, and Mexico); (iii) strengthen institutions (Colombia, Panama, and Uruguay); (iv) develop and evaluate strategies to improve caregiver-child interactions through mentoring (Mexico).

Throughout its technical assistance, the IDB has built regional platforms and tools for countries in the region. These include:

- The ECD Community of Practice, a network of governments from around the globe, organizations, development community and private sector actors, and academic institutions for exchanging knowledge, strengthening regional networks, and fostering dialogue among different stakeholders.

- The IDB also promotes and facilitates knowledge exchange through the Knowledge Hub on ECD in LAC, the first one-stop shop ECD website in LAC. It offers more than 2,000 ECD resources for anyone in the region interested in knowing and learning about the topic. These efforts build on the knowledge and networks created while implementing the projects of the IDB ECD Fund.[9]

[9] A partnership between the IDB and FEMSA Foundation, Open Society Foundations, *Fundação Maria Cecilia Souto Vidigal*, Porticus and Bernard Van Leer Foundation. Since 2017, the fund has financed, designed, implemented, and evaluated innovative and scalable approaches to improve the lives of children under five in LAC's most disadvantaged populations. This US$11 million portfolio of 25 projects has contributed to designing new strategies to improve service quality and to identifying key aspects for scaling up interventions.

School-age children

Objective and target population. Care initiatives for school-age children involve extending school hours for 4- to 12-year-olds.[10] In most countries in the region, school schedules do not match work schedules, which leaves working parents in need of alternative care arrangements. The objectives of extended school days are to increase quality time for teaching and learning,[11] promote protected environments for longer periods in school as a safety net,[12] and provide opportunities to mitigate gender inequalities. These programs can mitigate gender inequality in two ways. First, they reduce girls' involvement in household chores—girls and young women are very commonly assigned additional tasks like household chores or caring for younger siblings that can interfere with their educational

[10] The target population considered in the after-school care services include children 4-5 years old since preschools often operate only for 3-5 hours per day. After-school activities could also target secondary school and could be considered for adolescents up to 17 years old. The literature mentions some effects of extending the school day that are related to adolescents. Adolescents are not a target population in this policy brief because they do not demand the same amount of care as children under 12 years old.

[11] Students in the early levels of secondary education in Latin America and the Caribbean spend 1,070 hours per year in school, a figure well below the 2,956 hours spent by students in the European Union (initial value, OECD Stats, 2019). School closures in Latin America and the Caribbean due to the COVID-19 pandemic resulted in significant learning losses and exacerbated educational inequalities. These prolonged closures reduced instructional time, limited access to resources, and hindered student participation. The ensuing challenges in acquiring essential knowledge and skills may have long-term consequences on students' educational trajectory and future opportunities (CEPAL, 2022).

[12] Extending the school day promotes equality for low-income students (Ceballos, 2022), as it results in an additional two months of progress in the academic year (Educational Endowment Foundation, 2024). Spending more time in school can reduce rates of teenage pregnancy, exposure to domestic violence, and delinquency, while also increasing adult incomes (Wu, 2020). Extended school days provide protected environments, promote healthy lifestyles, and improve learning outcomes by meeting children's nutritional needs. Evidence from Latin America and the Caribbean demonstrates positive social and labor market results (World Bank, 2015). In Chile, for example, a combination of extending the school day and other specific policies had positive effects on preventing teenage pregnancy and reducing juvenile delinquency (Bertheleon and Kruger, 2011). Similar effects were identified in the Dominican Republic, where greater exposure to extended school days in secondary education reduced the incidence of teenage pregnancies, an effect that seems to be stronger once the program reaches at least half of secondary-level students (IDB, 2022).

opportunities.[13] Second, they give mothers more time and better conditions for joining the formal labor market. Studies show that as the amount of time children spent in school increases, the likelihood of mothers working longer hours does too (Berthelon, Kruger, and Oyarzún, 2022). A study conducted to estimate the impact of increasing enrolment in extended-day schools by 30% on gender-disaggregated employment in Argentina found that this policy could generate 444,400 jobs, 44% of which would be held by women (Díaz Langou et al., 2019).[14]

Services. Extended primary school services include public and private offerings that utilize existing primary infrastructure or other facilities. After-school care consists of supervision, food, and help with homework, as well as opportunities for children to socialize, play, and engage in physical activities. It can be offered at schools or in nearby facilities adapted for that purpose. Policies that increase the length of the school day offer an alternative to after-school programs. Extended school time can also be used to teach curriculum content, or alternatively, to conduct activities to help students who are lagging-behind academically catch up.

Human resources. There are different models for implementing extended school days, depending on the number of hours added,[15] the curriculum proposed, whether spaces used are inside or outside the school, how students are grouped, the level of autonomy of the schools to define the educational plan, and other factors. These variables determine the amount and profile of the staff needed to cover the additional hours—essentially, whether they must be teachers or can be workshop leaders. These decision will be shaped not only by policy objectives, but also by the availability of qualified human resources, especially in remote geographies (Torre et al., 2024).

[13] Extending the length of the school day has positive effects on academic results, particularly for low-income students. Research has identified that longer school days can have a positive impact on student learning and on other academic results such as dropout rates and grade repetition (Hincapié, 2016; Pires and Urzúa, 2011; García et al., 2013). The literature highlights that these effects are largest in the poorest schools and in rural areas, which means they improve equity (Hincapié, 2016; Bellei, 2009; Cooper, 2010). Moreover, extending school days could have other benefits, such as freeing up time for parents to work for more hours, or mitigating the negative impacts of students being exposed to risks. However, the effects are small, and extending school days at scale might not be cost-effective (Alfaro et al., 2015). See Contreras and Lepe (2023) for a review of existing evidence.

[14] In Mexico, lengthening the school day affected grandmothers, who worked more and were employed in greater numbers (Cabrera- Hernández and Padilla-Romo, 2020). In Chile, afterschool care for children ages 6–13 increased maternal labor force participation by 4.3 percentage points (from a mean of 60.5% participation among the control group). In addition, access to free afternoon care resulted in substitution away from other care arrangements (Martínez A. and Perticará, 2017)

[15] The hours per week can vary from 20 to 40.

Setting and supervising quality standards. A review of several studies that evaluate the impact of extending the school day on different variables associated with educational quality (Claus, 2020) showed significant positive effects on learning outcomes in Chile (Bellei, 2009; Puentes Campos and Ramos Yáñez, 2015), Colombia (Hincapie, 2016; Ovalle-Ramírez, 2018; Ovalle-Ramírez, Vila-Ocho, and González Gómez, 2018), Brazil (Xerxenevsky, 2012), Uruguay (Cerdan-Infantes and Vermeersch, 2007; Cardozo Piliti et al., 2017), Mexico (Silveyra et al., 2018) and Peru (Agüero, 2016). In addition, extending the school day allows students to enjoy more and diverse educational opportunities, especially in the areas of culture, art, sports, science, technology, languages, and environmental education. However, despite the fact that most countries in Latin America and the Caribbean have achieved almost universal coverage in primary education, access to an extended school day is still restricted in some countries (Torre et al., 2024) and in certain geographical areas, urban/rural environments, and socioeconomic settings within countries.[16]

Financing. Extended school day initiatives vary significantly by the size of the education system or scope of the program (targeted or universal). In this sense, the financial challenges that each country faces are very different. However, there are two central dimensions in terms of funding needs: additional teaching and non-teaching staff and food services (current expenses), on one hand, and building or adapting infrastructure and providing technological equipment and teaching resources (capital expenditure), on the other hand. Countries not only need to establish the sources of financing, but also the mechanisms for making the policy sustainable (Radinger and Boeskens, 2022).The cost of care for school-age children can be funded through a combination of parent fees, government subsidies, grants and donations, and private funding sources.

The IDB's work on extended school hours or after-school activities

[16] For example, in poor Argentine provinces such as Chaco, Corrientes, La Rioja, and Santiago del Estero, less than 10% of primary schools have an extended or full school day, while in rich jurisdictions such as Córdoba, Mendoza, and the City of Buenos Aires, this percentage exceeds 50% (Annual Survey 2022).

- The IDB recently approved the Explearn: Expanding Learning Time Facility. This facility's general objective is to contribute to the design and implementation of policies for extending the school day in Latin America and the Caribbean, with a particular focus on: (i) improving and diversifying learning opportunities; (ii) data-driven decision-making; and (iii) innovative teaching strategies, while promoting gender equality. The facility's specific objective is to increase public administrations' capacity to create, implement, monitor, and evaluate public extended school programs and policies. This specific objective involves supporting countries as they seek a full understanding of the opportunities for extending the school day; identifying existing institutional, legal, financial, and operational challenges so they can be addressed; and developing policies, programs, and intervention models to address these needs, as well as promoting gender considerations in extended school day programs. Under this facility, the IDB will carry out two US$250,000 technical cooperations in 2024 in Argentina and Brazil. For Brazil, the general objective is to support decision-making and the design of more effective and inclusive public policies to improve educational policies and quality. The beneficiaries include the municipalities of Pará, Amazonas, and Piaui. For Argentina, the general objective is to support implementation of an extended school day at the secondary level in the Argentine provinces of Mendoza and Misiones (beneficiaries).

- In 2016, the IDB approved the US$20 million loan "Project to Support Extended School Days and Improved Transportation Conditions for Students Attending Rural Official Schools" in Paraguay. The project's general objective is to improve the learning outcomes of students in the first and second cycles of basic education at schools already implementing an extended school day, and to implement a pilot program offering transportation to students attending public schools in rural areas. The specific objectives include: (i) developing and implementing educational innovations that support extending the school day at public schools; (ii) supporting the development of schools' management autonomy and capacity by making school management tools available in the administrative, pedagogic, organizational, and community spheres; (iii) showing the impact of these changes on learning outcomes; and (iv) producing documented evidence of the transportation needs of students in rural or sparsely populated zones, and performing a cost-benefit analysis of transportation options as intersectoral inputs for the education policy.

Long-term care

Objective of long-term care and target population. Long-term care consists of any health or personal care, or social actions provided by unpaid or formal care providers, that allow people of any age who have lost or are at risk of losing their intrinsic capacity, to maintain a level of functional ability that is consistent with their basic rights, fundamental freedoms, and human dignity (World Health Organization, 2015, 2021a, 2021b). Long-term care services help people complete activities of daily living, whether basic (e.g., eating, washing) or instrumental (*e.g.,* cooking, getting groceries, cleaning their home). Through support for these activities, long-term care services aim to protect the wellbeing of people with care needs—most of whom are older people. At the same time, they also support the wellbeing of family members who, in the absence of long-term care services, bear most of the care responsibilities.

Long-term care has a **double gender dimension.** Among the older population with care needs, there are approximately two women for each man. (Aranco et al. 2018). Moreover, women make up about 80% of paid or unpaid caregivers. Fabiani 2018; Stampini et al. 2020). Although care can be rewarding, being solely responsible for it has negative consequences for wellbeing (stress, depression, increased consumption of medication) and economic participation. In Mexico, for example, having a parent in need of long-term care reduces the probability of employment, as well as the number of hours of work among those who remain employed, but only for women (Stampini et al. 2022).

Eligibility. To identify the target population, countries need to define and implement an assessment of care dependence (known in Spanish as baremo). (Oliveira et al. 2022). This includes a series of questions on the need for help with activities of daily living. The level of care dependence is the primary criterion for determining eligibility, since high dependence automatically implies vulnerability. In

countries with advanced long-term care systems, other criteria like income and family structure are often used to decide subsidy/copay levels for the services.

Services. After determining eligibility, the next step is to create an **individualized care plan.** Each person or household needs a different combination of services: for example, one person may need several home visits for preparing meals and feeding, while another may only require rehabilitation or occupational therapy. The services are provided by professionals with different types of training, ideally under the supervision of a care manager. Services can be provided in a residential care facility, typically for those with high levels of care dependence (like those with low mobility or severe cognitive impairment), or at home.

Thereis a worldwide trend towards home-based services that allow persons with care needs to live in their community, as is often preferred by care recipients and their families. In most cases, it is also the most financially efficient option. Services that support aging in place include home visits by caregivers, day care centers, telecare, and respite services for family caregivers (Aranco and Ibarrarán 2020; Benedetti et al. 2024; Benedetti et al. 2022). Home caregiving, for example, is at the core of Uruguay's long-term care system, which also provides telecare to support home-living for people with lower levels of care dependence (Aranco and Sorio 2019).

Cash transfers can be a good practice, but only when part of a cash and counseling scheme that requires that family caregivers be trained and hired under a formal employment contract (Doty 2023).

Human resources. Care workers are the backbone of quality in long-term care services (Fabiani et al. 2024). Care is provided by multidisciplinary teams that include, among others, caregivers, nurse assistants, nurses, occupational therapists, nutritionists, and speech therapists (Villalobos et al. 2022). For creating personalized care plans and ensuring coordination between long-term care and healthcare services, developing the profession of care manager is key. For example, care managers are central to the long-term care system in Japan.

Training for human resources should cover technical skills (e.g., how to support changes in posture), relational skills (e.g., how to deal with depression or communicate with people with dementia), and self-care skills. To provide training that increase long-term care quality, systems must transition from

a model based on services to a person-based care model. (Aldaz Arroyo et al. 2023). Under this approach, caring is about more than applying techniques and protocols and is based mainly on the quality and strength of the bond created between care providers and recipients. As an example, this approach requires developing the daily schedule jointly with the care-dependent persons, respecting their rhythms, preferences, and abilities (rather than optimizing time).

Setting and supervising quality standards. The quality of care is a priority in care policies. Despite this, in Latin America and the Caribbean care service quality is generally low or very low (Aranco et al. 2022). Governments have the responsibility to regulate and supervise quality to protect the quality of life of fragile and vulnerable people who need support (OECD, 2013). However, there is no single definition of quality. In general, quality is associated with safety, efficacy, and patient-centered services. More recent definitions emphasize people's experience, quality of life, and ability to maintain their identity and autonomy. There are different instruments and tools for promoting and evaluating quality, including regulation, incentives, and collecting and publishing information (Malley et al. 2015).

Financing. A long-term care system that provides a mix of residential care services, home care, day centers, and telecare to all care-dependent older population would cost an estimated 0.52% to 2.54% of GDP in the different countries of the region. An important lesson from Europe's experience is that population aging trends must be taken into account when setting benefit levels. When the population is aging rapidly, countries must forecast expenditure in upcoming decades and choose coverage levels and service types that will be affordable in 20 or 30 years. The cost of full-coverage systems for LAC is predicted grow to 1.34–7.35% of GDP by 2050. Given these figures, it is recommended to start with lower coverage. For example, a system with 35% coverage would currently cost between 0.11% and 0.56% of GDP (Fabiani et al. 2022).

Long-term care systems are typically funded through social security (as is the case in the Netherland, France, or Korea), general taxation (Sweden), or a mix of the two. Private insurance typically covers less than 2% of the costs, except in few countries, and is never the main source of funding. The same holds for co-payments, which are a way to make the system more sustainable and equitable. Fabiani et al. (2022) assert that only four countries of the region could afford a reform that

increases social security contributions to fund long-term care (Argentina, Brazil, El Salvador, and Paraguay). This system, however, would have low coverage and unequal access (lower for women than men). In contrast, funding a system with 35% coverage through general taxation would be feasible in all countries in the region.

The IDB's work on long-term care.

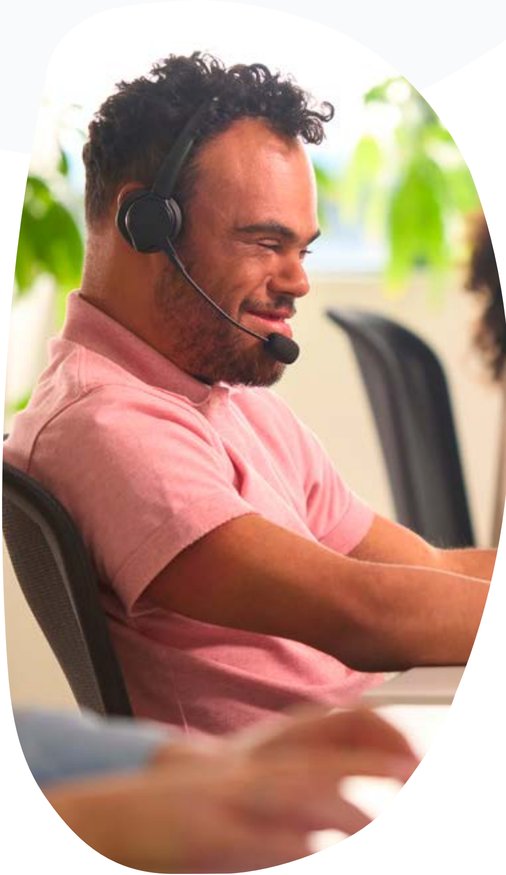
- The IDB, in collaboration with the French Development Agency and the European Union's EUROsociAL+ program, implements the Long-Term Care Policy Network in Latin America and the Caribbean (REDCUIDAR+). This network facilitates policy dialogue on long-term care and builds countries' institutional and technical capacity.

- Through loan operations, the IDB has supported the creation of national care systems (in Uruguay and Colombia) and pilots of integrated care in selected municipalities (in Panama and Dominican Republic). These operations have included support for improving the quality of home care services, as well as initiatives to develop or improve management and information systems. Through technical cooperations, the IDB has supported the design or improvement of curricula for caregivers' training (in Uruguay, Colombia, Costa Rica, El Salvador and Mexico), the design and implementation of long-term care services (day service centers in Mexico, the development of cooperatives in Uruguay), studies on sustainable financing and governance (in Uruguay and Colombia), and the design or improvement of information systems (Uruguay).

- Technical cooperation is partly funded by the Aging Facility: Strengthening Capacity for Health, Long-Term Care and Social Services, which is financed by the French Development Agency. All knowledge and operational work is disseminated through IDB's Panorama of Aging and Long-term Care website.

- Finally, as part of the IDB Lab's Silver Economy agenda, the IDB group has been creating a portfolio of private-sector operations focusing on long-term care. Some of these operations were selected through the Silver Economy Challenge. This work highlights how population aging is also an engine of economic development that can help create employment and entrepreneurship.

People with disabilities



Objective. People with disabilities (PwD) are a core target population for care systems, as some PwD require support,[17] and caregivers themselves may have disabilities. Higher quality caregiving and services that include PwD can enhance the autonomy of people with disabilities.[18] Disability and functional dependency are related but distinct concepts. Not all people with disabilities are functionally dependent, and not all persons who are functionally dependent have disabilities. A specific legal framework for disability inclusion applies to caregiving services. The protocols and policies for people with disabilities should align with the specific legal framework established in the UN Convention on the Rights of Persons with Disabilities (CRPD) and other international and national statutes. The CRPD, ratified by every country in Latin America and the Caribbean, upholds the autonomy and decision-making power of PwD, including their rights to live independently in the community. There is thus a distinct legal framework for people with disabilities who require assistance with daily activities, compared to people with functional limitations but without a disability. More specifically, long-term care policies must address the additional requirements for elderly PwD with functional limitations.

[17] Support provided to PwD with high support needs is preferably described as personal assistance rather than caregiving to reinforce that PwD are not objects of care. The term functional dependence implies the need for personal assistance. Given its long-standing associations with policies that have restricted the decision-making power of PwD, the term "dependence" also causes frictions. The preferred terms are support and high support needs, rather than caregiving and dependence (Jaramillo, F., Guzmán, Y., Cortés, M., 2023). When referred to as part of a broader care system, as is the case in this conceptual framework, the term caregiving is often maintained.

[18] This section was written by S. Duryea, drawing heavily from the 2023 report by Parra, *Analysis y Resultados sobre la Perpectiva y Marco de Discapacidad en El Sistema Distrital de Cuidado*, and other sources.

Services and target population.

PwD make up approximately 15% of the population of Latin America and the Caribbean, with higher prevalence at older ages. A subset of this population is PwD with functional dependence, which means assistance is needed from others to perform activities necessary for daily living (WHO 2015). Data from Peru indicates that 40% of PwD require personal assistance. The UNCRPD's social model of disability defines disability as the interaction between a permanent impairment and external barriers. Strictly speaking, individuals without a permanent impairment do not have a disability, even if they have functional limitations for daily living.

Disability-focused caregiving services are in a much more emergent phase in the region than caregiving services for children or older people. Two types of services for people with disabilities with functional dependence are central for integrated caregiving services: personal assistance programs and center-based day programs.[19] These services, along with others provided in the community, should be combined to keep people with disabilities from being institutionalized. [20]

To address the higher costs of PwD with high support needs, countries like Ecuador, Panama, Paraguay, and Peru have provided cash transfers at higher levels than for people without disabilities or people who can function without care. These programs assume that the transfer can be used to hire personal assistant services but do not provide referrals. The impact of these programs on the well-being of caregivers or on people with high support needs has not been evaluated. Uruguay's approach differs in two important ways. First, to support personal assistance for PwD with functional dependence, Uruguay provides a voucher which is part of a broader care system.[21] Second, the transfer is paid directly to the personal assistant rather than the PwD [22] and can be used to support up to 80 hours a month, depending on the person's

[19] Both should be developed as options that de-institutionalize PwD, a goal emphasized in the CRPD and in national legislation on caregiving in some countries.

[20] While we do not have good measures of the number of children and adults with disabilities living in institutions, reports to the CRPD find many such institutions in the regions, with individuals with physical or other disabilities who have been denied the opportunity to live in the community. Economic arguments are often used to justify this institutionalization.

[21] The 2010 Law 18651 for the Protection of Persons with Disabilities establishes the right to personal assistants of people with severe disabilities and requires that personal assistants be certified. This legal commitment is enforced through the broader program described in the long-term care section.

[22] In many of disability transfer programs, cash is transferred directly into the bank accounts of family members, infringing the rights of PwD to direct the use of these resources for their own care.

needs. In Costa Rica, the program *Promoción de la Autonomía Personal de las Personas con Discapacidad* targets PwD with high support needs, providing access to a personal assistant and emphasizing the legal capacity of PwD to make decisions about their own care. The disability agency assesses support needs, designs an individual support plan, and provides monetary resources to hire a personal assistant to ensure independent living. In 2022, the budget was approximately $US1.1 million, and there were 179 beneficiaries (FODESAF 2022). In contrast to the Uruguayan program, there is no limit to the number of hours of personal assistance that beneficiaries can receive. However, scaling up this program beyond 200 beneficiaries has proved challenging.

Governments, NGOs and the private sector also provide center-based day programs. Chile, Colombia, Costa Rica, Ecuador, and Uruguay are among the countries with day programs, which often combine rehabilitation, recreation, and training for PwD. These programs give unpaid caregivers the opportunity to do errands, work, or pursue other interests outside the day center. However, accessible transportation is often an obstacle. Some metro and bus routes may be largely accessible, but the challenge of transportation to and from the bus/metro station may keep some families with limited income from using day services. Another challenge with this modality is the segregation of PwD at most centers, which is highly discouraged by international legal frameworks.[23]

Personal assistance and day centers form part of a broader network of policies for inclusion in areas beyond care that together promote the autonomy of people with disabilities, and, in doing so, can also have important effects on the distribution of caregiving within families. In other words, to achieve maximum impact on both caregivers and PwD, a caregiving system with a disability focus should emphasize the cross-cutting nature of accessibility and inclusion in the inventory of programs and services provided by government, NGOs, and the private sector. Higher levels of inclusion of PwD with high support needs in schools, training programs, and the workforce lessens the need for unpaid care at home and increases the autonomy and independence of PwD.

[23] According to the CRPD and other treaties, children with disabilities should attend school alongside children without disabilities. Day centers should not be used as an alternative to mainstreaming children with disabilities in an inclusive educational environment.

Human resources. Caregivers face some common challenges, such as very low or no pay and the feminization of the paid and unpaid workforce.[24] However, training for a corps of respite care workers must address certain topics to equip them to appropriately support people with disabilities either in private homes or in day centers. The first is concepts and statutes specific to disability. The second is the interaction between caregivers and people with disabilities.[25] A paid personal assistant can become dependent on the earnings, which can place the PwD in a position of co-dependency. Finally, whether paid or unpaid, the caregiver is often involved in very private and intimate matters, which can place PwD at risk of physical or financial exploitation. Along with training and certification programs for respite and other caregivers, it is important to promote an overall awareness of concepts of autonomy and self-determination, including with family members.

Setting and supervising quality standards. Establishing and monitoring standards for personal assistants and day programs is a major area for improvement. Quality standards should cover training and certification for personal assistants and processes to monitor the care beneficiaries receive. While most personal assistance programs in the region do not focus on monitoring, the program Bono Joaquín Gallegos Lara in Ecuador has incorporated important elements. In this program, social workers accompany families and visit at least once a year to monitor whether family caregiver are fulfilling their co-responsibilities, which include completing training and providing required personal support (Acuerdo Ministerial N. 00043). If the monitoring finds that caregivers are not meeting standards for food and hygiene, they may be recommended for training or replaced. Approximately 21,000 people were registered as part of the program in 2023.

To receive government support for meals or services, most countries require adult day centers to be licensed and approved by local or national authorities. Licensing typically involves requirements for indoor space, staff training, and record-keeping systems. Requirements related to devices to support PwD, such as visual and auditory emergency alarms or evacuation chairs, vary by country. Some countries provide specific benefits, such as rehabilitation

[24] The task of caring for family members with functional dependence may fall disproportionately to school-age daughters in households with members with disabilities, potentially impacting their studies or transition into the workforce. The relationship between gender and disability status changes with age. While women are more likely to have a disability among people over age 25, males have a higher rate of disability among children and youth.

[25] Third parties will often interact with the personal assistant and ignore the person with disabilities. The personal assistant should understand their role and facilitate the self-determination of the PwD.

services or aids, to PwD with high support needs. It is neither necessary nor ideal for a day center to be segregated, serving PwD only.

We need more information about the characteristics of people with disabilities living in residential care facilities in the region. In most countries, these institutions are not included in censuses or other surveys. Their conditions are not systematically monitored, in part because many are run by non-governmental organizations. Reports on specific institutions in the region revealed abusive conditions, as well as a lack of specific mechanisms to appeal involuntary commitments in institutions (Human Rights Watch 2018, Giraldo-Rodríguez, Rosas-Carrasco, & Mino-León 2015).

The IDB's work on inclusion for PwD

- In addition to mainstreaming disability inclusion in more than 100 loans across all sectors of the IDB in the past few years, three loan operations have had components related to personal assistance for people with disabilities (Ecuador, Panama, and Uruguay), and the IDB has supported assessments of innovative practices for incorporating a disability perspective into caregiving systems in Bogota, Colombia (Parra).

- A programmatic policy based loan (PBP) in Guyana aims to better protect vulnerable populations by building the efficiency of the Ministry of Human Services and Social Security (MHSSS) in managing the safety net and promoting gender empowerment. The loan addresses several challenges for the MHSSS, including the empowerment of PwD. The direct investment in diversity aims to expand the coverage of the Public Assistance program and provide training through the Learning Lab that provides training to PwD with physical and/or sensory disabilities. In turn, this will boost their employability, adaptive living skills, and general quality of life.

4 Caring for paid and unpaid caregivers

Objective and target population. Care systems also aim to support and bring together policies and services that promote decent working conditions for caregivers by recognizing care as work, redistributing unpaid care work between men and women in a more balanced manner, reducing women's responsibility in providing unpaid care work, rewarding and remunerating the care workforce, and granting care workers representation in collective bargaining (Addati, Cattaneo, and Valarino, 2018). Both unpaid workers who provide care or support to individuals within their household or community and paid care workers, including domestic workers who do care work, are important target populations for care systems.

Services. Services for this group mainly target unpaid workers who care for children, older people, and people with disabilities. Respite services provide temporary relief to unpaid caregivers, allowing them to attend to personal needs. Respite care can refer to a wide range of interventions that temporarily ease the responsibility of care. Often, the objective of these breaks is to increase or restore a caregiver's ability

to bear their load (Van Exel et al., 2006). The most common forms of respite care include daycare services, in-home respite, and institutional respite. An important element of respite care is its length. Some services offer short stays (such as daycare services), while others cover longer periods of time (vacation breaks for caregivers, emergency care, etc.). Both the duration and frequency of respite breaks are relevant when assessing their importance for caregivers and care recipients. Some countries offer more diversified "packages" of support (combining both short and long-term breaks) to better meet caregiver needs. Respite breaks can be provided in various settings, such as community centers, and by family, friends, or providers (e.g., nurses or paid caregivers). Examples of integrated systems that provide respite services for caregivers can are the "Programa Maior Cuidado," in the Brazilian city of Belo Horizonte, and the "Manzanas de Cuidado," in Bogotá, Colombia [26] (IDB, 2022).

Policies. Some countries provide a cash transfer in lieu of a package of services. While this supports consumption and thus the wellbeing of care-dependent people, it can perpetuate a situation in which the responsibility of care falls to families, especially their female members. It is therefore not considered good practice (IDB, 2019). By contrast, in some countries, family caregiving is guided by rules that empower the care-dependent person (who self-directs the choice of the caregiver) and formalize the care work relationship through a contract and participation in social security. With these elements in place, such schemes become a good practice (IDB, 2023).[27]

Integrated care systems can also help other agencies design policies for redistributing care responsibilities within society, such as parental and family leaves. These leave arrangements can help distribute care duties in a more balanced way among working parents. Maternity leave ensures that mothers can take time off for childbirth and still return to their jobs, which protects their health and the newborn's well-being. Similarly, paternity leave offers fathers job-protected time to bond with their newborns. Additionally, parental leave can be shared between both parents, encouraging their active involvement in caregiving. However, isolated extensions of maternity leave beyond ILO recommendations or the unbalanced use of parental leave

[26] This program provides care services to give traditional family caretakers time to complete secondary education or take an entrepreneurship course. The initiative also uses courses and workshops to promote male involvement in care activities.

[27] As mentioned in the section on long-term care, this experience is known as "Cash and Counseling" in the United States.

by women can negatively impact women's employment prospects (Tamm, 2018; Patnaik, 2019; Machado and Pinho Neto, 2016; Faundez, 2019;[28] Olivetti and Petrongolo, 2017, Monserrat, et al., 2024)[29]

Another example of complimentary policies promoted by other agencies are flexible work arrangements. Flexible work arrangements allow workers with care responsibilities at home to adjust their work hours (e.g., part-time), work schedules (e.g., flextime), and place of work (e.g., remote work or telework). Flexible work arrangements can only prompt a change in social norms related to care roles if both men and women across industries, sectors, and occupations are encouraged to use them.[30] These arrangements can also be a way to reduce the child penalty.[31] Goldin (2014) suggests that a factor that does impact gender gaps is labor market structure, especially jobs' temporal flexibility and family-friendliness. The main limitation of such policies is that they are exclusive to workers under formal work arrangements. This is a particular concern for Latin America and the Caribbean, since 47% of workers in the region are informal (OIT, 2022).[32] For this reason, the region needs to come up with other policy solutions to actively promote changes in social norms and incentivize a more balanced distribution of care responsibilities within families, firms, and communities.

Through its institutional framework, a care system can also support labor agencies in the political discussion about decent work for care workers, especially about valuing paid domestic work, a field in which women are overrepresented.[33] The IDB policy

[28] Faundez, L. (2019). *Impact of Chilean Maternity Leave Expansion on Female Labor Market Outcomes & Gender Discrimination.* Working paper presented at the 2019 Annual Meeting of the Population Association of America.

[29] A recent study explores data on family leave for 15 Latin American and Caribbean countries from 2000 to 2019 and finds that in countries with more traditional views about gender and less generous initial leave policies, extending leaves improved female employment, while in countries with more egalitarian views, employment participation was not affected but gender gaps in earnings declined (Galván et al. 2022). This evidence differs from results from Austria that suggest that parental leave policies have limited impact on reducing the motherhood penalty due to the persistence of gender norms (Kleven et al., 2020).

[30] When uptake of flexible work arrangements differs by gender, these arrangements can inadvertently reinforce gender roles and keep women from attaining high-level jobs, pay raises, and professional development (Berniell et al., 2021; Arntz, Gregory, and Zierahn, 2016).

[31] In Latin America and the Caribbean, women are more likely than men to be employed in part-time jobs and use home-based work arrangements. In 2019, 30% of women in 19 Latin American and Caribbean countries aged 25–64 worked part time (less than 30 hours a week). Only 13% of men worked part time. Women also worked from home in greater numbers than men. In Ecuador, 17.1% of women worked from home, while only 5.3% of men did. Gender gaps are more significant in part-time and home-based work for men and women who have children younger than 13 than among those with older or no children (IDB Harmonized Surveys, 2022).

[32] Informalemployment rates vary from 26.1% (Chile) to 81.5% (Bolivia) according to the ILO (2022)

[33] Paid domestic labor plays a key role in the economy because it replaces unpaid labor and facilitates women's access to the labor market. International evidence indicates that domestic workers do care work and chores that would otherwise be unpaid. This substitution effect enables many women who were outside the labor market or only worked a few hours a week to change their time use patterns by increasing the hours they spend on paid work and reducing those spent on care (IDB, 2023).

brief Public Policies for Unlocking the Value of Paid Domestic Labor in Latin America and the Caribbean describes the potential for action on this issue.[34] Promoting formal employment is the most important step, since labor informality in this sector is twice the average for other workers in the region (IDB, 2023). Additionally, there is evidence that caregiving tasks will be more demanding in the future (IDB, 2019), which provides an opportunity to add value to the care tasks that the region's domestic workers currently perform. Training courses and certifications could improve the type of work performed by these workers, leading to better income, higher formal employment rates, and better job prospects.

Other initiatives focused on social norms. Finally, a care system may also use communication to promote cultural change so that men and women share caregiving duties equally. Example activities include campaigns to raise awareness about the right to care and about social and gender co-responsibility, training on care with a gender-balanced perspective, and local awareness-raising on social and gender co-responsibility in care. Another example is interventions that work with parents to promote early childhood development (parenting programs), which aim to improve childrearing and caregiving practices. Through individual home visits, group sessions, or a combination of both, these programs teach parents how to facilitate learning through play and enhance the quality of adult-child interactions in the early years of life. Parenting programs often target a child's main caregiver, so they mainly work with mothers. However, there have been initiatives to engage fathers in this type of intervention to promote their involvement in caring for their children.

The IDB's work on care, unpaid workers, and gender norms. The IDB supports countries with technical cooperation and loans to design care systems with a gender perspective. Examples include:

[34] Paid

- In Uruguay, the the bank is financing the Program to Support the National Integrated Care System (SNIC), which aims to improve service access and quality for care-dependent people. Specifically, the loan supports institutional strengthening for the SNIC and the expansion of quality care services for children under age 3. The program designed and supported the implementation of the Positive Parenting Program, which teaches parents, mothers, and/or family caregivers how to develop and strengthen their caregiving skills. Since few interventions of this type include male parents and the few promising programs that exist in the region have not yet been rigorously evaluated, this program has high potential as an innovation and source of evidence in this field. The program will foster a critical examination of beliefs and behaviors about parenting, caregiving, and gender socialization. It will also provide information and an opportunity to practice skills in communication, conflict resolution, and equitable and non-violent relationships. The program also finances construction of 50 new child and family care facilities (CAIF) throughout the country, prioritizing neighborhoods with the highest concentration of children under age three from vulnerable households that currently lack adequate service coverage.

- Through technical cooperation in Colombia and Peru, the IDB supports the development and implementation, respectively, of integrated care systems. The IDB also supported the program Manzanas de Cuidado, in Colombia. "Manzanas de Cuidado" are one of the operational forms of the District Care System, centralizing infrastructure and services to provide close, convenient and simultaneous assistance to caregivers and their families. At "Manzanas de Cuidado," caregivers have time and free services to study, find employment, develop a business, rest, exercise, receive legal and psychological advice, and wash their own or their family's clothes in community laundries. While they are using these services, the people they care for are tended to in spaces where their abilities can be developed (Bogotá, 2024).

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