

# CARE AS ESSENTIAL INFRASTRUCTURE

DEFINITIONS OF AND DEBATES ON CARE INFRASTRUCTURE FROM KENYA, MEXICO, PERU, THE PHILIPPINES, THE UNITED STATES, AND ZIMBABWE



Drawing on six case studies (Kenya, Mexico, Peru, the Philippines, the United States, and Zimbabwe), this paper explores the definitions, debates, and demands related to the concept of care infrastructure. The paper finds the following components of care infrastructure across the case studies: care-supporting physical infrastructure, knowledge production, community networks, national care frameworks and public financing, social protection, and public care services, programs, and regulations. It examines the role of the state in supporting and investing in care infrastructure and in advancing care as a right or care as a public good.

## Oxfam Discussion Papers

Oxfam Discussion Papers are written to contribute to public debate and to invite feedback on development and humanitarian policy issues. They are “work in progress” documents, and do not necessarily constitute final publications or reflect Oxfam policy positions. The views and recommendations expressed are those of the author and not necessarily those of Oxfam.

**Lead authors:** Sara Duvisac and María del Rosario Castro Bernardini

**Contributing authors:** Mansi Anand, Charlotte Friar, Ana Heatley Tejada, Riva Jilpa, Regis Mtutu, Aprille Grace Nazaret, Carolina Oviedo, Nana Ouko, Leah Payud, and Rebecca Rewald

This discussion paper draws on the following case studies and briefs:

- Collaborative Centre for Gender and Development (CCGD). (2022). “Care Infrastructure in Kenya: Study Report.” Internal document. Nairobi: Oxfam Kenya.
- R. Jalipa. (Forthcoming 2024). *Oxfam Care Infrastructure: A Kenya Case Study Policy Brief*. Nairobi: Oxfam Kenya.
- H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). “State, Public Policy and Care: A Methodology for the Analysis of State Policy on Care.” *International Journal of Care and Caring*, 1–16. <https://doi.org/10.1332/239788221X16890895484088>
- J. Angelo, E. Bata, and M.S. Quiogue (2023). *Care Is Essential Infrastructure: The Case of the Philippines*. Quezon City: Oxfam Pilipinas and Fieldwork PH. <https://oxfam.org.ph/download/care-is-essential-infrastructure-the-case-of-the-philippines/>
- Oxfam Pilipinas (2023). *Care Is Essential Infrastructure: The Case of the Philippines*. Research Brief. Quezon City: Oxfam Pilipinas.
- L. Cuba , E. Goñez , and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria: estudio de caso del Comité Comunitario Anti-COVID-19 de Santa Rosa de Comas (Lima, Perú)*. Lima: Oxfam Perú and Chakakuna. <https://peru.oxfam.org/lo-%C3%BAltimo/publicaciones/infraestructuras-de-cuidados-y-salud-comunitaria-de-santa-rosa-de-comas>
- L. Cuba Vargas, E. Goñez Fernández, F. Encalada Yong, C. Oviedo, and C. Navarro Lopez. (2024). *Santa Rosa de Comas y la crisis de cuidados: Aprendizajes desde la organización comunitaria durante la pandemia de COVID-19*. Brief. Lima: Oxfam in Peru. <https://peru.oxfam.org/lo-%C3%BAltimo/publicaciones/brief-santa-rosa-de-comas-y-la-crisis-de-cuidados>
- R. Rewald and L. Pascarella. (2022). “United States: Debates and Discussion around Care during COVID-19.” Internal document. Boston: Oxfam America.
- C. Dziva. (2022). “Understanding Care Infrastructure by Civil Society Groups in Rural Areas and Government Actors in Zimbabwe.” Internal document. Harare: Oxfam in Zimbabwe.

# ACKNOWLEDGMENTS

The authors express their deepest gratitude for the numerous study participants, Oxfam partners, and organizations in Kenya, Mexico, Peru, the Philippines, the United States, and Zimbabwe, who provided their knowledge and time to inform and support the data collection for the case studies. This research would not have been possible without their valuable insights.

The authors would like to thank Oxfam colleagues across the Oxfam confederation who guided and supported the development of this research project, the development of the case studies, and provided comments: Alejandra Benítez Silva, Blandina Bobson, Randee Cabaces, Paige Castellanos, Nathan Coplin, Nick Galasso, Estefanie Hechenberger, Max Lawson, Cleto Manjova, Cinthia Navarro, Kimberly Pfeifer, Tania Ramirez Farias, Alivelu Ramisetty, Luz Rodea, Stephanie Smith, Shreya Subedi, and Anjela Taneja. The authors are also grateful for the administrative and logistical support provided by colleagues from Oxfam Kenya, Oxfam Mexico, Oxfam in Peru, Oxfam Pilipinas, Oxfam in Zimbabwe, and Oxfam America. Finally, the authors thank the colleagues at the WE-Care Initiative and Oxfam LAC Care Board. The authors would like to give special thanks to the editor of this piece, Namalie Jayasinghe, and to the peer reviewers Blandina Bobson, Rosianette Cadayong-Caalim, Nancy Folbre, Thalia Kidder, Charity Namara, Nasheli Noriega, Ruth Oloo, Verónica Paz, and Sarah Tuckey.

For more information or to comment on this paper, email [sara.duvisac@oxfam.org](mailto:sara.duvisac@oxfam.org) or [rosario.castro@oxfam.org](mailto:rosario.castro@oxfam.org).

# CONTENTS

|                                                       |    |
|-------------------------------------------------------|----|
| EXECUTIVE SUMMARY                                     | 5  |
| 1 INTRODUCTION                                        | 7  |
| 2 FRAMEWORK AND LITERATURE REVIEW                     | 10 |
| 3 RESEARCH OBJECTIVES AND METHODOLOGIES               | 16 |
| 4 FINDINGS FROM THE CASE STUDIES                      | 19 |
| 5 CONCLUSIONS AND KEY LESSONS                         | 41 |
| 6 APPENDIX A. CASE STUDY OBJECTIVES AND METHODOLOGIES | 45 |
| 7 APPENDIX B. CASE STUDY SUMMARIES                    | 44 |
| ENDNOTES                                              | 66 |

# EXECUTIVE SUMMARY

Care work is central to our collective and individual well-being and to the functioning of our economies. This work, however, is often not valued, and responsibility for carrying out paid, unpaid, and underpaid care work falls largely on women and girls, creating a heavy and unequal gender distribution of care work and leading to economic and social inequalities.

Advocates have called for

- **reducing, redistributing, and recognizing** unpaid care work,
- ensuring that paid and unpaid care workers are **represented**, and
- **rewarding** paid care workers equitably for their labor.

A variety of approaches can be used to achieve these goals. This paper explores some approaches to the transformation of care by looking at care infrastructure. It examines the definitions, debates, and demands from various social actors related to the concept of care infrastructure across six countries in which Oxfam has ongoing work on care: Kenya, Mexico, Peru, the Philippines, the United States, and Zimbabwe.

Broadly speaking, care infrastructure refers to the network of resources, services, and systems that are available to meet the care needs of people (with special priority to children, elderly people, people with disabilities, and sick people), including those who provide care themselves. The paper finds no singular approach to care infrastructure across the case studies but identifies six components that can constitute care infrastructure:

1. care-supporting physical infrastructure;
2. community networks;
3. care-related knowledge production, including social norms;
4. care regulatory frameworks and public investments;
5. social protection policies; and
6. public care services, programs, and regulations.

These components of care infrastructure can look different from country to country, based on country-specific factors, including time use related to care, national laws and legal frameworks, and civil society and community mobilization. The existence of different approaches to care infrastructure, even between different stakeholders within countries, highlights the need to consider the local context of any intervention related to care.

The paper also examines the responsibilities of different social actors (communities, civil society, the state, and the private sector) to support care infrastructure, with a focus on the role of the state. Across regions there are significant ongoing debates about the responsibilities of the state, which can be categorized into two frameworks: (1) the state and care as a right; and (2) the state and care as a public good. Under the framework of care as a right, states recognize a legal obligation to guarantee that people can receive and give care with dignity. They accept the need to establish well-funded national care systems that recognize the right of care as an integral component of all public policies and that address the unequal gender division of care work in an intersectional manner. Under the care as a public good framework, states recognize the vital role of care in our societies, economies, and well-being by developing strong care-related public policies with robust public investments, but they do not use the language of rights. These two approaches are not mutually exclusive; for example, under care is a right, care is also a public good. Rather, they highlight distinct framings for the state's responsibility for care.

The research has the following overall conclusions:



**States need to expand their co-responsibility for care provision.** In all the case studies, states fall short of fulfilling a vision of care as either a right or a public good. They fail to ensure the high levels of state investment in care infrastructure that would allow them to take their share of responsibility for guaranteeing and supporting the provision of care and for reducing the gendered inequalities in care work.



**Interventions and advocacy by state and non-state actors should recognize and invest in community care networks.** In some regions, community care networks are the ones that supply vital care investments by providing care services, building care-related knowledge to identify care needs and challenge care-related social norms, serving as intermediaries between the state and communities, and redistributing care work. States need to invest in and support community care networks, build their leadership and capacity, and support civil society and community efforts to expand care-related knowledge, make visible their care realities and demands, and challenge social norms related to care. These investments are vital to ensure that community care is sustainable and responds to the community's social practices and needs and that there is equitable gender distribution of labor within community care networks.



**Transforming social norms around care is critical and needs sustained public investment in community and civil society efforts.** Many of the cases highlight how civil society and community efforts to challenge social norms around care play a key role in shifting the inequitable division of care work in the household. Such efforts need to be supported by continued public investment.



**Care-related public policies need to recognize and address the unequal gender distribution of care work.** The unequal gender burden of care work is not always explicitly recognized in care-related public policies, programs, and frameworks, such as women's economic empowerment or social protection policies. If such policies and frameworks, including those related to social protection and gender justice, do not recognize and address the unequal gender distribution of care work, they may entrench these inequalities in care work rather than mitigating them. Moreover, as past Oxfam research demonstrates, universal rather than means-tested social protection policies can better address gender inequalities and ensure a gender-transformative approach to tackling the unequal gender distribution of care work.

# 1 INTRODUCTION

It is well established that care work is central to the well-being of societies and the functioning of economies and that, globally, it is disproportionately women and girls who undertake it. This is especially the case, as Oxfam notes, among “those living in poverty and those from groups that experience social and economic discrimination based on their gender identity, race, ethnicity, nationality, migration status, sexuality, class, and caste.”<sup>1</sup> Undoing the unequal gender distribution of care work (and its harmful intersections with other systems of oppression such as race and class) is critical to tackling social and economic inequalities,<sup>2</sup> reducing poverty, and ensuring overall well-being. One of the most prominent global frameworks for transforming care work is the 5Rs Framework for Decent Work, which calls for unpaid care work to be **reduced**, **redistributed**, and **recognized**, for paid and unpaid care workers to be **represented**, and for paid care workers to be **rewarded** equitably for their labor.<sup>3</sup> To achieve these goals, diverse approaches are being undertaken globally. This paper explores some of the approaches to transforming care in our societies by examining care infrastructure. To do so, it looks at the definitions, debates, and demands of various social actors related to the concept of care infrastructure across six countries in which Oxfam has ongoing work on care: Kenya, Mexico, Peru, the Philippines, the United States, and Zimbabwe.

The COVID-19 pandemic reignited global conversation and debate on the centrality of care work in our societies. Moreover, governments around the world implemented a multiplicity of public interventions and policies to respond to the COVID-19 crisis, reinvigorating debates about the role of the state vis-à-vis care work.<sup>4</sup> Across countries there is significant variation in the framing of care-related policies and interventions, in the role of the state, and in approaches to undoing the unequal gender distribution of care work.

In the context of the COVID-19 pandemic, one framing articulated in the US by civil society actors and some national political leaders was care as essential infrastructure. They argued that care work underpins the functioning of societies and economies, and as such, just as governments view investments in physical infrastructure as long-term investments for the well-being of economies and societies, they should make large public investments in care-supporting policies, initiatives, services, and physical infrastructure.

Put another way, this framing argues that care is a public good that governments must invest in. Pan-African feminists also articulate the need for African governments to invest in care: the Africa Care Economy Index argues that a “socialised, public sector response is crucial to reverse the gendered distribution and extreme undervaluing of caring work normalised in the continent.”<sup>5</sup>

As another example, in countries across Latin America discussions and debates on state responsibilities regarding care have framed care as a right. This framework is highlighted in a number of regional agreements, including the Montevideo Strategy for Implementation of the Gender Regional Agenda (2017) and the commitments through the years of the Economic Commission for Latin America and the Caribbean’s Regional Conferences on Women.<sup>6</sup> Various countries in the region have committed to develop regulatory frameworks to guarantee the right of care through the design and implementation of national integrated care systems from a “gender, intersectional, intercultural, and human rights perspective.”<sup>7</sup> A number of countries (Chile, Colombia, Costa Rica, Dominican Republic, Mexico, Paraguay, Peru, and Uruguay)<sup>8</sup> have developed lines of work with the aim of developing national-level care systems, regulations, and policies. In 2023 the government of Argentina submitted to the Inter-American Court of Human Rights a request for an advisory opinion on recognizing care as a right.<sup>9</sup>

<sup>1</sup> The 5Rs Framework for Decent Work put forth by the ILO builds on Diane Elson’s 3Rs framework: D. Elson. (2017). ‘Recognize, Reduce, and Redistribute Unpaid Care Work: How to Close the Gender Gap.’ *New Labor Forum*, 26(2): 52–61. <https://journals.sagepub.com/doi/10.1177/1095796017700135>

The diversity of these approaches highlights the ongoing debates, initiatives, and contestations, locally, regionally, and globally, about the core policies, investments, interventions, and systems needed to ensure that care is valued and centered in societies. There is enormous variation both between countries and within countries in how different social actors (the state, the private sector, families, civil society, communities, and the media) conceptualize care and care infrastructure. This paper pulls from the six country case studies to offer a typology or range of possibilities of what can constitute care infrastructure and describes the types of care infrastructure investments being made by the state, communities, civil society, and the private sector.

This research project was developed collaboratively with members of Oxfam offices and affiliates in the six countries where the case studies were conducted, and their inclusion in the study reflects their offices' ongoing engagement around the issues of care. Although the overall research project is grounded in a particular set of research questions, it is important to note that each country's team autonomously defined its own foci in relation to their Oxfam office's programming, advocacy, and priorities related to care. The case studies, thereby, reflect a range of methodological approaches, including literature reviews, policy analysis, and primary data collection based in qualitative research and participatory research methods (primarily interviews and focus groups).

Although the case studies do not all necessarily center on the term "care infrastructure," they do highlight different components of what can constitute care infrastructure. Furthermore, the case studies demonstrate that care infrastructure is intertwined with the social organization of care—that is, how responsibility for and provision of care are distributed and organized among different social actors and stakeholders (such as women, men, families, communities, states, or the private sector). This research does not aim to offer a definitive country-specific approach or understanding of care infrastructure, but it does elucidate the salient components of care infrastructure across regions—a typology of care infrastructure.

**Care infrastructure, broadly, refers to the network of resources, services, and systems that are available to meet the care needs of people (with special priority to children, the elderly, people with disabilities, and sick people), including those who provide care themselves.**

The analysis highlights six components of care infrastructure: (1) care-supporting physical infrastructure; (2) community networks; (3) care-related knowledge production, including social norms; (4) care regulatory frameworks and public investments; (5) social protection policies; and (6) public care services, programs, and regulations. This research finds no singular approach to care infrastructure; what each component of care infrastructure entails can vary from country to country and is determined by country-specific factors, including time use related to care, national laws and legal frameworks, and civil society and community mobilizations. The existence of different approaches to care infrastructure, which might vary even among stakeholders within countries, highlights the need to consider the local context of any intervention related to care.

This paper also examines the responsibilities of different actors (communities, civil society, the state, and the private sector) in relation to care infrastructure, with a focus on the state. In five of the case studies, there are significant ongoing debates about the state's responsibilities in relation to care infrastructure, which can be grouped into two frameworks: (1) the state and care as a right and (2) the state and care as a public good. The case studies of Mexico and Peru ground their analysis in the state's responsibility to guarantee care as a right. Under this framework, states recognize a legal obligation to guarantee that people can receive and give care with dignity and to establish well-funded national care systems that recognize the right to care as an integral component of all public policies, ensuring that the unequal gender division of care is addressed in an intersectional manner. We categorize the case studies of Kenya, the Philippines, and the US under the framework of care as a public good. In this framework, states recognize the vital role of care in societies, economies, and well-being by developing strong care-related public policies with robust public investments, but they do not use the language of rights. These two approaches are not mutually exclusive; when care

is understood as a right, for example, it is also a public good. Rather, the two approaches highlight distinct framings for the state's responsibility for care.

This research shows that public investments across the case study countries are insufficient to ensure that states can take their share of responsibility in guaranteeing, carrying out, and supporting the provision of care and reducing the gendered inequalities in care work. At the same time, three of the case studies highlight the ways in which communities and civil society are investing in and supporting care provision. States need to invest in and support community care networks, build their leadership and capacity, and support civil society and community efforts to expand care-related knowledge.

Finally, the unequal gender distribution of care work goes unrecognized in care-related public policies, programs, and frameworks, such as women's economic empowerment or social protection policies that are part of care infrastructure. Some of these policies—including social protection, which is vital to tackling economic inequality and poverty—can provide crucial support for caregiving activities. If, however, they do not explicitly recognize the gendered inequalities in care work, they may exacerbate gender inequalities in care work rather than mitigating them. Moreover, as past Oxfam research demonstrates, universal social protection policies work better than means-tested ones to ensure a gender-transformative approach toward tackling the unequal gender distribution of care work.

The rest of this paper is organized as follows: Section 2 gives an overview of current trends and debates around care and care infrastructure within regions and country case studies, including Oxfam's literature. Section 3 presents the research objectives and questions guiding this study and the multicountry study approach used, outlining methods, data, and analysis for each country case study and the overall report. Section 4 describes the findings across the case studies, providing a synthesis analysis. Section 5 presents conclusions and key lessons. Lastly, the appendix includes more detailed information on the methodology and summaries of the case studies.

## 2 FRAMEWORK AND LITERATURE REVIEW

This section provides a brief overview of the existing literature on (1) the definitions of care and care work; (2) the role of care in societies and economies and the shared responsibility for care provision among various social actors; and (3) transformative care agendas and care infrastructure.

### DEFINITIONS OF CARE AND CARE WORK

There are multiple approaches to understanding what constitutes care. Some see care as encompassing activities that support the development and social well-being of people.<sup>10</sup> Others take a broader view, where care encompasses activities for the maintenance and repair of the world,<sup>11</sup> the sustainability of life,<sup>12</sup> and/or the flourishing of life,<sup>13</sup> including people and the planet.<sup>14 15</sup>

In the first approach, care work includes activities that support, assist, or help children and dependent persons in their daily lives. It can also include activities that help adults maintain their well-being in their daily lives, such as cooking, cleaning, and rest. In a multidimensional understanding of care, these needs include not only people's material, physical, and economic needs but also their emotional and psychological needs.<sup>16 17</sup>

Care work activities may involve direct care and face-to-face relationships, such as taking care of children or the ill, or indirect care (or preconditions of care), such as cooking, washing, collecting water or fuel, and supervising childcare while direct care work is being carried out.<sup>18 19</sup> Direct or indirect care and domestic work, including care management, can be targeted toward others, toward self-care, toward objects, or toward the environment.<sup>20 21</sup> Care work can be paid or unpaid. Unpaid care work takes place mainly within the home and is provided to family members, neighbors, or community members through activities related to domestic and care work such as food preparation, cleaning, childbearing, and healthcare.<sup>22 23</sup> Paid care work, as its name indicates, consists of work performed for explicit compensation and includes workers engaged in various economic activities and services as well as domestic workers who perform care work within homes.<sup>24</sup>

Under the second, broader approach to care, care activities are those that create the “political, social, material, and emotional conditions”<sup>25</sup> that allow for life (and sometimes, as expressed at the 2022 Regional Conference on Women in Buenos Aires,<sup>26</sup> for the planet itself) to repair and flourish.<sup>27</sup>

The case studies in this paper, with the exception of Mexico and Peru, use the framing of the first approach to care. In the analysis here, however, all of the case studies focus on care activities related to the well-being of people and do not include care activities related to the repair or flourishing of the planet or nature.

# CARE, THE ECONOMY, AND SOCIETY

## CARE ECONOMY AND SOCIAL REPRODUCTION THEORY

Feminist economists have pointed to the ways in which care work—specifically unpaid care—is central to the market economy despite the historical lack of economic, social, and political recognition of its centrality.<sup>28 29</sup> Such care work can include biological reproduction,<sup>b</sup> education, childcare, elder care, care for the ill, self-care, and the reproduction of labor power.<sup>c 30</sup> The term “care economy” aims to capture this relationship between care work and formal market production and encompasses the sectors that are critical to the provision of unpaid and paid care: childcare, elder care, education, healthcare, and domestic work.<sup>31</sup>

Along these lines, social reproduction theory argues that it is important to recognize the labor required to reproduce the workers that produce the economic activity (that is, the production of commodities) central to the functioning of capitalism.<sup>32</sup> Social reproduction theory takes an expansive approach by arguing that this work includes reproductive labor, emotional labor, and domestic labor, inclusive of childcare, that is necessary for workers to reproduce themselves to engage in paid economic labor. Some social reproduction theorists go further and argue that theory must also include the public services (such as housing and healthcare) that are needed for workers to be able to reproduce themselves and engage in economic labor.<sup>33</sup> Lyn Osesome, drawing on the sub-Saharan context, adds to this framework by arguing that in countries where agricultural production remains central to the economy, women’s reproductive labor includes not only care work but also “non-capitalist forms of production” often tied to their access to land.<sup>34 35</sup>

Feminist economists have also demonstrated how the care provision undertaken primarily by women is often undervalued in social and economic terms; as a consequence, women experience an implicit and at times hidden “reproductive tax,” which can create economic penalties for women over the course of their lives and perpetuate gender and economic inequalities.<sup>36</sup> As Nancy Folbre argues, patriarchal systems continue to emphasize care work as women’s work, and some public policies that aim to support caregivers can entrench patriarchal systems by reinforcing traditional gender roles for care work, thereby failing to mitigate gender economic and social inequalities.<sup>37</sup>

## SOCIAL ORGANIZATION OF CARE

The provision of care should be the shared responsibility (“co-responsibility”) of a number of social actors, and the social organization of care refers to how care is organized, produced, and distributed among interrelated social actors or stakeholders such as the state, the private sector, families, and communities.<sup>38</sup> Similarly, Shahra Razavi uses the term “care diamond” to capture “the architecture through which care is provided.”<sup>39</sup> The points of the diamond consist of families/households, markets (private sector), the state (public sector), and the not-for-profit sector (community, civil society), which encompasses community provision of care and voluntary provision of care.

Feminist scholars in Latin America have developed a framework of the social organization of care, drawing on Razavi’s care diamond, that captures “the dynamic configuration of care services provided by different institutions, and the way in which households and their members benefit from them.”<sup>40</sup> The framework tries to account for the reality that care policies have socially differentiated impacts on families based on their economic status and/or social identity (related, for example, to race, ethnicity, caste, gender identity, disability, or religion).<sup>41</sup>

<sup>b</sup> This includes gestational labor and activities related to childbearing and giving birth; some theorists argue that such labor is care work.

<sup>c</sup> The reproduction of labor power refers to the activities required to ensure that workers have the needed nutrition, rest, shelter, etc., to be able to perform paid labor in the market. For more details, see T. Bhattacharya. (2017). ‘Introduction: Mapping Social Reproduction Theory.’ In T. Bhattacharya, ed., *Social Reproduction Theory: Remapping Class, Recentring Oppression*. London: Pluto Press.

How these actors (families, the private sector, the state, and community/civil society) share responsibility for care provision—that is, the social organization of care—is shaped by factors such as the gender division of labor and traditional gender roles (which traditionally link women with domestic and care work), the levels of heterogeneity in society, socioeconomic inequalities, and how public institutions and policies support or provide care work. In addition, as Razavi<sup>42</sup> argues, demands by social networks and social movements (including trade unions and women’s groups) can shift how responsibility is shared. As argued by Martínez Franzoni,<sup>43</sup> co-responsibility implies equal sharing of responsibilities rather than only aid or support for the responsible agent (most often families and the women within them).

Still, the literature shows that care work across countries remains feminized, with women and girls carrying out most care activities and tasks. In addition, women and girls undertaking care work are primarily from groups that experience discrimination or different forms of socioeconomic stratification based on race, ethnicity, nationality, sexuality, caste, or income. Moreover, paid care work is often carried out by workers in informal jobs.<sup>44 45</sup>

For example, in Latin America, care work is carried out predominately by women and girls, with women doing 70% of all unpaid care work.<sup>46</sup> A 2021 survey by Oxfam in Peru with the Flora Tristán Peruvian Women’s Center found that in 82% of Peruvian households, it is women who assume the largest share of care work. The survey also sheds light on the impacts this division of care work can have on women’s life trajectories: although the pandemic affected the work and educational trajectories of Peruvians in general, women cited care overload as the main reason for stopping employment and education, and women exited work and education more often than men.

Likewise, some estimates indicate that in the African continent as a whole, 70% of care is provided by women within the family.<sup>47</sup> Oxfam in Kenya’s policy brief *Addressing Unpaid Care and Domestic Work for a Gender-Equal and Inclusive Kenya*<sup>48</sup> surveyed time use in one informal settlement in Nairobi. Women reported spending an average of 5 hours a day on primary care, compared with about 1 hour a day reported by men, and an average of 5 hours per day on any care, compared with just 2.9 hours a day for men. This pattern reduced the amount of time women could spend on paid work by about half.

In a 2020 report on the US, Oxfam America and the Institute of Women’s Policy Research found that women spend an extra 2.1 hours a day doing unpaid care work compared with men.<sup>49</sup> Furthermore, during pandemic lockdowns the unequal distribution of care work within the family, where women and girls take more responsibility, continued and increased.<sup>50</sup> This care burden can hinder women’s ability and capacity to fully participate in social, economic, and political spheres.

By the same token a family-oriented social organization of care exempts other social actors, such as the private sector, communities, civil society, and the state, from the responsibility of providing care-related services and infrastructure, and it can discourage the creation of alternatives for the provision of care beyond the ones that families, and women, provide. A 2023 survey in Peru similarly finds that 8 out of 10 respondents identified a woman as the main caregiver in their home throughout the course of their life.<sup>51</sup> The survey also finds that respondents place more trust in the family—that is, women in the family—to provide care, and they see the family as uniquely responsible for its provision (for example, only 1 in 10 respondents thought the state also holds responsibility for the care of children age 5 and younger). Furthermore, the survey reveals that the majority of respondents do not have access to public early education (80%) or public care services for family members with disabilities (60%).<sup>52</sup>

Globally, the public provision of care has been dismal.<sup>d</sup> Until now, women within the family structure have been held responsible for care provision, and the state, the private sector, and communities play at best complementary roles. The private sector affects care provision through multiple pathways: (1) ensuring labor protections for care workers; (2) ensuring workplace protections and rights that

<sup>d</sup> For the African perspective see S. Valiani. [2022]. *The Africa Care Economy Index*. Nairobi: Africa Women’s Development and Communication Network (FEMNET).

support the care work responsibilities of workers, including making contributions to publicly funded social protection or social insurance programs; and (3) providing care services.

Communities also play an important role in supporting care providers and providing care services. For example, Ferreyra (2022) argues that “the experiences of community care are based on the interdependence between people and communities, which goes beyond family or economic ties, [and it] proposes the need for a new paradigm of relationships, which will be oriented to the protection of human beings and nature and to care from the community space.”<sup>53</sup> Community care can also be defined as unpaid work undertaken for those outside of one’s own household, including friends, neighbors, or extended family, because of a sense of “responsibility for the community as a whole.”<sup>54</sup> A number of feminists, scholars, practitioners, and activists have noted the ways in which community care was crucial during the COVID-19 pandemic.

## TRANSFORMATIVE CARE AGENDAS

Various social movements, including the women’s and labor movements, have called for transformative care policies and interventions—those that guarantee human rights, agency, dignity, and the well-being of caregivers and care recipients—to push governments toward increased recognition of care and subsequent investments in care.<sup>55</sup>

### Oxfam and Care

Oxfam advocates for a world where everyone can give and receive care, where everyone has the time and resources to care as well as time and space away from care responsibilities, and where care work appears visible and relevant in policy and economic decision-making.<sup>56</sup> Since 2014, Oxfam’s expansive WE-Care Initiative and its research and advocacy in different countries and regions have highlighted interventions that are critical to promoting transformative care agendas guided by the 4R<sup>e</sup> and 5R frameworks. Oxfam has also developed innovative research frameworks and methodologies to produce context-specific evidence on care work in participating countries.<sup>57 58 59 60 61 62 63</sup> The WE-Care Initiative seeks to advance gender equality to improve women’s well-being and agency, to reduce poverty, and to allow men and boys to benefit from involvement in care. The initiative has highlighted the critical roles played by different stakeholders (such as communities, governments, the private sector, and civil society) to make visible the realities of care as a societal issue and a public good and to challenge social norms around the distribution of care work in society.

The WE-Care Initiative has had a number of on-the-ground impacts. Among other things, it has influenced local government officials in the Philippines to include unpaid care in local budgeting efforts. In Zimbabwe it supported women’s efforts to gain better access to water to reduce care responsibilities. In Kenya it promoted the government’s recognition of care work by supporting the first-ever time-use survey and the development of a national care policy between 2020 and 2023. Currently in its fifth phase, WE-Care is being implemented in Ethiopia, Kenya, Uganda, and Zimbabwe. In addition to its programmatic interventions, WE-Care research methodologies, such as the Rapid Care Analysis and the Household Care Survey, have been used in at least 27 countries.

Alongside the WE-Care Initiative, Oxfam’s research and advocacy have highlighted the core care public policies that are needed to transform how care is received and provided in society and to ensure that care is a public good. For instance, Oxfam’s Care Principles and Barometer argue that care policies are “public policies that allocate resources to recognize, reduce and redistribute unpaid care work in terms of money, services, and time or level of effort invested.”<sup>64</sup> And Oxfam’s Care Policy Scorecard identifies core categories of care public policy: (1) care-supporting physical infrastructure; (2) care services; (3) social protection benefits related to care; (4) care-supporting workplaces; (5) labor protections for paid care workers; (6) workplace environment regulations; (7) migrant care workers’ protections; and (8) right to organize. It has been applied to Canada, Palestine, the Philippines, Puerto Rico, Timor-Leste, and the US.

<sup>e</sup> The 4R framework calls for unpaid care work to be recognized, reduced, redistributed, and for the representation of the “most marginalized caregivers.” Please see Oxfam (2020).

Furthermore, Oxfam’s past research and advocacy have argued that fiscal policies need to support significant state-led interventions and investments to achieve transformative care agendas.<sup>65</sup> These include investments in the policy areas identified in the Oxfam Care Policy Scorecard as well as investments in gender-responsive budgeting and data production and analysis related to care work as part of care-supporting policies.<sup>66</sup> Oxfam has also noted the crucial role international financial institutions (IFIs) play in advocating for transformative care policies to build a gender-just future.<sup>67</sup>

The work on care carried out by different Oxfam offices and affiliates in Latin America and the Caribbean, including the Oxfam Regional Platform for Latin America (Oxfam LAC), has been central to the development of new frameworks within the confederation, such as the understanding of care as a way of sustaining life, community care, and care as a universal right (discussed below). Oxfam in Bolivia’s recent report *Time to Care* notes that care should be considered a universal right and part of a new social contract that recognizes and guarantees care for the entire society.<sup>68</sup>

## Care As a Right

Feminist movements in Latin America and the Caribbean advocate for a transformative care agenda. They call for the recognition of care as a universal right, where the government, the private sector, society, and families share responsibility—or hold co-responsibility—for care. They also call for governments to develop national integrated care systems that recognize the needs and rights of caregivers and care recipients as well as the right to self-care.<sup>69</sup> The regional commitment to this approach advocated by feminist movements, collectives, and civil society is evidenced in a number of formal commitments made at ECLAC’s Regional Conferences on Women. Valeria Esquivel documents the evolution of the recognition of care in these conferences, from the recognition of the social and economic contribution of women’s unpaid care work to social security in the Lima Commitment (2000) to the recognition of care as a right and a public good that “involves the redistribution of care tasks between the government, market, society and men and women” in the 2013 Santo Domingo commitment and the 2017 Montevideo commitment.<sup>70</sup> The 2022 Buenos Aires commitment also recognizes care as a right and the state as the guarantor of this right.<sup>71</sup>

The right to care is often viewed in three dimensions: the right to care, the right to be cared for, and the right to self-care. Laura Pautassi argues that the state, as the bearer of obligations, must guarantee the right to provide and receive quality and universal care, so that care needs throughout one’s life are not met only by families, communities, and the private sector.<sup>72</sup>

At the time of writing this report, the Inter-American Court of Human Rights in Costa Rica was reviewing a request for an advisory opinion on “the right to care and its interrelation with other rights,” which was submitted by the government of Argentina in 2023.<sup>73</sup> As part of this request, Oxfam LAC prepared and submitted a commentary to the court.<sup>74</sup> In the commentary, Oxfam LAC calls for the establishment of a legal framework endorsed by the Inter-American Human Rights System that guarantees the right to care in the three dimensions identified by Pautassi; for understanding the right to care as an autonomous right, as care is essential to a dignified life and to peoples’ development throughout their life cycles; and for the recognition of the right to care in national legislation such that the central responsibility of care does not fall disproportionately on women or solely on families.

Oxfam LAC also reaffirms the need to adopt an intersectional and rights-based approach to reduce gender, racial, and social inequalities.<sup>75</sup> Finally, Oxfam LAC calls for states to guarantee care as a right by adopting a rights-based approach to tax justice and public financing that puts “life is at the center of public decisions”<sup>76</sup> and to allocate “maximum resources” to establish this right.<sup>77</sup>

## CARE INFRASTRUCTURE

Care infrastructure is related to these calls for a transformative care agenda. When care is viewed as integral to society and the economy, states must accordingly invest in policies and initiatives that transform how care is provided and who provides it. One definition of care infrastructure (as presented in the Peru and the Philippines case studies, and first coined by Nancy Folbre<sup>78</sup>) refers to

the network of resources, services, and systems that are available to meet the care needs of people (with special priority to children, the elderly, people with disabilities, and sick people), including those who provide care themselves.<sup>79</sup>

Helen Jarvis distinguishes between hard and soft approaches to care infrastructure. Hard care infrastructure refers to physical or tangible infrastructure and support for care activities.<sup>80</sup> Along these lines, the Oxfam Care Policy Scorecard defines basic care-supporting physical infrastructure as infrastructure that “can reduce the time and intensity of household/domestic care tasks,” such as cooking, cleaning, and washing, and thereby free up women’s time for “studying, engaging in income activities, in civic and political life, and in social and leisure activities.”<sup>81</sup> Care-supporting physical infrastructure can be especially impactful in low-income countries and in low-income and rural communities.<sup>82</sup> Examples include piped water, household electricity, sanitation services and facilities, public transport, and time- and energy-saving equipment<sup>f</sup> and technology.<sup>83</sup>

Soft care infrastructure consists of policies, services, programs, networks, and social practices that help meet the care needs of people, including those who provide care. Examples include social protection, care services, or data for care gender-responsive budgeting. Soft and hard components are interrelated, as some care services and programs also have physical components. For example, some childcare policies call for the construction of physical childcare centers. Past research has shown how cutting social protection and services can negatively impact women and girls and increase their care workloads.<sup>84</sup>

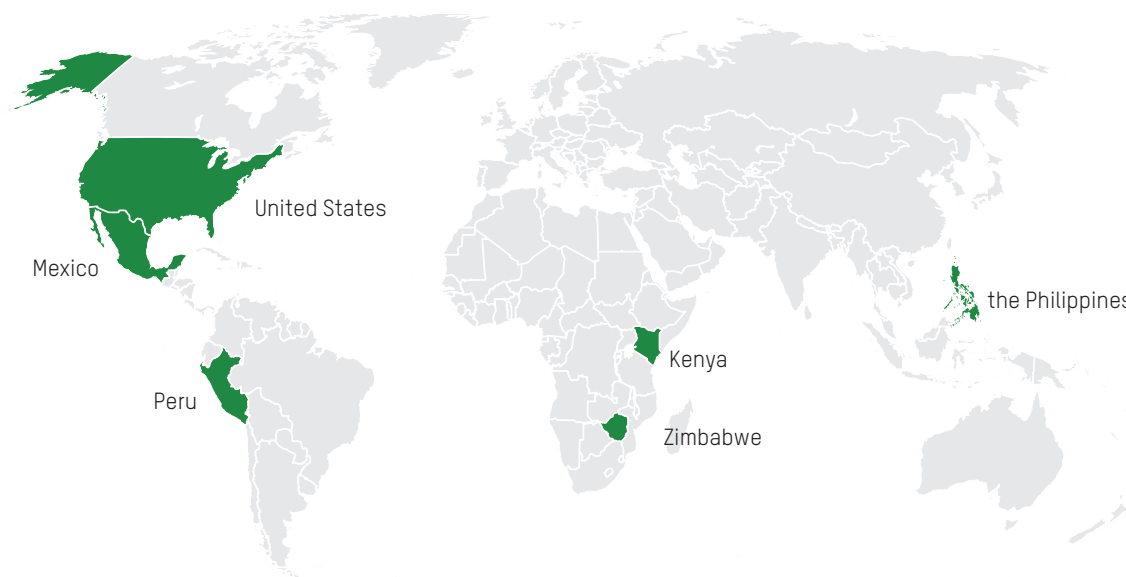
---

<sup>f</sup> Examples provided in the Care Policy Scorecard include “grinding mills, clean-energy cookstoves, washing equipment and machines, dishwashers, gas cylinders, and vacuum cleaners” (p. 39).

# 3 RESEARCH OBJECTIVES AND METHODOLOGIES

## RESEARCH QUESTIONS AND OBJECTIVES

As mentioned in the introduction, this paper aims to explore the current debates and discussions around care infrastructure in different country contexts. It does so by examining the demands, definitions, and investments associated with care infrastructure in six countries: Kenya, Mexico, Peru, the Philippines, the US, and Zimbabwe. Furthermore, some of the case studies examine the ways in which different social actors (the state, civil society, and communities) understand and approach the concept of care infrastructure.



The following questions guided the development of the case studies, though not all case studies sought to answer all questions. Rather, they focused on one or more of the following questions:<sup>9</sup>

**RQ1. What are the definitions of and demands related to care infrastructure within and across different country contexts?**

**RQ 2. What are the areas of common ground and differences across different country contexts explored in question 1? How does this shape a working definition or typology of care infrastructure, demands, and investments?**

**RQ 3. How are investments in care infrastructure connected to broader socioeconomic and macroeconomic policies and broader civil society movements or community initiatives in the different countries analyzed for this paper?**

<sup>9</sup> Initially the research considered a fourth research question: what are some relevant examples of care infrastructure investments that could foster inclusive economic recovery or social and economic restructuring? However, the case studies did not pursue this question as a part of their research focus, particularly given that the case studies find inadequate public investments in care infrastructure.

## METHODS, DATA, AND ANALYTICAL APPROACHES

This research uses a multi-case study approach. The six countries represented in the study all have Oxfam offices and a history of extensive Oxfam care-related programmatic work, such as the WE-Care Initiative,<sup>85</sup> the Oxfam Regional Platform for Latin America (LAC) Care Board, and the Care Policy Scorecard. Their inclusion in the research was based on their interest in participating in the research project and their ongoing programmatic work on care-related issues.

The study team aimed to foster a collaborative process for developing the research process and writing the report. Working collaboratively, the six Oxfam offices formulated the study's research questions, which structured the analysis of the six country case studies. However, each case study's particular thematic focus was developed in relation to its own line of work. As such, the case studies and research sought not only to inform the objectives of this synthesis report but to also meet the programmatic needs of Oxfam offices in the case study countries. The case studies also sought to complement and draw on Oxfam care-related research in their country contexts, namely the WE-Care Initiative and the Care Policy Scorecard. After the initiation of the research, Oxfam colleagues shared preliminary findings of their respective case studies with the research group, which could then benefit from preliminary lessons.

All six case studies drew on qualitative analysis. In addition, some studies conducted primary data collection as well as policy and document reviews, and other case studies focused only on policy, document, and literature reviews. Case studies defined stakeholders as social actors that have a co-responsibility for care and included households/families, communities, civil society, the state, and the private sector. Sources of literature and policy reviews included national and local government laws, policies, guidelines, workplans, monitoring and evaluation frameworks and reports, and media and other reports. The literature review also included previous Oxfam reports, such as national time-use surveys, and the WE-Care methodologies (Rapid Care Analysis and the Household Care Survey). In addition, where relevant, case studies drew on secondary quantitative data on budget and investments.

For case studies engaging in qualitative primary data collection, researchers conducted interviews and focus group discussions. Interviews included national and local government officials and community and civil society leaders. The cases of the Philippines and Zimbabwe interviewed civil society and community actors that are partners in the WE-Care Initiatives, and findings reflect the work of these partners. Some case studies also examine private sector policies and initiatives in relation to care. For more details, please see Appendix A ("Research Objectives and Methodologies").

Given that Oxfam offices and affiliates aimed to develop case studies that would also be impactful for their own lines of work, three of the case studies—for Mexico, Peru, and the Philippines—were published prior to the completion of this synthesis report. The Mexico case study was published as an academic article in the journal *International Journal of Care and Caring*. Preliminary findings of the synthesis report and two case studies were presented by colleagues from Oxfam US, Oxfam in Peru, and Oxfam Philippines at the Third Global Carework Summit held in Costa Rica in 2023.

## STUDY LIMITATIONS

One of the strengths of the research approach—the flexibility of each case study to develop its research focus, scope, and methodological approach—also creates some challenges for comparing the case studies with one another. Some case studies shed light on how different social actors define care infrastructure, whereas other case studies focus on existing policies to understand care infrastructure. For example, the Mexico case study develops a methodology to evaluate whether a state action on care should be considered a care public policy, whereas the Philippines case study

focuses on exploring how different actors (from the community and the state) define and understand care infrastructure and provides an analysis of current national care-related policies. Furthermore, the case studies have different scales of analysis and therefore do not seek to present representative results at the country level. In addition, methodological variations mean that some case studies draw on interviews and focus group discussions whereas others analyze policy documents.

This diversity of thematic, scope, and methodological approaches has allowed us to give meaning to the concept of care infrastructure and to anchor it in a specific country context. However, this inductive design creates challenges for drawing direct comparisons across the case studies. In the synthesis analysis, we have worked to clearly articulate how the respective case studies arrive at their findings when comparing findings across case studies.

The term “care infrastructure” is not necessarily popular in all country contexts, and one of the case studies, Mexico, does not use the term. In some interviews, respondents’ understanding of the term evolved over the course of the interviews. The analysis therefore provides an overview of the different types of interventions, structures, and networks that can be considered part of care infrastructure, but it does not claim to make a case for how popular or salient the framing of care infrastructure is in the country contexts. For example, the Peru case study explores one aspect of care infrastructure by examining a community-led health group, and although the group itself does not use the term “care infrastructure,” the case provides an analysis of specific components that could constitute care infrastructure.

Thus, although the case studies do not offer a nationally representative definition of care infrastructure, they offer typologies of approaches to care infrastructure and reflect debates on its components, shedding light on the concept.

## 4 FINDINGS FROM THE CASE STUDIES

This section explores the findings from the six case studies by comparing (1) the definitions of care and the care stakeholders identified; (2) the demands and definitions related to care infrastructure; (3) the components of care infrastructure; (4) the role of the state in care infrastructure; (5) the relationship between women's economic empowerment and care infrastructure; and (6) investments in care infrastructure.

### DEFINING CARE AND IDENTIFYING CARE STAKEHOLDERS

The six case studies define care work as activities aimed at caring for others that require dedication and time and argue that care work should be valued because of its positive impact at the societal level. At the same time, the case studies all emphasize different forms of care work (see Box 1). For example, the Philippines case study emphasizes both paid and unpaid care work (direct and indirect), the Zimbabwe case study focuses largely on unpaid care work (direct and indirect), and the Peru case study focuses on community care. These differences in the types of care work have implications for the demands and definitions around what constitutes care infrastructure.

#### Box 1. How is care framed in the six country case studies?

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>Kenya:</b> Care is framed as care (unpaid and underpaid, direct and indirect) for children and elderly, sick, and dependent people as well as indirect care work such as domestic work.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|  | <b>Mexico:</b> Care is framed as a way to sustain, repair, and reproduce the life we know. It is a way to inhabit the world, not just particular actions. It implies a practice and a cosmovision about what constitutes care and how care should be.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|  | <b>Peru:</b> Care is framed in the context of community care, understood as meeting the needs of the population through the use of community resources such as collective organization, local ties, practices, and communal knowledge to the fulfilment of life. Community care implies the collaboration and active participation of community members to promote well-being. These activities contribute to central aspects of life such as care for children, the elderly, and the sick; supporting mental illness prevention; nutrition and food management; and disease prevention. <sup>86</sup> The study also sees care as way to “sustain life” through a social responsibility and rights-based approach. |
|  | <b>Philippines:</b> Care is understood as unpaid and underpaid care (direct and indirect) and can encompass meeting basic needs; caring for dependent adults, children, and the sick; and carrying out the daily tasks necessary to sustain life and well-being.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|  | <b>United States:</b> Care is understood as direct and indirect care, within and outside the home, and its contributions to the economy and general well-being of society.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|  | <b>Zimbabwe:</b> Care is viewed as unpaid care work and care and support provided to family or community members (caregiving and domestic chores), including agricultural activities, without recognition or monetary remuneration.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

The case studies identify four main stakeholders in the provision of care in society (see Table 1). For the purposes of this paper, “stakeholders” refers to social actors and institutions that hold co-responsibility for care.

1. All the case studies find that society continues to assign and view families, and **women within families**, as the main providers of care.
2. All the case studies identify the need for **the state** to play a role in care, including by, in some cases, guaranteeing the provision of care and supporting families in giving and receiving care. Some case studies, such as those for Mexico and the US, focus almost exclusively on defining the role of the federal state in guaranteeing the right to care or exploring federal care regulatory frameworks, which include significant public investment.
3. Most of the case studies identify **civil society** as a central actor in supporting the provision of care, in challenging social norms around care work, and in demanding a more active state role in supporting the provision of care and in developing care regulatory frameworks and public investments.
4. Three of the case studies (Peru, Kenya, Zimbabwe) identify the different ways in which **community members and leaders** play a role in carrying out, supporting, or redistributing the provision of care. As the case of Peru explores, communities and their leaders often have to work to fill the gaps in publicly provided care services and serve as bridges between the state and families. They do so by assessing the care realities and needs of communities as well as by channeling collective demands to state representatives and working with the state to implement care-related programs and services in communities.

A few of the case studies also briefly mention but do not focus on three other social actors: the private sector (or markets), the media, and care workers associations. Three of the case studies identify the role of the private sector as providing some care services (related to childcare, healthcare, and elder care); making financial contributions to state social protection programs; protecting the rights of care workers; and ensuring the implementation of care-related regulation (such as parental leave).

All the case studies argue for more equitable distribution of care work not just within the family but among different societal actors. For this reason, although the family is traditionally viewed as the primary stakeholder in the provision of care, when analyzing the concept of care infrastructure, the case studies highlight the need to define the roles of other stakeholders in supporting families and addressing women’s disproportionate provision of care.

**Table 1. Stakeholders identified as holding responsibilities for the provision of care**

| Stakeholders identified                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Kenya</b></p> <p>This case study identifies multiple stakeholders:</p> <ul style="list-style-type: none"> <li>• families, with women mainly responsible;</li> <li>• national government agencies in charge of social protection, social insurance, adult education, daycare services, universal healthcare, healthcare support services, parenting training, legal support, and regulations and policies regarding wages and occupational health of employees;</li> <li>• civil society organizations such as community outreach organizations, community health volunteers, and nongovernmental organizations;</li> <li>• the private sector, as a provider of care services and implementer of care-related employment regulations;</li> <li>• association of care workers; and</li> <li>• the media, as an actor that can shape social norms around care work.</li> </ul> |

### **Mexico**

This case study focuses on the Mexican state, noting that the state should ensure access to public care provision in line with cultural practices, promote principles of justice and equity, and adopt a co-responsibility approach.

### **Peru**

This case study focuses on community organizers (*agentes comunitarios*)—in particular, women community organizers. It examines the role the community played in providing integrated services to meet health, care, and economic needs during the COVID-19 pandemic. The study identifies how community leaders act as a bridge between the state and families.

### **Philippines**

This case study identifies multiple stakeholders:

- families, with women as primary care providers of the family;
- civil society, to fill gaps in government policies, advocate for the valuing of care, and push a care agenda, including investments in care infrastructure;
- the state at the national and local level;
- communities; and
- the private sector, as a provider of care services and as an implementer of care-related regulations such as parental leave.

### **United States**

This case study focuses on the role of the state—specifically the federal government—in supporting public care infrastructure. The case also highlights the differences within the US federal government around the role of the state in care.

Other actors identified in the case study are

- civil society, as an advocate for care as a public good that requires collective and public policy-supported solutions; and
- the private sector, as a provider of care services and an implementer of care-related protections for workers.

### **Zimbabwe**

This case study identifies multiple stakeholders:

- women, as the main unpaid care providers who hold significant care duties and thus experience exclusion and discrimination in the public space;
- civil society and organizations on the ground (WE-Care Initiative) and “Care Champions,” including progressive men who openly perform care work; and
- communities, through cooperative practices such as *Nhimbe* that redistribute care work from women to the community, including men and youth.

Source: Authors’ own elaboration based on six country case studies.

# DEMANDS AND DEFINITIONS RELATED TO CARE INFRASTRUCTURE

The case studies all focus on different dimensions of care infrastructure and present distinct findings on how care infrastructure is defined and framed in their contexts. For example, whereas Mexico and the US cases focus on public policies and care infrastructure, the Peru case focuses on community care. The cases of the Philippines, the US, and Zimbabwe also highlight the significant ongoing debates in those contexts about how to approach and understand care infrastructure. Below we present summaries of the main approaches, definitions, and framings of care infrastructure in each case study.

**Kenya.** In examining care infrastructure, the Kenya case study focuses on public policies—in particular, those related to social protection and care services. The case study argues that the governance of care in Kenya is grounded in the country’s constitution, which stipulates that the government must ensure that minorities and vulnerable and marginalized groups can engage in socioeconomic and political participation and have access to public services. The case study highlights public policies that focus on providing or supporting care services for elderly people, children (particularly orphans and vulnerable children), the sick (including professional healthcare and community-based care), people with disabilities, and forced migrants (refugees, internally displaced persons, and stateless persons). In addition to childcare, healthcare is a significant part of the case study’s assessment of Kenyan public care policies, partly because of Kenya’s history with the HIV/AIDS epidemic and significant public investment in health infrastructure. The case study also highlights care-related regulations designed to protect domestic workers. Interestingly, Kenyan care-related public policies formally recognize the care that extended families and community members provide. The case study highlights the role of community members in providing and supporting care work and the need for public policies to recognize and support this community care.

**Mexico.** The Mexico case study focuses on public care infrastructure or ‘state actions on care’ (that is care public policies, programs, and budgets). State actions on care encompass three aims: “to transform the social organization of care so that its provision is not based in oppressions and inequalities; to constitute a cross-cutting principle of all governmental actions; and to assume the responsibility to guarantee the right to care for others, to be cared for, and to self-care.”<sup>87</sup> Care policies impact “caregiving, the conditions in which people care for each other, and the way in which we understand social relationships.”<sup>88</sup> In addition, an identified state action must have a federal budget allocation to be classified as a part of public care infrastructure. The case study provides a practical tool to identify gaps and novel possibilities for public policy to address care in an integrated way using a care-centric approach with a gender perspective.

**Philippines.** In the Philippines, interview respondents (community, civil society, and state actors) did not identify “care infrastructure” as a salient term. The term prompted “hazy definitions and not always an articulation of how it may differentiate or overlap with social protection and healthcare infrastructure.”<sup>89</sup> Over the course of the interviews, however, respondents began to identify various components of care infrastructure. Based on these interviews and secondary literature, the study defines “care infrastructure” as a “network of structures, frameworks, and systems that enables and supports the delivery, access, and provision of care to a wide segment of the population that is necessary for survival and well-being, particularly to those who have less in life.”<sup>90</sup> These elements of care infrastructure include social norms; high-quality, affordable, and accessible childcare services; healthcare services; long-term care for people with disabilities, the sick, and the old; social insurance and other forms of social protection; and paid medical, parental, and vacation leave. The case study puts forth a typology of care infrastructure: physical care infrastructure, care services, care policies and regulations, employment-related care provision, and norm-reorienting investments.

**Peru.** Care infrastructure in this case study refers to care provided by community organizations and their community organizers. Specifically, the case study examines the role of community organizers and the community Anti-COVID-19 Committee of Santa Rosa (Anti-COVID-19 Committee), which is a subcommittee within the community committee in the urban settlement of Santa Rosa in Comas, Lima. The community organizations serve as a bridge between the state, community members, and families by demanding and providing direct and indirect care in times of crisis such as during the COVID-19 pandemic. The authors of the case study argue that “the community occupies a fundamental place in care infrastructures to improve the quality of life of the population and reduce inequalities in care.”<sup>91</sup> However, if the state does not assume its role as guarantor of the right to care, the community is forced to undertake activities beyond its abilities and under precarious conditions. Furthermore, the activities carried out by the committee do not escape the effects of the gender division of labor, since they are usually carried out by women, whose unpaid work supports the well-being of the community. The community also demands access to care-supporting physical infrastructure—namely, medical equipment and resources and the construction of health center.

**United States.** The US case study examines definitions of care infrastructure articulated by civil society actors and the country’s two main political parties. The civil society definition of care infrastructure from the organization Caring Across Generations articulates a demand for a “national care agenda” that treats care like “a public good that requires collective, public policy-supported solutions.”<sup>92</sup> The focus of civil society advocacy in the US around the national care agenda is to implement public policies that provide universal access to care services, support and protections for paid and unpaid care providers, and universal care benefits. In contrast, one of the two main political parties, the Republican Party, does not see care infrastructure as a public good. The current US president, a member of the Democratic Party, defines care infrastructure as including a state role in providing care (childcare, elderly and dependent care, and child tax credits) and entails a responsibility to pass policies (such as paid leave) that make it easier for people to give and receive care. This expansive approach has not been pursued and funded by state actors in the US outside the context of COVID-19 pandemic.

**Zimbabwe.** Civil society, state, and community actors in Zimbabwe have differing definitions of care infrastructure. Civil society actors define care infrastructure as encompassing physical infrastructure, norms, and practices that support care work. These actors did not initially point to policies and laws as a part of care infrastructure, but over the course of the interviews, urban civil society actors came to identify some policies, such as maternity leave, as a part of care infrastructure. In contrast, state actors focused on defining care infrastructure as care-supporting physical infrastructure that can redistribute or alleviate care work responsibilities. The case study defines care-supporting physical infrastructure as “structures and innovations such as the immovable physical, visible structures and devices that support care delivery work such as obtaining water and sanitation, conducting reproductive chores, and procuring energy as well as the general mental well-being of women.”<sup>93</sup> Community actors interviewed also focused on physical infrastructure, largely because of the importance of this infrastructure to meeting the challenges of daily life. Urban and rural community actors did not initially include policies, knowledge, and initiatives as a part of care infrastructure, but as the interviews went on, they also began to identify practices and community networks and initiatives as a part of care infrastructure.

# COMPONENTS OF CARE INFRASTRUCTURE

The case studies do not identify any one singular approach to care infrastructure, but they do describe overlapping components that taken together offer a typology of care infrastructure. This section explores the common demands, policies, and initiatives that the case studies identify as components of care infrastructure (see Table 2 below for an overview). These components are:



Although these components are presented as distinct entities, they are also often interlinked, as the discussion below will illuminate.

## CARE-SUPPORTING PHYSICAL INFRASTRUCTURE

One of the core components of care infrastructure identified in four of the six case studies (Kenya, Peru, the Philippines, and Zimbabwe) is care-supporting physical infrastructure, such as water infrastructure, roads, mobile clinics, childcare facilities, schools, and community health centers. In the Philippines and Zimbabwe, community and state actors (including both rural and urban respondents in Zimbabwe) understood care infrastructure primarily as care-supporting physical infrastructure. It was only with the prompting of researchers that these respondents discussed other forms of care infrastructure. State actors in Zimbabwe defined care infrastructure as including physical infrastructure that would redistribute care work, particularly the share of care work that women take on.

The types of care-supporting physical infrastructure highlighted in the Kenya, Philippines, and Zimbabwe case studies are tied to the care activities that caregivers, namely women and girls, spend their time on in those contexts. In Zimbabwe, rural community members cited water infrastructure as a critical part of care infrastructure whereas urban community members cited roads, clinics, and schools. Rural community members noted that women spend a significant amount of time collecting water, and water infrastructure such as pipes and water containers can significantly reduce time spent on care activities. Similarly, rural community members highlighted energy stoves, which would reduce the time spent both looking for wood and cooking, as part of care infrastructure. Although rural community actors in Zimbabwe also highlighted the importance of roads, schools, and clinics, interviewees' main focus was on water infrastructure and stoves.

Similarly, the Kenya case study highlights investments in water provision and electricity as core to care infrastructure. In the Philippines, community members highlighted daycare centers, health centers, evacuation centers, farm-to-market roads, community centers (*barangay*) halls, water systems, and streetlights as physical care infrastructure. Again, community respondents focused on physical infrastructure that would reduce the time required to complete care activities. In Peru, given the case study's focus on the Anti-COVID-19 Committee, the community's physical infrastructure demands focused on building and reactivating the community health center post in the wake of the COVID-19 pandemic.



A water tank constructed by MID-P in partnership with Oxfam in Skuma village in Ngaramara, Kenya. March 2023. Photo by Mark Wahwai. ©Eyeris Communications/Oxfam.

In contrast, the US case study highlights a different relationship between physical infrastructure and care infrastructure. In the US, physical infrastructure is not widely seen as directly relevant to people's ability to give and receive care. There is overall agreement among various and even opposing stakeholders about the role of the state in investing in basic physical infrastructure such as roads, electricity, and water systems. At the same time, there is variability in people's access to these infrastructures owing to differences in municipal and state funding for them,<sup>94</sup> and these differences can impact caregiving. However, given the baseline political support for investing in basic physical infrastructure, the case study focuses on the demands around public care services and regulations.

In sum, although there is agreement about the types of basic care-supporting infrastructure needed (such as water, electricity, transport/roads, and clinics), there are variations across regions about the particular infrastructure needed within these broad categories. For example, in Peru the community is focused on the need for a community healthcare center and not clinics in general, as in the Philippines and Zimbabwe. This highlights the need to have data on the local context and care needs relating to care-supporting physical infrastructure.

## COMMUNITY NETWORKS

The findings from Kenya, Peru, the Philippines, and Zimbabwe highlight the vital role played by communities in providing networks, interventions, and services critical to the provision of care and redistribution of care work. In Peru, a community organization and network provide vital care services; in Zimbabwe, community practices play an important role in redistributing and sharing care work; and in Kenya, state policies formalize the role that community members play in providing and supporting care activities.

The Peru case study, focusing on the Anti-COVID-19 Committee in the community of Santa Rosa in Lima, explores the critical role that community organizing and networks can play in supporting and providing care. With the collapse of the limited existing public health services in the wake of COVID-19, community organizers in Santa Rosa reactivated the community's health committee to develop networks of support and care management to confront the health crisis. Among other things, the committee delivered care baskets to families, supported members who were facing loss of income or housing, supported the sale of basic food items at low prices, distributed oximeters, and

initiated a mental health campaign. The committee also worked to slow the spread of COVID-19 and supported national vaccination campaigns. These activities not only met families' critical care needs but also strengthened the social fabric of the community.

Community organizing and networks in the Peru case play a unique role compared with the examples in the Kenya and Zimbabwe cases in that they were also vital in identifying the health needs of the community during and after the pandemic. The committee bridged the gap between the state and the community by making the community's needs visible and by calling for state action; they demanded access to tests, organized testing in the community, demanded access to vaccines, and helped the state organize vaccination campaigns.

**Community organizing and networks can thus play an integral and vital role in reducing inequalities in providing and receiving care.**



Janet Fuentes talks about the Anti-COVID-19 Committee she leads in her community. The group is walking through the community talking about the situation with the neighbors. Lima, Peru. December, 2021. ©Miguel Villalobos/Oxfam

Similarly, the Kenya case study highlights the role played by community members and community health volunteers in the provision of care services. The Kenya Community Health Policy 2020–2030 recognizes “nurturing care,” defined as the environment created by caregivers, as an important component of community health. The policy mentions community health volunteers and other personnel as having a significant role in ensuring that children in communities receive nurturing care, get playful opportunities to learn, and are protected from any form of harm<sup>h</sup>—with the government linking childcare and healthcare and investing in the training of healthcare volunteers, preschool teachers, and healthcare workers on “nurturing care.” Through its Alternative Care Guidelines, the Kenyan government also recognizes alternatives to the nuclear family structure, such as kinship care and child-headed households.

The Zimbabwe case offers a slightly different example, showing how community networks can use cooperatives and the practice of *Nhimbe* to redistribute care activities among community members rather than providing care services or linking community care needs to the state. *Nhimbe* refers to a practice where community members work together to harvest crops. The sharing of agricultural labor

<sup>h</sup> The idea of nurturing care has been adopted by numerous counties throughout Kenya. One county, Siaya County, implemented a nurturing care framework in 23 of 213 health facilities in 2013. In 2018 this was scaled up, and in 2020 the county government launched the Nurturing Care for ECD Strategic Plan (2020–2025) and anchored the Nurturing Care for Early Childhood Development in the 2020 Siaya County Health Act. As a part of this program, the county trained frontline healthcare workers, community health volunteers, and preschool teachers.

has an impact on women's care work as women contribute between 60% and 70% of agricultural labor. Study participants in two rural areas (Bubi and Zvishavane) use *Nhimbe* and cooperatives to redistribute unpaid care work from women to men and youth in the community. The cooperatives, which are also primarily in rural areas, provide assistance specifically to women to complete unpaid care tasks.

The Philippines case study highlights a similar practice of *dagyaw*, or *dayum*, as a form of community-led care infrastructure.<sup>95</sup> Here community members provide labor for other community members when needed, pool financial resources to help meet hospital or burial expenses, or provide crops or food items when community members are in need. Community members in WE-Care Program areas identified this form of community care, but members in non-WE-Care areas did not. Unlike *Nhimbe*, the practice in the Philippines does not necessarily imply a gender redistribution of care work.

Both the Peru and Kenya case studies, in different ways, highlight the importance of state investments in and support for community care. In Peru, the leaders and members of the health committee provide community care while their own care workloads remain unaddressed. During the pandemic, women leaders' care work for their fellow community members increased, leaving them with little time for their own self-care. Moreover, the gendered division of care work persists: the leaders and members of the committee are women, who are providing unpaid care work for the community. The case study highlights the need for young people to assume leadership tasks and positions as well as to be willing to learn from the experiences of other community leaders in order to make these efforts sustainable. This inequality and precarity in the provision of care is exacerbated by the absence of the state in fulfilling its duties in protecting care as a right. The long tradition of community organizing and leadership in the country in general, and in the community of Santa Rosa in particular, fills gaps left by the state.

The Kenya case study also finds that the state must do more to support community care. Despite the existence of national policy that recognizes community health workers and national care guidelines that recognize kinship ties in care provision, this recognition has not been adopted across national policy frameworks, and the state does not ensure that it is monitored or enforced. Furthermore, these public policies do not do enough to recognize the gender inequality in the provision of care by community members. As in Peru, community care work in Kenya is taken on predominantly by women. Past research on the role of home-based care workers in sub-Saharan Africa during the HIV/AIDS epidemic found that many national policies were formulated to take advantage of unpaid home-based care, undertaken primarily by women, which created cumulative economic disadvantages for vulnerable women in the long run.<sup>96</sup> Both the Kenya and Peru case studies highlight the need for state support of community care and for public policies to explicitly undo the continued unequal gender distribution of such care or risk further entrenching gender inequalities.

## CARE-RELATED KNOWLEDGE AND SOCIAL NORMS

The case studies of Kenya, the Philippines, and Zimbabwe highlight how knowledge around care work can lead to shifts in care-related social norms as well as in the distribution of care work duties within the household. They also highlight the critical role played by civil society and communities in challenging social norms around care work. In the Philippines and Zimbabwe, Oxfam's WE-Care programming on challenging social norms around care work has been implemented with Oxfam partners. Oxfam's evaluation of WE-Care programs in the Philippines and Zimbabwe found that efforts to increase people's knowledge about care and to challenge social norms around care have helped undo some of the unequal gender distribution of care work in households.<sup>97</sup>

**Community and civil society respondents in Zimbabwe noted that initiatives that increase people's understanding of how care work is distributed in society and that help individuals challenge dominant social norms related to care work are critical parts of care infrastructure.**

In particular, civil society respondents highlighted that Oxfam-supported WE-Care programming, which raised awareness of the role of care work in society, has helped to shift attitudes toward the distribution of care work in the household.

The study identifies a few important initiatives: First, as a part of the WE-Care initiative, an Oxfam partner, Bethany Project, helped train 20 community members to be “Care Champions.” These Care Champions strive to work with communities to explore the gendered dynamics of care work and the importance of sharing care responsibilities between men and women. Study participants from Bethany noted that they have seen measurable changes, with men taking on some care duties in the household. Second, community-based laundry and cooking competitions for men are producing knowledge and shifting social norms in Zimbabwe. These competitions not only get men more comfortable in the kitchen and at the communal laundry facility but also shift women’s attitudes by showing them that men can do these household tasks and show the community that it is not shameful or unmanly to do laundry in public. Third, women community members engaging in income-generating activities as a part of WE-Care programming with Oxfam partners in Zimbabwe have used those funds to invest in the water infrastructure of the community.

The Philippines case study also highlights the importance of using trainings and seminars to shift community norms in regard to unpaid care work. In the WE-Care Program with Oxfam partners in Libungan Torreta in 2019, seminars helped women articulate the importance of their care work and laid the foundation for shifting community practices around the unequal distribution of unpaid care work.

In Kenya, civil society advocacy has been critical to increasing awareness about the role of unpaid care work in society. Civil society has used the media to do this, despite the media’s role in also upholding social norms around women and girls as the main caregivers in society.

Peru offers another example of the importance of knowledge building. Unlike the other case studies, which focus on social norms, the Peru case study explores the role of data. The community health committee started its work by gathering survey data to assess the health, economic, and care impacts of COVID-19 in the community. They then disseminated this knowledge to the media as a means of



A WE-Care Champion prepares a meal for his family in Zvishavane, Zimbabwe. 2019. ©Vin Aranas/Oxfam.

documenting and highlighting the existence of a health emergency in the community and as a strategy to reach out to the Ministry of Health and demand intervention. In this case, increasing and sharing knowledge about care realities and needs were integral to meeting care needs in a context of crisis.

## CARE REGULATORY FRAMEWORKS AND PUBLIC INVESTMENTS

One of the core components of care infrastructure identified directly in the Mexico, Peru, and US case studies and indirectly in the other case studies is the need for a systematic regulatory framework that guarantees and administers care as a right and/or a public good as a part of the national/federal agenda. Furthermore, such systems and frameworks need to be well resourced and funded through public investments.



National conference on “The Future of Care in Mexico,” May 25 and 26, Mexico City. 2023. © Oxfam Mexico.

In Mexico and Peru, this regulatory framework uses a rights-based approach that recognizes the state’s responsibility as a guarantor of the right to care. In contrast to other case studies, the Mexico case study argues that although social protection policies are vital to minimizing social risk, such policies “alone do not suffice as care policies”<sup>98</sup> (this will be further elaborated in the next section), and the state should work toward building a coherent and systematic public approach to care and care interventions. In Peru, although the country has a national framework for the state to guarantee care as a right, the state falls behind on fulfilling this obligation.

The US case study describes an effort to establish a national integrated regulatory framework for care with accompanying public investment. A federal government initiative generated a national debate on the passage of systematic care policies accompanied with large public care-related investments. Care-related civil society actors and one of the main political parties, the Democratic Party, argued that these policies would ensure investment in care as essential national infrastructure—care infrastructure—for the functioning of society. Although the initiative attracted national political opposition and was not passed into law, it highlighted the current demands and initiatives pushing for more integrated national care regulatory frameworks and concomitant public investment in the US.

## SOCIAL PROTECTION POLICIES

Two of the case studies, Kenya and the Philippines, identify social protection policies as a component of care infrastructure. The social protection policies identified in the two cases are cash transfer programs, national health insurance, and national social security. None of the policies mentioned here are universal programs with the exception of the universal health insurance program in the Philippines.

The Kenya case study identifies a number of social protection public policies related to childcare and elder care as a part of care infrastructure. The programs related to elder care include a cash transfer program for Kenyans over the age of 70, the National Health Insurance Fund, and the National Social Security Fund. The social security and health insurance programs are contributory programs; employers are required to contribute to the funds, and self-employed workers can voluntarily contribute. As a consequence, many informal workers, who are primarily women, likely do not benefit. In fact, an Oxfam analysis finds that only 15% of workers have employers who contribute to the National Social Security Fund, leaving many workers without coverage.<sup>99</sup> The case study notes, however, that domestic workers can access the National Social Security Fund. The Kenyan government has cash transfer programs for poor and vulnerable households, targeting orphans and vulnerable children, elderly persons, persons with disabilities, and widows. Social protection related to childcare includes cash transfers for orphans and vulnerable children. As will be discussed later in the paper, evidence suggests that these cash transfer programs do not have sufficient funds to cover all those who would qualify.

In the Philippines, community respondents identified the national conditional cash transfer program (Patawid Pamilyang Pilipino Program, or 4Ps) as a part of care infrastructure. Poor households (those at or below the provincial poverty line) with children aged 0–18 or with a pregnant person in the household are eligible and can use the cash transfer for care investments in health and education for their children. The program is a poverty alleviation program of the government that contributes to care provision through direct cash transfer. At the same time, the policy itself does not explicitly connect with or acknowledge the unequal distribution of unpaid care work in the home. Moreover, studies indicate that the program falls far short of providing coverage for all eligible households.<sup>100</sup> The case study also highlights the country's universal health insurance program as a part of care infrastructure.

In contrast, the Mexico case study proposes a wholly different approach. It argues that social protection can be a basis for care policies in that social protection policies are instrumental to people's well-being. However, for social protection policies to be classified as care public policies, they must be extended to provide care services and transform the social organization of care. The Mexico case study classifies one social protection policy as a care public policy: the policy creates a precondition for care by providing a cash transfer for working mothers or fathers whose children (until the age of 16) have been diagnosed with cancer. The cash transfer covers up to 60% of the parent's salary and can be used to take time off of work or for the medical care of the child.<sup>101</sup> This is a care public policy because it directly impacts the provision of care and ensures that both mothers and fathers can take advantage of the policy to provide care.

Although both the Kenya and the Philippines case studies identify different social protection policies as a part of care infrastructure, they also argue that such policies must more explicitly acknowledge care work and its gendered division. The social protection policies identified in those two case studies do not acknowledge or address the gendered division of care work, although they may support caregiving activities; they also do not provide coverage for a significant proportion of households that are eligible.

**Social protection systems must be expanded to recognize the integral role of care in people's well-being and must directly address the way care work is distributed in society and in the household.<sup>102</sup>**

Moreover, as Oxfam's past research demonstrates, social protection policies and programs must be universal, and not contributory or conditional programs, to help reduce inequalities, including gender inequalities in care work.<sup>103</sup>

## PUBLIC CARE SERVICES, PROGRAMS, AND REGULATIONS

All six of the case studies highlight public care services and programs related to unpaid and paid care work, targeting both caregivers and care recipients, as a component of care infrastructure. In doing so they identify different vulnerable groups that require care services: elderly people, those with disabilities, and children.

Because of Kenya's national context and history, the Kenya case study is unique in highlighting state policies related to the protection of orphans, widows, and forced migrants (refugees, internally displaced persons, and stateless persons) as a part of care infrastructure. Additionally, the US is the only case study that also examines the ways in which public care services fail to meet the care needs of LGBTQ+ communities.

The most common public care services associated with care as infrastructure in the case studies include childcare support and systems, elder care, and disability support systems.<sup>i</sup> The most common care-related regulations discussed in the case studies include labor rights for domestic and care workers, maternal or family/parental leave, and workplace protections for breastfeeding and lactation. However, many of these regulations do not apply to the informal sector, and hence many informal workers, who are primarily women, do not benefit from such regulations. The Kenya and Philippines case studies note the importance of the private sector in recognizing and ensuring these rights for their workers.

Five of the case studies highlight public policies protecting the rights of paid care workers. In Kenya, domestic workers can benefit from the two primary national social protection funds (the National Health Insurance Fund and the National Social Security Fund). In the Philippines, formal government regulations need to do significantly more to protect the rights of care workers. In the US, civil society demands around care as infrastructure include improving the rights and dignity of paid caregivers.

Given Oxfam's past and ongoing work on public care policies through the Oxfam Care Policy Scorecard, this section delves into understanding the different national policy approaches to public care services and programs identified in the case studies rather than listing the different policies. Specifically, it examines different national policy approaches for fostering co-responsibility for care and specific public policy interventions for addressing healthcare and childcare. Healthcare and childcare are two of the most prominent areas for public care services as a part of care infrastructure emerging from the case studies. Policies related to provision of healthcare are discussed in the cases of Kenya, Mexico, Peru, the Philippines, and Zimbabwe, and policies related to provision of childcare are discussed in the cases of Kenya, Mexico, and the Philippines.

### Fostering Co-Responsibility for Healthcare and Childcare

The Kenya case study's discussion of national policies around healthcare highlights the role of family and community members in the provision of care. The Kenya National Care System Assessment, published in 2020, defines family-based childcare "as short-term or long-term placement of a child in a family environment with one consistent caregiver and a nurturing environment where the child is part of a supportive family and the community."<sup>104</sup> In 2022 the government of Kenya established the National Care Reforms Strategy, which focuses on childcare and seeks to strengthen the ability of

<sup>i</sup> These policies reflect many of the policies captured in Oxfam's Care Policy Scorecard. Among the case study countries, the Kenya and Zimbabwe Oxfam offices are currently conducting research for the Care Policy Scorecard, and the Philippines and the US recently completed their national Care Policy Scorecards.

families and households, rather than only institutions or the private sector, to provide childcare. It thereby aims to support family and community provision of childcare, not just the outsourcing of that care to other providers.

Kenya's healthcare policies include national government guidelines, developed in 2002, for home-based care for people living with HIV and AIDS. The Kenya National HIV/AIDS Strategic Plan of 2000–2005 defines health-related home-based care as care given to sick persons in their homes, including care that extends from hospital or health facilities to their homes, provided by hospitals, families, and communities and covering physical, psychological, and spiritual support. The government developed systems and capacities to ensure provision of care for people living with HIV/AIDS, targeting individuals, families, and communities, to help reduce demands for care from overburdened national healthcare systems.

More broadly, the Kenya Health Policy, 2012–2030, puts forth a vision of healthcare that ensures equity and is people-centered with a participatory approach. Kenya's recent Universal Health Coverage Program, 2020–2030, aims to ensure that populations can access primary health facilities and highlights maternal and child health, including tackling high maternal mortality. In this way, healthcare is explicitly linked to aspects of care provision and care work. At the same time analysts have found that in implementing universal health coverage, the Kenyan government is channeling public healthcare funds to private healthcare providers.<sup>105</sup> In 2021, 64% of funds from the National Health Insurance Fund went to private health services, compared with only 30% 10 years earlier.<sup>106</sup> This privatization of public healthcare funds has diminished the quality and accessibility of healthcare services in Kenya.<sup>107</sup>

The Kenya case study also critiques existing childcare- and healthcare-related policies for not explicitly recognizing the gendered division of care labor, and the role specifically played by women and girls in care services. The policies treat the family as a homogenous unit and do not compensate home caregivers, even though they are taking on public health responsibilities.

Similarly, Peru's public policies do not adequately recognize the work done by community organizers, who receive no remuneration or social protection benefits (healthcare, social security) for their labor upholding community care. Building on the experiences of the Anti-COVID-19 Committee, the case study recommends making civil society and community leaders more visible in the national care system, formally including them in national health policies, and providing them with state financial and technical support.<sup>108</sup>

The US case study's exploration of the debates surrounding childcare highlights another approach to the inclusion or exclusion of families and communities in public care services and programs. Broadly speaking, childcare policies, in comparison with other care-related policies, have more support from both political parties, as the Republican Party sees childcare as being aligned with its politically conservative values. However, the two parties have significantly different policy approaches to childcare. The Republican Party supported a national law that would incentivize the private sector, rather than the federal government, to offer and pay for family and medical leave. In contrast, the Democratic Party advocated for public solutions funded by public investments. Civil society advocated for universal childcare benefits as a part of its approach to public childcare services. The US case study also highlights US subsidies for childcare such as the childcare tax credit. Under current law, subsidies exist at the national level but are not universal public childcare services. The provision of childcare still rests primarily with families and individuals, who often rely on the private market with minimal state support.

The Mexico case study identifies two public care service programs that aim at creating co-responsibility for care work. The two programs, with attached budgets, focus on state co-responsibility for care but do not address the co-responsibility of care between men and women within households or between the private sector or the community and households. One program is meant to protect the rights of children whose "rights are violated or restricted."<sup>109</sup> The case study

classifies this as a program of public care services as it creates co-responsibility between the state and households for the care of minors.

**The findings from these case studies highlight how public policies related to care services often fail to address the unequal gender division of labor, even when they try to redistribute some responsibility to the state (as in Mexico case) or community actors (as in Kenya).**

**Public Care Services and Programs and Infrastructure**

The Zimbabwe case study demonstrates a different set of priorities. Instead of focusing on the provision of care services related to healthcare and childcare, respondents in rural communities identified the need for physical infrastructure in the form of schools and clinics. Study participants noted that daycares and preschools can significantly reduce women’s childcare work. In rural areas, primary schools are often too far from communities, forcing women to spend a significant amount of time taking their children to and from school.

Similarly, the lack of health centers means that caregivers, mainly women, have to travel significant distances to find healthcare for their sick children, increasing their overall care work. Community participants in two rural communities highlighted mobile health clinics as an important state initiative that reduces women’s care responsibilities by making it easier to ensure appropriate healthcare for their children. They called for the Zimbabwean state to invest in and increase the density of health centers in rural areas as a part of care infrastructure.

In the Philippines case study, community participants in some regions (Mangaldan) discussed the care-related benefits of local healthcare centers. In particular, they noted that the local health center provides free care to pregnant women, who therefore did not have to spend energy worrying about paying for pre- and postnatal checkups. They also noted that the policies that ensure free immunization and nutrition for children are part of care infrastructure. This discussion highlights the ways in which even under the rubric of healthcare and childcare the types of policies and investments needed vary by regional context.

Table 2 outlines the core policies, programs, and initiatives discussed in this section as they relate to the different components of care infrastructure. This list is not exhaustive but focuses on the primary and illustrative examples from each case study. The table captures much but not all of the diversity found within each component across the countries.

Table 2. Core policies, programs, and initiatives highlighted in case studies, by care infrastructure component

|                                                             | Kenya                                                                                                                                                                                                                                                                                       | Mexico                                                                                                                                                                                                                                  | Peru                                                                                                 | Philippines                                                                                                                                                                                                                | United States                                                                                                                                                                                            | Zimbabwe                                                                                                                                                              |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Care-supporting physical infrastructure</b>              | <ul style="list-style-type: none"> <li>• Water</li> <li>• Electricity</li> </ul>                                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Health center for the community</li> </ul>                  | <ul style="list-style-type: none"> <li>• Health facilities</li> <li>• Education facilities</li> <li>• Water</li> <li>• Time- and labor-saving equipment</li> <li>• Community centers</li> </ul>                            | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>• Water</li> <li>• Electricity</li> <li>• Energy-saving stoves</li> </ul>                                                      |
| <b>Community networks</b>                                   | <ul style="list-style-type: none"> <li>• Community healthcare volunteers</li> <li>• Kinship care</li> </ul>                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Community health committees</li> </ul>                      | <ul style="list-style-type: none"> <li>• <i>Dagyaw</i> or <i>dayum</i> (community pooling of labor or funds for burials or hospital expenses; in-kind support such as crops or food)</li> </ul>                            | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>• <i>Nhimbe</i> (community members sharing agricultural labor)</li> <li>• Care cooperatives</li> </ul>                         |
| <b>Knowledge</b>                                            | <ul style="list-style-type: none"> <li>• Civil society's challenging of social norms through the media</li> </ul>                                                                                                                                                                           | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Data on care needs collected by health committee</li> </ul> | <ul style="list-style-type: none"> <li>• Civil society-led training to challenge social norms</li> <li>• National Household Care Survey</li> </ul>                                                                         | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>• Community and civil society initiatives to challenge social norms with cooking competitions, laundry competitions</li> </ul> |
| <b>Public care regulatory system and public investments</b> | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                                                                                                     | <ul style="list-style-type: none"> <li>• National care system (under discussion)</li> </ul>                                                                                                                                             | <ul style="list-style-type: none"> <li>• National care system</li> </ul>                             | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                                    | <ul style="list-style-type: none"> <li>• Debate on national approach to care infrastructure</li> </ul>                                                                                                   | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                               |
| <b>Social protection</b>                                    | <ul style="list-style-type: none"> <li>• Conditional cash transfers (orphans and vulnerable children; elders; and persons with disabilities)</li> <li>• National Pension Scheme</li> <li>• National Health Insurance Fund</li> </ul>                                                        | <ul style="list-style-type: none"> <li>• Health, care, nutrition, education, security for children (ages 60 days to 6 years) of working parents</li> <li>• Cash transfer for parents with children with cancer</li> </ul>               | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                              | <ul style="list-style-type: none"> <li>• Conditional cash transfers for children's health and education</li> <li>• Universal healthcare</li> </ul>                                                                         | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                                                                                               |
| <b>Public care policies, programs, and regulations</b>      | <ul style="list-style-type: none"> <li>• Women's Economic Empowerment Policy</li> <li>• Labor rights and social protection for domestic workers</li> <li>• Public care services for vulnerable children</li> <li>• State support for kinship care and community health volunteer</li> </ul> | <ul style="list-style-type: none"> <li>• Services to groups with special needs (accommodation services and comprehensive services for older adults)</li> <li>• Program to protect rights of children of incarcerated mothers</li> </ul> | <ul style="list-style-type: none"> <li>• N/A</li> </ul>                                              | <ul style="list-style-type: none"> <li>• Protections for decent work for care workers in the Philippines and overseas</li> <li>• Mandatory provision of workplace nursing facilities</li> <li>• Maternity leave</li> </ul> | <ul style="list-style-type: none"> <li>• Paid leave benefits</li> <li>• Child tax credits</li> <li>• Child and dependent care tax credit</li> <li>• Home- and community-based services (HCBS)</li> </ul> | <ul style="list-style-type: none"> <li>• Maternity Leave</li> <li>• Mandatory provision of workplace nursing facilities</li> <li>• Infant care</li> </ul>             |

Source: Authors' own elaboration based on country case studies. This list of policies is not exhaustive but highlights the main policies discussed in the case studies.

Note: N/A = not applicable.

# COMMON DEBATES AROUND CARE INFRASTRUCTURE

Two themes emerge in common debates about the components of care infrastructure: (1) the role of the state in supporting the components of care infrastructure, including in relation to community care; and (2) the importance of centering and tackling the unequal gendered division of care labor in all public policies.

## THE ROLE OF THE STATE IN SUPPORTING CARE INFRASTRUCTURE

A number of the case studies (Kenya, Mexico, Peru, the Philippines, and the US) explore the debates over and demands of the role of the state in care infrastructure, showing that this debate remains largely unresolved in those countries. At the center of the debates is the question: What are the core responsibilities of the state with regard to providing and supporting care work? We categorize the five case studies into two buckets: those that frame care as a right and those that frame care as a public good. These two frameworks are intersecting and complementary; they do not exclude one or the other. For example, the framework of care as right includes providing care as a public good.

The framing of care as a right, which is the dominant legal framework toward care in Latin America, requires states to invest resources in ensuring that everyone has a right to care, the right to be cared for, and the right to self-care.<sup>110</sup> States have a co-responsibility along with families, communities, civil society, and the private sector to realize this right and to undo the unequal gender distribution of care work.

**Recognizing care as a right also requires building national care regulatory frameworks or systems that put care at the center rather than on the periphery.**

The Kenya, Philippines, and US case studies articulate frameworks of care as a public good. In these cases, the debates center on the need for the state to expand public care policies and care-related public investments as well as to recognize the integral role of care in societies, economies, and people's well-being. They do not call for the state to recognize care as a right, and thus these case studies do not discuss demands that the state develop national care systems to address care and its unequal gendered distribution in an integrated policy or regulatory framework.

### The State As Guarantor of Care As a Right

Two of the case studies, Mexico and Peru, examine the role of the state as a guarantor of care as a right through the provision of national care regulatory systems. Both case studies note that although the ambition for the state to institutionalize care as a right exists, state actions are so far woefully behind in recognizing care as a right.

The Mexico case study authors argue that the central and basic function of the state is to provide care to its citizens, and it must therefore assume responsibility for guaranteeing care as a right along the three dimensions mentioned. Mexico's Congress is in the midst of discussing and potentially approving a National Care System Law, raising the importance of achieving clarity and consensus on the role of state actions (that is, budgets, policies, and social programs) in recognizing care as a right. The study proposes that state actions related to care consist of any state policies, social programs, or budgetary allocations that (1) provide direct care; (2) meet the needs of caregivers; and (3) promote an equitable distribution of care responsibilities between the state, the private sector, families, and communities as well as an equitable gendered division of care responsibilities. The case study further classifies the types of care infrastructure that the state can provide as (1) establishment of institutions and norms related to the provision of care; (2) building of cultural norms around the provision of care; and (3) provision of just economic compensation for care work.

Using this framework, the study finds that of the 56 stated care-related programs and associated budgets it examined, only nine can be classified as care programs. Of the nine, the authors classify

two as related to direct care provision, five as related to the preconditions for care, and two as related to the redistribution of care responsibilities.<sup>1</sup> Existing policies and programs are thus far from realizing care as a right. The case study argues that much can be done to advance progress by modifying existing state programs and policies to more directly address one of the three foci of care policies identified by the study.

Similarly, the Peru case study argues that co-responsibility for care requires that the state assume its role as holder of the obligation to guarantee care as a right (along the three dimensions mentioned above). It must guarantee—among other care policies—coverage, quality, and timeliness in the provision of public services, incorporating a focus on disasters and emergencies. Further, it argues that the state must recognize the right to care in all its dimensions and scope, including creating the conditions for effective community care, and it must plan, implement, and evaluate care services to guarantee their quality, accessibility, and coverage. In the context of the Montevideo Strategy of 2017, there is a national and regional push to implement national care systems. Yet despite recognition of the state’s obligation to guarantee care, organized community networks end up replacing public institutions in the face of limited and poor-quality public services and deepening inequalities. The case study explicitly calls on the state to increase its investments in community care to alleviate, recognize, and support the work taken on by community networks as a part of its obligation to guarantee care as a right.

### The State and Care As a Public Good

In three of the case studies—the US, Kenya, and the Philippines—the state’s role relates to care as a public good. In all three cases, the state does not yet quite recognize care as a public good, and there is continuing debate about to what extent care is a public or private responsibility.

The US case study analyzes the intense 2021 public debate on whether the US government should invest in and develop care infrastructure, with significant budgetary allocations oriented to care. On one side of the debate, civil society and some lawmakers worked to highlight the central role played by care work in the functioning of society and the economy. They sought to ensure that the state would support and provide care as a public good, investing in care infrastructure just as it invests in physical infrastructure. The US president, Joe Biden, and several lawmakers from his political party, the Democratic Party, were able to increase some government funding related to childcare services, paid family leave benefits, tax credits for children, and dependent care costs. However, a number of initiatives related to childcare, elder care, and care for persons with disabilities advocated for by civil society actors, including the Care Can’t Wait coalition, were not adopted.



Oxfam America joined with labor unions and other allies calling on the US Congress to fund affordable, accessible child care, and help ensure living wages for providers and all workers. 2022. ©Nancy Andrews/Oxfam.

On the opposite side of the debate, several lawmakers from the opposing political party, the Republican Party, asserted that care services are primarily a private rather than a public responsibility

<sup>1</sup> For a longer discussion of these programs, see the Mexico case summary in Appendix B.

and opposed the idea that the state should enact long-term public investment in care services. Rather, these lawmakers largely supported state investments in care services if they were short-term, one-off policies, such as childcare in the context of COVID-19 pandemic. They also supported care policies (namely childcare) that would incentivize private sector investment in care services rather than expand the state's responsibilities or investments.<sup>k</sup> As such, the case study underscores the ongoing debate within the US about whether care is a public good and about the types of investments required to recognize it as a public good.

Similarly, in the Philippines, civil society calls for the state to take on more responsibility in relation to care, but the state does not invest in care as a public good. Communities and state actors see the provision of care as the responsibility of the family, and particularly women in the family, and state actors make almost no acknowledgement of the role care work plays in the overall development of economy and society. As such, the case study finds that the state plays only a minimal role in supporting care, and there is no comprehensive national approach to care.

There is, thereby, no explicit discussion in national policy circles around care infrastructure, despite the Filipino government's commitment to improving and investing in infrastructure writ large to improve quality of life and expand economic opportunities. The country does have a gender and development policy framework that articulates the government's commitment to "making women's and men's experiences a vital dimension of the design, implementation, monitoring, and evaluation of policies, programs, and projects in all spheres for women and men to benefit equally, and 2) assessing the implications for women and men of any planned action, including legislation, policies or programs in all areas and at all levels."<sup>111</sup> This policy provides a framework for the government to invest in care work, but the state does not use this mandate to foster public investments in care infrastructure.

In addition, although a number of public programs impact the provision of care, from social protection to healthcare to childcare, these programs and policies do not explicitly recognize or center the gendered redistribution of unpaid care work. National-level discussions of care infrastructure are limited to topics related to health and education but omit other direct care-related activities. In contrast, Filipino civil society organizations and women's rights movements argue for the centering of care in the country's economy and society and for the recognition of care as a public good by the state.

The Kenya case study also finds that the state does not fully recognize care as a public good, even though the state's responsibility for the provision of care is grounded in the Kenyan constitution's commitment to fostering access to public services by marginalized communities, including women; older people; persons with disabilities; children; youth; and members of ethnic, religious, and cultural minorities or other marginalized communities. The Kenyan government's commitments to care work fall under policies that define other public goods, such as social protection, child protection, healthcare, labor rights, protection of persons with disabilities, and protection of forced migrants (refugees, internally displaced persons, and stateless persons).

In Kenya, however, as in the Philippines, there is no national framework that explicitly recognizes the role of care in society, though a national care policy is currently being developed. State investments in care-related sectors are woefully inadequate to ensure that care is provided as a public good. However, the Kenyan legal system recognizes that childcare includes not only financial support but also the provision of unpaid childcare and that both parents have equal and joint responsibilities for childcare. Therefore, there is some legal recognition of the role of unpaid childcare in the Kenyan national context, although it has not yet translated into an expanded role for the state vis-à-vis care.

In all three countries—Kenya, the Philippines, and the US—members of civil society advocate for state recognition of care as a public good, but states lag in implementing this framing. The case studies highlight the country-specific political and policy contexts that could undergird the state's responsibility to treat care as a public good in Kenya (the constitutional mandate to empower marginalized and vulnerable groups) and in the Philippines (the gender and development policy). Yet, as the Philippines case points out, in the absence of explicit state recognition of how care is linked to gender equality, development, and poverty alleviation, states must do more to recognize care as a public good.

---

<sup>k</sup> An example is the 2021 draft Protecting Worker Paychecks and Family Choice Act, which sought to incentivize the private sector rather than the US government to pay for family leave.

## DIFFERENTIATING WOMEN'S ECONOMIC EMPOWERMENT AND CARE WORK EQUITY

The Philippines and Kenya case studies examine the ways in which national policies related to women's economic empowerment differ from policies to address care needs and care inequities. In the Philippines, no existing policy framework at the national level explicitly recognizes the role of care work in society and the economy; there is a national policy framework for gender and development that does not directly address care work. In some instances, because this framework does not directly address care work, local governments are unable to fund care-related programs. The case study argues that unless policies also address the public-private divide of care provision, policies around women's economic empowerment will be hampered in achieving their goals. Women end up having to balance both care work and paid work and often have to redistribute the care work within the family (to other women or girls) or to other institutions or people outside the family.

In contrast, the Kenya case notes that the country's Women Economic Empowerment Strategy (2020–2025),<sup>112</sup> which aims to move women toward paid work, acknowledges the need to address women's unpaid care work. The policy seeks to develop affordable care centers for babies and increase women's access to water, electricity, and roads to mitigate their unpaid care work. At the same time, the policy makes no explicit mention of measuring the role of care work in overall development and women's economic empowerment.

The Kenya and Philippines case studies highlight that economic empowerment policies do not directly translate into policies that address the unequal gender distribution of care and again point to the need to center care in interventions.

## INVESTMENTS IN CARE INFRASTRUCTURE

All six case studies find that public investment in care infrastructure is woefully insufficient. In part, the case studies argue that this is because states do not view care as a public good or enforce it as a right. As the US case study finds, moments of crisis, such as the COVID-19 pandemic, did create brief recognition of the need for public investment in different components of care infrastructure. Unfortunately, some of these initiatives were discontinued with the end of the pandemic. At the same time, two of the case studies, Peru and Zimbabwe, highlight significant investments by civil society movements and community organizations and leaders in components of care infrastructure. Table 3 provides an overview of the care infrastructure investments discussed in the case studies.

**Table 3. Care infrastructure investments**

### Investments in care infrastructure

**Kenya:** Kenya has limited public budgetary allocations for early childhood education, health, agriculture, social protection, water, and irrigation. Public investments are insufficient to meet the care needs of the population and are therefore likely exacerbating unequal gendered division of care work.

**Mexico:** The state assigns a very limited budget to care actions: only 0.4% of the federal budget is spent on the programs selected.

**Peru:** Two types of investments are made in relation to the work of the community health committee: First, there are physical and economic investments in the committee's activities, care baskets, and community health center. Second, there are less tangible investments in transforming care regimes and the social organization of care. These investments are made by the community, primarily women, and not the state. They often overwhelm families and communities, in particular women community organizers. There is a need to invest in younger generations of leaders to involve them in communal leadership.

## Investments in care infrastructure

**Philippines:** Investments in care infrastructure are limited, and they are often by-products of investments in other policies.

**United States:** The debate around care infrastructure in the US did not lead to permanent public investment, since the proposed “Build Back Better” bill did not pass. The final legislation that did pass included limited funding for childcare and paid leave and home- and community-based care services for elderly people and people with disabilities. However, there were temporary budgetary allocations for temporary care provisions as a part of the COVID-19 relief bills.

**Zimbabwe:** Zimbabwe has made investments in care-related physical infrastructure, such as laundry stalls constructed at strategic places along piped water schemes, water schemes to benefit livestock and humans, cooking stoves, clinics and mobile clinics, and schools. In addition, civil society and communities have made investments in reducing the care burden and redistributing care work. Among these initiatives are the work of the WE-Care Initiative, the “Care Champions” interventions, and the support received by cooperatives. Additionally, it is important to continue to invest in knowledge as a strong tool for advocating for investments in care and care infrastructure.

Source: Authors’ own elaboration based on country case studies.

The Filipino government has made physical infrastructure investments a budgetary and policy priority. However, given that the state does not frame or view care work as the responsibility of the state, but rather that of households and families, direct public investments in care services and programs are minimal. Moreover, although the Philippines has a significant gender and development budget, the resulting activities do not fully address the unequal gender division of care work. At the local government level, gender-related investments are tied to the gender and development budget, and because programs and policies are prescribed in the national gender and development framework, local governments have little flexibility to use the gender and development budget for directly providing care or proposing new programs or spending. Further, the case study demonstrates that even though tackling gender inequality is a priority, there is no explicit recognition of care work and thus limited investment in care-related programs. Although the case study does not conduct a financial analysis, it highlights how the lack of recognition of care and its links to gender inequality and development means there is limited direct investment in care programs.

The US case study underscores a similar tension around whether investing in care-related infrastructure should be considered part of infrastructure and a public good. At the height of the COVID-19 pandemic, there was broad-based political support for the state to temporarily invest in care as essential infrastructure. Even members of the Republican Party, which traditionally opposes investments in care-related programs as a function of the federal government, voiced the importance of care work to the economy. However, this broad-based support from political actors was short-lived, and consequent national bills that would have included long-term federal funding for care-related programs and policies were not passed. Instead, a number of lawmakers, primarily from the Republican Party, argued that the government could subsidize or facilitate families’ investments in care services in the private sector.

In a similar vein, the Kenya case study highlights the ways in which care is not viewed as essential infrastructure by the state. Although the state’s responsibility to address the provision of care has a constitutional basis, the case study argues that the state is not adequately meeting its obligations. The case study classifies investments in the following sectors as relating to care: health, early childhood education, water, agriculture, social protection, and the State Department for Gender. This includes investment by the government to produce a national time use survey. Allocated public investments in these sectors comprised 11% of the total budget from 2021–2022. Although 11% may seem significant, it is important to note that this covers six different sectors, and the budget for national security is nearly 50% of the combined allocation for these six sectors. Moreover, analysis by the University of Nairobi Women’s Economic Empowerment hub finds that this spending is inadequate

to meet the needs of women and other marginalized groups. In particular, cash transfer programs for orphans and vulnerable children, elderly people, and people with severe disabilities do not cover all those who qualify.

Over the years the Kenyan government has taken on significant debt for large-scale infrastructure, but these infrastructure investments have not been tied to sectors such as health, early childhood education, water, agriculture, and social protections that would impact unpaid and underpaid care work. As such, these sectors continue to lack investments despite overall expansionary fiscal policies.

**The heart of the issue is that the Kenyan government, like the governments of the Philippines and the US, does not explicitly view spending in these categories as investments that can spur growth.**

The Mexico case study finds dismal levels of state investment in care as infrastructure. The case analyzes 56 care-related budgetary programs and identifies nine of them as care programs: two direct care programs, five programs that establish preconditions for care, and two equity and co-responsibility programs. The funds allocated to care in 2020 through these nine care-related programs constituted 0.4% of the federal budget. Although state efforts directly toward care are quite limited, the state invests in a myriad of care-related activities that can be redirected toward care and that could help build care systems from existing efforts in an organized and coherent fashion.

In contrast, community and civil society actors have heavily invested in care as infrastructure. The Peru case study demonstrates the critical role that community organizers play in ensuring that basic and critical care needs of a community are met. The Santa Rosa community health committee implemented “community care infrastructure that includes economic, material, emotional, and physical support.”<sup>113</sup> This approach to care as infrastructure is much more expansive than some of the interventions of policy frameworks advocated by states. At the same time, this labor by community organizers takes a toll on the organizers themselves, highlighting the need for state support and investment. The case study argues that the Peruvian state should assume some economic obligations for the provision of care as infrastructure and support the work of community organizers.

**Community and civil society actors have heavily invested in care as infrastructure... At the same time, this labor by community organizers takes a toll on the organizers themselves, highlighting the need for state support and investment.**

Importantly, the Zimbabwe case study highlights how civil society movements can spur government investments in care infrastructure. Geographic areas that were part of Oxfam’s WE-Care Program had public care infrastructure investments that addressed women’s needs and economically empowered them. In contrast, in non-WE-Care areas there are limited public investments in care infrastructure and little focus on the needs of women as primary care providers. Both community and government actors note how investments in water infrastructure have helped women and communities in carrying out care work. Investments being made by civil society and community actors are building knowledge-related care infrastructure. Finally, community networks have used care-related programming to raise funds for investment in physical water infrastructure.

The Zimbabwe study notes that the state has invested in some forms of care infrastructure, particularly water infrastructure and mobile clinics, but interviews and focus group discussions highlighted that there are demands for increased investments. Respondents noted that the state needs to improve transportation, roads, and the density of school and health facilities.

## 5 CONCLUSIONS AND KEY LESSONS

This paper examines how care infrastructure is understood and defined across six different country contexts where Oxfam has programmatic work related to care: Kenya, Mexico, Peru, the Philippines, the US, and Zimbabwe. The case studies, using a qualitative methodological approach, draw on national policy frameworks, interviews with community members and state actors, the work of community organizations and civil society, including Oxfam's, and secondary literature to articulate the demands and definitions related to care infrastructure in these country contexts. Being exploratory in nature, this paper aims to give meaning to care infrastructure as a concept by anchoring it in specific country contexts.

All the case studies highlight communities' and civil society actors' high interest in and demand for systematic care interventions and more equitable distribution of care responsibilities among all social actors (families, communities, the state, civil society, and the private sector). All the case studies, in alignment with Oxfam's programmatic work, advocate for a social organization of care under the "care diamond" or co-responsibility approaches. These approaches argue that all care stakeholders have a role to play in care work and in maintaining the well-being of society by undoing the unequal responsibility of families, and of women and girls within them, for the provision of care.

Below we outline some key lessons from the paper.



***Care infrastructure embodies six core components that vary and are shaped by local contexts, highlighting the importance of centering local context for any care-related intervention.***

There is no single understanding of care infrastructure. Each component of care infrastructure identified in this paper is context specific, determined by country-specific factors including social organization of care, time use related to care, legal frameworks, and civil society and community mobilization.

This paper finds six core components of what could constitute care infrastructure across the six case studies: (1) care-supporting physical infrastructure, understood as physical infrastructure that would reduce the labor and time associated with caregiving duties; (2) community care networks that provide vital care services, offer ways to share care work duties, and/or serve as a bridge between families and the government; (3) knowledge as education or evidence generation around care and the care realities of underserved populations, which can lead to shifts in social norms, the distribution of care work duties within households, and demands for state care interventions; (4) care regulatory frameworks and public investments, understood as the need to create integrated systems with accompanying legal frameworks, budget allocations, and public investments; (5) social protection policies; and (6) public care services and care-related regulations.

This paper delves mainly into the responsibilities of the state in relation to care infrastructure (or a national system approach to care) and highlights the importance of community and civil society approaches to care and care infrastructure as part of novel understandings of care relationships.



***States need to expand their co-responsibility for care provision through well-funded public financing of public care systems or public care services, programs, and care-related regulations.***

Most of the case studies argue for the need to expand the role of national or federal governments in relation to care. They also document civil society and community efforts to push states, including at different governmental levels, to recognize their central role in guaranteeing care

as a fundamental right or as a public good. To do so, states should strengthen public policies, budgetary allocations, and systematic regulatory frameworks to provide equal access to care and public care infrastructure.

Some of the case studies, such as Mexico, Peru, and the US, articulate already defined pathways or demands from civil society related to how states should take on co-responsibility for care. In the case of Mexico and Peru, both countries are part of regional agreements to develop national integrated systems of care. In these two countries, the state is a guarantor of the fundamental right to care and must make public investments following the “maximum allocation of resources” framework. In the US, there is an ongoing debate about whether the federal government should consider care essential infrastructure or play a leading role in developing and supporting public care policies with expanded public investments. Although all the case studies argue for the need for states to play a more visible and central role, the case studies also observe that the national or federal governments analyzed still have not implemented systematic legal frameworks or allocated significant investments for care infrastructure or care systems.

This key lesson is intrinsically tied to Oxfam’s longstanding advocacy for states to invest in free public services ensuring universal coverage in health, education, and childcare (in addition to other public services, such as water and electricity) and to invest in universal social protection policies to reduce economic and gender inequalities.<sup>114</sup>



***The unequal gender distribution of care work must be explicitly recognized in care-related public policies, including those related to women’s economic empowerment and social protection policies.***

The case studies of Kenya and the Philippines demonstrate that gender justice frameworks or women’s economic empowerment cannot be achieved unless public policies with these aims also center care and how care work is organized and distributed in society. Both of these case studies, along with the Mexico case study, highlight how social protection policies that provide some support to caregivers and tackle economic inequalities may also entrench gendered inequalities in care provision as they do not address the gendered division of care work. Moreover, the findings from Peru show that community care can often be based on women’s unpaid work and impact their care workloads at home.

As such, public policies—from gender equality frameworks to social protection policies to initiatives that seek to support community care—must explicitly address the gendered division of care work to achieve gender justice and overall well-being for women caregivers and leaders.



***Interventions and advocacy by state and non-state actors should recognize and invest in community care networks where they exist and not exacerbate gendered inequalities in community care.***

The case studies note the important role played by civil society and community actors in investing in and creating care infrastructure. Community leaders, organizations, and networks can engage in providing care services, redistributing care work within communities, channeling families’ and communities’ care-related demands to state representatives, connecting public officials with realities on the ground, and creating knowledge and transforming social norms around care work. The Peru case study also underscores the ways in which community care often relies on the labor of women organizers or leaders, exacerbating their own care workloads in their homes and highlighting the need for systematic state support. In a similar fashion, the Kenya case study highlights a state policy that seeks to recognize and support community care but falls short in terms of financial support for community volunteers and fails to tackle the unequal gendered distribution of care work.

As such, an important lesson from this study is the need to recognize, maintain, and invest in networks and relationships as central components of care infrastructure. The Peru case study, in particular,

highlights the need to invest in capacity building to support a new generation of young leaders, with a gender justice focus that does not rely solely on women's and girls' provision of community care.



*Transforming social norms around care is critical and needs sustained public investment in community and civil society efforts.*

The Kenya, Philippines, and Zimbabwe cases highlight the importance of investing in community and civil society activities to transform norms around who carries out care work in households and the role of care work in society. These shifts in attitudes are key components of “soft” care infrastructure and can help redistribute care work more equitably. In Zimbabwe, the combination of awareness raising on social norms and the provision of new and improved water and laundry infrastructure was key to achieve a more equal distribution of unpaid care work tasks. Additionally, Zimbabwe's experience highlights how civil society movements that promote a view of care as essential infrastructure can spur government investments in care infrastructure. Thus, investments in care relate not only to care services and programs but also to social networks, capacity, leadership, and social movement building.

## AREAS FOR FUTURE INQUIRY

The findings from this research highlight some important areas for future research. First, most of the case studies only touch on the **role of the private sector**. Some of the case studies (Kenya, the Philippines, and the US) examine the private sector as a consequential provider of care services (for example, daycares); as an actor responsible for care-related protections in the workplace; as responsible for providing decent and dignified work for care workers; and, in the case of Kenya, as a contributor to social insurance programs. In Kenya childcare services are predominantly private, and healthcare is becoming increasingly privatized. In the US, one side of the public debate on care infrastructure argues that the provision of care infrastructure is a function not of the US federal government (except during crises) but of the private sector, which plays a significant role in providing care services such as childcare and elder care. However, further research across countries is required to better understand the shared responsibility of the private sector in providing care, including the ways in which it should be regulated. Previous Oxfam research has shed light on the ways in which privatization of public services in education and healthcare entrench inequalities and negatively impact service quality.<sup>115</sup> Last, the private sector's financial contributions to care-related public policies (such as childcare and parental leave) and care-related social protection are areas that require further research.

Second, additional **research on public finance** is needed. Almost all of the case studies note the paucity of public investment in components of care infrastructure or in a public care system. This research was not able to comprehensively account for public budgets for each case study. Some of the case studies drew on secondary literature to better highlight the gaps in funding, while others showed gaps in how the state approaches investments in care-related services and programs. Additional research is needed to highlight public investment gaps in care infrastructure and can build on the typology of care infrastructure offered by this paper to identify areas for analyzing public investments. Future inquiries could also highlight the interlinkages of fiscal and tax justice and care investments, which could also shed further light on the links between care and economic inequality.

Third, further research is needed on **the role of the media**. In some of the cases studies (Peru, Zimbabwe, and the US), the media appears as an important actor. It can push for shifting the traditional gender division of labor within households and families or make visible existing care crises, including the care realities of underserved populations. It can serve as a tool of civil society to demand care infrastructure or influence a political debate.

As an exploratory research piece, this paper could not touch upon every important topic related to these themes. Left unaddressed, for example, are the relationship between property rights and care as a right and the ways in which racial, ethnic, and class cleavages (among other social identities) impact access to care infrastructure and even advocacy around care infrastructure.

In sum, this paper demonstrates the growing demands and public debates around the recognition of care as a public good or as a right and the types of interventions, initiatives, community networks, knowledge, and public policies (including care-supporting physical infrastructure, social protection, and public care services) that can make up care infrastructure. *Although civil society continues to shine a light on how care is tied to well-being, poverty alleviation, inequality reduction, women's economic empowerment, and development, state investments in care infrastructure do not reflect a sufficient acknowledgment of these ties.* As such, there continues to be a need to highlight and frame the importance of care investments in states' efforts to tackle these other socioeconomic goals. Findings from the research show that there remain significant challenges to ensuring that responsibility for care is more equitably distributed both within the home and within society, among families, the state, communities, civil society, and the private sector. As the cases of Mexico and Peru demonstrate, it is challenging to ensure substantive changes to policies, programs, and investments, even after recognition of the state's obligations regarding care. To do so requires continued investments in care leaders, networks, and organizations already pushing for such change.

# APPENDIX A. CASE STUDY

## OBJECTIVES AND METHODOLOGIES

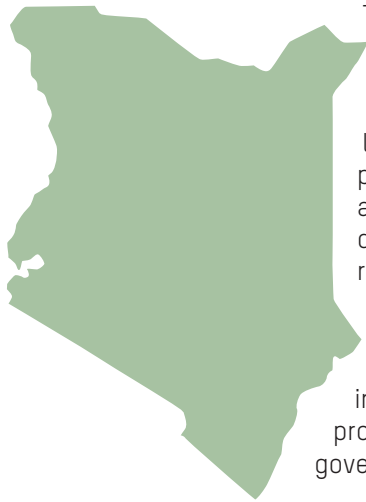
Table A1. Research objectives and methodologies by country

| Country              | Research objectives                                                                                                                                                                                                                                                                                                                                                                          | Methodology                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Kenya</i>         | To assess the status of care infrastructure by identifying the care policy environment as well as gaps and best practices.                                                                                                                                                                                                                                                                   | Stakeholder mapping, literature and desk review on care work, and qualitative data collection with stakeholders from the government, civil society organizations, and communities (46 interviews).                                                                                                                                                                                                                                                    |
| <i>Mexico</i>        | To develop a methodology to examine state care actions and to assess whether these actions can be considered care infrastructure or not.                                                                                                                                                                                                                                                     | Design and testing of a methodological framework to classify state care policies and interventions, including examination of Mexico's assigned federal care-related budget in 2020.                                                                                                                                                                                                                                                                   |
| <i>Peru</i>          | To characterize the role of organized civil society in generating community health infrastructures in the context of the COVID-19 pandemic and to examine the associated challenges.                                                                                                                                                                                                         | A qualitative case study of the Santa Rosa Community Anti-COVID-19 Committee in Comas, Lima, Peru. Methods included a literature review and systematization of secondary data, five in-depth interviews, participant observation, and a focus group.                                                                                                                                                                                                  |
| <i>Philippines</i>   | To understand the conceptualization and framework of care infrastructure and its impacts in women's lives with the aim to develop a typology of care infrastructure investments in the Philippines.                                                                                                                                                                                          | Methods included literature and desk review, complemented with qualitative field research and data collection. Qualitative field research consisted of interviews with care stakeholders (community members, civil society organization members, and local government officials).                                                                                                                                                                     |
| <i>United States</i> | To analyze the debates around care infrastructure and related investments by the US federal government during the COVID-19 pandemic, in the executive and legislative branches, the civil society space, and the media. This was in the context of the US federal government's efforts to pass the Build Back Better (BBB) Act in 2021, which included unprecedented public care provisions. | Content analysis of secondary sources on the national discussion and debate around "care infrastructure" and "care as infrastructure" that occurred in the US in the context of the pandemic between March 2020 and July 2022. Secondary sources included civil society organization reports, news stories, op-eds, social media messages, public statements, and policy and legislation documents.                                                   |
| <i>Zimbabwe</i>      | To examine how care infrastructure is conceptualized, contextualized, and understood across governmental and civil society stakeholders in rural and urban Zimbabwe. Furthermore, to explore the implications of unpaid care work, available care infrastructure, and its contribution to improving women's participation in decent paid employment, education, leisure, and political life. | Literature review and analysis of secondary sources, complemented with qualitative data collection. This included key informant interviews (27), focus group discussions (8) with stakeholders from the central government, local government, private sector, communities, women's right organizations, local activists, and beneficiaries in targeted communities (Budi, Harare, Zvishavane) in which Oxfam was implementing the WE-Care Initiative. |

# APPENDIX B. CASE STUDY SUMMARIES

## KENYA<sup>1</sup>

### BACKGROUND, RESEARCH OBJECTIVES, AND METHODOLOGY



The Kenya case study examines how the national government, county governments, communities, the private sector, the courts, and the media conceptualize care work and care infrastructure. The case study aims to identify, at the national and county government levels, existing laws, policies, and administrative guidelines and procedures related to care work as well as government initiatives to address the challenges associated with care work. The study uses qualitative research methods such as stakeholder interviews and a review of relevant published and unpublished literature on care work, with special attention to childcare, elder care, care for the sick, and domestic work. The literature review includes an analysis of laws, policies, and programs as well as community practices. Stakeholders in the study are defined as social actors that have responsibility for the provision of care; 46 interviews were conducted with representatives of government, civil society, and community organizations.

### SOCIAL ORGANIZATION OF CARE

The study finds that the main stakeholders of care work in Kenya are families, primarily women and girls, who carry out the majority of unpaid work; the national and county government agencies, which provide public care services and social protection; the private sector, which provides childcare services, healthcare, and domestic care and has an obligation as an employer to contribute to national social insurance schemes and recognize care-related employment regulations (e.g., workplace spaces for lactation); associations of care workers; civil society; and the media, which has an important role in shaping social norms about care and domestic work. The study also documents the role of the courts in issuing legal judgments that recognize the role of unpaid care work and its unequal gendered distribution within the household.

### DEFINITIONS AND DEBATES OF CARE AND CARE INFRASTRUCTURE

The governance of care is grounded in the 2010 Constitution of Kenya, which ensures socioeconomic and political participation and access to public services for minorities and vulnerable groups (Article 21[3]) and marginalized communities and groups (Article 260). Under the constitution, public finance should work in service of building an equitable society by addressing the needs of marginalized groups (Article 201). The constitution defines marginalized communities and groups as communities that have “been unable to fully participate in the integrated social and economic life of Kenya as a whole,” and “a group of people who, because of laws or practices . . . were or are disadvantaged by discrimination on one or more of the grounds in Article 27 (4).”<sup>116</sup>

<sup>1</sup> This summary is based on the case study written by the Collaborative Centre for Gender and Development: CCGD. (2022). “Care Infrastructure in Kenya: Study Report.” Internal document. Nairobi: Oxfam Kenya. The summary contains citations as well as textual references to this country case study.

According to the study, there is no singular definition or coherent all-encompassing policy related to care in Kenya. As mentioned, the authors state that “the governance of care work in Kenya is group-based, focusing on the groups requiring care and/or providing care such as the elderly, children (particularly orphans and vulnerable children, child protection in general, early childhood development and education and children in conflict with the law), domestic workers, the sick (including professional healthcare and community-based care), people with disabilities, and forced migrants (refugees, internally displaced persons, and stateless persons).”<sup>117</sup> The frameworks for the governance of care work are housed under laws and policies related to social protection, child protection, healthcare, labor rights, protection for persons with disabilities, and forced migrant protection.

Interestingly, a few courts “have ruled positively in relation to domestic work, childcare, and the redistribution of care work”<sup>118</sup> between spouses, showing an understanding of the value of care work. For example, a decision by the High Court in Kenya in 2021 (MW v AN [2021] eKLR) found that housework and care work performed by the mother entitled her to an equal share of the matrimonial property at the time of the dissolution of marriage.

## **COMPONENTS OF CARE INFRASTRUCTURE**

### **Role of Social Protection in Care Infrastructure**

Many of the public policies related to care in Kenya are enmeshed with the provision of social protection policies. For example, care for elders in Kenya is under the State Department of Social Protection, Pensions and Senior Citizens Affairs. Policies include the (1) National Policy of Older Persons and Ageing (2014), whose goal is to provide an enabling environment for older persons in society (a universal benefit) and (2) the Older Persons Cash Transfer program, where Kenyans 70 years old and above (who are not in receipt of a civil service or other contributory pension) receive 2,000 Kenyan shillings (\$12) monthly. Social insurance takes the form of the National Hospital Insurance Fund (NHIF) and the National Social Security Fund (NSSF), a pension scheme. These are both universal benefits to which private employers must contribute and in which self-employed workers can voluntarily participate.

Social protection policies related to childcare include Cash Transfer for Orphans and Vulnerable Children (CT-OVC), which supports caregiving families with monthly transfer of 2,000 Kenyan shillings (\$12) toward education, health, civil registration, and strengthening of capacities within the household.

### **Approaches to Childcare and Domestic Work**

At the national government level, childcare services are offered by the Directorate of Children’s Services (DCS) and the National Council for Children’s Services (NCCS), with interventions mainly around educational support, daycare services, healthcare support services, parenting training, legal support, community outreach, and economic empowerment. However, the study notes that a number of the public institutions that serve and house children have dilapidated conditions and limited budgetary allocations. The private sector plays an increasingly large role in the provision of childcare services, and there are calls for the private sector to provide different forms of subsidized childcare for workers (examples include an employer-funded voucher or reimbursement system or subsidized childcare centers for the children of workers).

The regulatory framework for domestic work can be found in Kenya’s constitution, which provides protections for workers, including domestic workers, and in a number of laws that specifically cover domestic workers. Domestic workers in Kenya are also covered by two of the major social protection schemes in Kenya: the National Health Insurance Fund (NHIF) and the National Social Security Fund (NSSF). The Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers

(KUDHEIHA) plays a pivotal role in disseminating information and providing training on conflict prevention and dispute resolution in employment relations.

### **Health Services As Part of Care Infrastructure**

In terms of healthcare services, the case study focuses on home-based care and palliative care, which have been scaled up by the formation of the Kenya Hospices and Palliative Care Association (KEHPCA). The Ministry of Health developed a palliative care policy that endeavors to improve the quality of life of patients with life-limiting diseases and their families, addressing health concerns and related psychosocial and spiritual well-being. The case study also explores the role of community care in the provision of healthcare services, primarily in relation to community health volunteers and the state's support of this care via the Kenya Community Health Policy 2020–2030. Last, the case study finds that public health services are being replaced by private facilities and that an increasing share of public financing for health is being redistributed to private sector actors.

### **Care and People with Disabilities**

The case study also examines public care services for persons with disabilities. The National Council for Persons with Disabilities (NCPWD), a state corporation in Kenya, provides a wide range of services, including provision of assistive devices, economic empowerment, education assistance, infrastructure and equipment grants, and legal and advisory services. The Cash Transfer for Persons with Severe Disabilities (PWSD-CT) aims to enhance the capacities of caregivers through cash transfers and to thereby improve the livelihoods of persons with severe disabilities.

### **Women's Economic Empowerment and Care Infrastructure**

The case study highlights the national Women Economic Empowerment Strategy (2020–2025)<sup>119</sup> for the ways in which it seeks to address women's unpaid care work in efforts to promote women's economic empowerment. The policy encourages the private sector to hire women, develops affordable care centers for babies, and strengthens women's employable skills through formal and informal education and training and advocacy campaigns. The policy also articulates the need to invest in and improve water, electricity, and road infrastructure to reduce women's unpaid labor, and it calls for addressing the impacts of early marriage, female genital mutilation, gender-based violence, and reproductive health. At the same time, the policy has no specific intervention to measure care work or its contribution to development. There is a general monitoring and evaluation framework to facilitate effective assessment of outcomes, indicators, and impacts in line with the Sustainable Development Goals.

## **INVESTMENTS IN CARE INFRASTRUCTURE**

The case study finds that government financing for key sectors related to care work is inadequate. These key sectors are early and basic education, health, agriculture, social protection, water, and irrigation. The University of Nairobi Women's Economic Empowerment Hub's recent analysis of the 2021–2022 budget (presented in the case study) found that the total budget allocated to sectors that have an impact on women's care work is 11% of total government spending. This number includes investments in health, education, agriculture, water, and energy.

The hub's analysis argues that this spending is inadequate to meet the needs of women and other marginalized groups and has led to a gap between those who need public care services and those who can receive them. This gap includes individuals who need to access the cash transfer programs for orphans and vulnerable children, elderly people, and persons with severe disabilities. For example, the orphans and vulnerable children cash transfer program targets 540,500 households with orphaned children, whereas Kenya has an estimated 3.6 million orphans. Also, the current amount of

cash transferred to a beneficiary is 2,000 Kenyan shillings (\$12) per beneficiary per month, which may not be sufficient to guarantee a decent living standard. The low coverage of the social protection schemes means that women continue to take care of the vulnerable population with inadequate support systems.

Moreover, the hub notes that health expenditures between 2018 and 2022 have not been more than 4% of the national budget—far below the 15% target that Kenya committed to under the Abuja Declaration. Spending on education is only 2.9% of total government spending, which is inadequate to ease the financial burden on Kenyan households. At the same time, the case study argues that public debt has risen significantly with public spending on large infrastructure projects (but not care-supporting infrastructure), whereas spending on care-related sectors remains inadequate.

Finally, the case study argues that the minimal expenditures on water, irrigation, and sanitation (2.1% of total government spending) and agriculture (1.7% of total government spending) increase income insecurity and precarity for women and girls. Underinvestment in these sectors means that citizens will not receive the care they need and women will have unequal opportunities as they continue to meet the care needs of families and communities.

## **CONCLUSION**

The case study of Kenya highlights the unequal care responsibilities women hold and the need for public policies to better address this inequality. It argues that the government of Kenya has a constitutional responsibility to address care, which it does through programs and policies related to domestic care, childcare, elder care, and care of the sick. However, a number of these policies do not redress the unequal gender distribution of care work. There is also no overarching general care policy or strategy that integrates all of these various policies. Last, the government must increase and expand public investments related to care infrastructure.

# MEXICO<sup>m</sup>

## BACKGROUND, RESEARCH OBJECTIVES, AND METHODOLOGY



In Mexico, care has gained relevance in public debate in recent years. A primary example of this is the current discussion taking place in the national Congress on the development of a National Care System. In this context, a number of research investigations have examined the government of Mexico's actions related to care with the aim of developing public care policies.<sup>120</sup> However, the case study notes that previous research efforts faced several obstacles, such as a lack of agreement on the methodology for examining public policies and budgets related to care, a lack of agreement on what policies can be classified as care policies, and a lack of a complete view of the multiplicity of care needs since most of the care has been confined to the private sphere with the unpaid work of women in the home. In Mexico, around two billion hours of care work are

carried out each week, and of them, only 6% are paid.<sup>121</sup> For the rest, there are no data regarding the needs of people who received or provided care.

The lack of categorization of state actions on care in the literature and in available methodologies complicates the analysis of care systems and budgets. Developing a consistent set of criteria to evaluate which public policies and programs are public care policies is important as a fundamental resource for current national and regional discussions and the potential approval of a National Care System Law. The case study of Mexico aimed to propose a methodology to evaluate whether the Mexican state's actions on care can be considered care public infrastructure or not. With this aim, the case study offers a definition of care, develops a categorization of state or government actions on care, proposes a definition of public care policy (or care infrastructure), and designs and tests a methodological framework, which includes an assessment of the 2022 Mexican federal budget.

## CONCEPTUAL FRAMEWORK

The case study discusses various definitions of care and defines care, paraphrasing the work of Angela Giglia,<sup>122</sup> as "a way of inhabiting the world . . . 'a way of relating with the world' to produce and reproduce a (world) order. . . . Inhabiting is a way of relating to all aspects of the environment: the home, the family, the city, the environment and so on."<sup>123</sup> That being said, the case study focuses on public policies related to care practices in relation to people.

### Social Organization of Care

The case study recognizes the existence of different care stakeholders or stakeholders with care responsibilities, such as families, communities, the state, and the private sector, with all having important and distinctive roles. However, the current social organization of care is characterized by inequality based on factors such as gender, race/ethnicity, class, and caste. For the case study, the authors focus on the Mexican state as the main stakeholder. The state is responsible for ensuring people's access to public care in such a way that it transforms care practices, undoing inequalities in its provision, and brings it close to the social ideal of care, where caring is understood as "a way of

<sup>m</sup> This summary is based on the case study published as a research article in the *International Journal of Care and Caring*. The summary contains citations as well as textual references to this research article. For more details, see H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). "State, Public Policy, and Care: A Methodology for the Analysis of State Policy on Care." *International Journal of Care and Caring*, 1–16. <https://doi.org/10.1332/239788221X16890895484088>

conceiving and experiencing our relationship with our immediate surroundings, with the community and with the environment.”<sup>124</sup>

### **Care As State Actions and Care Public Policies (As Care Public Infrastructure)**

From a public perspective, this case study conceptualizes “care” from a rights-based approach. It emphasizes the role of the state as guarantor of this right by pointing out the need to define the state’s responsibilities for care, which should be different from the responsibilities of other care stakeholders, such as the family. The state’s role should center on implementing policies to transform current care practices and the current unequal social organization of care and on “ensuring the exercise of the right to care for others, to be cared for, and to self-care.”<sup>125</sup>

Following this conceptual framework, the authors of the case study argue that a state action can be considered a care action if

- its objectives or operating regulations are directed to care—in other words, if the action’s goals are in direct relation to the people who need care or the care providers or aim to ensure equity and co-responsibility in care; or
- its activities
  - involve the direct provision of care: policies, budgets, or social programs focusing on people’s care needs;
  - facilitate or allow conditions for care (care preconditions or indirect care): policies, budgets, or social programs that provide what is required for a person to tend to another person’s care needs or their own; or
  - promote equity between men and women or co-responsibility between the state, the market, families, and communities: policies, budgets, or social programs that promote equal participation in care by all agents involved in care.

The case study goes deeper, identifying state actions directly related to care and peripheral to care. It develops four categories of implementation strategies for these state actions on care: (1) institutional; (2) cultural; (3) transfers and services (that is, policies that provide financial compensation for a care service); and (4) mixed (that is, policies that include two or more of the aforementioned implementation strategies).

## **INVESTMENTS: CARE-RELATED BUDGETARY PROGRAMS**

Based on this methodological framework, the Mexico case study analyzes 56 care-related budgetary programs; based on the framework criteria developed in the case study, the authors classify only nine programs as state actions on care. Of the nine programs identified, two are classified as relating to direct care, five to preconditions for care, and two to equity and co-responsibility.

In 2020 the total care budget assigned through these nine programs was 0.4% of the federal budget. Of the nine programs, the two direct care policies are related to childcare and elder care services.<sup>126</sup> In relation to the pre-conditions for care, programs include a child development and welfare services program that mandates supervision and compliance with existing services (rather than direct services) and a program providing subsidies to the parents of children with cancer.<sup>127</sup> Finally, one of the programs classified as relating to equity and/or co-responsibility in care is the Protection and Restitution of the Rights of Children and Teenagers program, which requires the state to take co-responsibility for the care of minors who are adopted or whose mothers are incarcerated.<sup>128</sup> Of the remaining 48 programs, the authors categorize 44 as peripheral to care. The case study includes examples and recommendations on how to modify some programs so they can be considered care public policies.

## CONCLUSION

The authors of this case study call for a clear definition of a state action related to care. They argue for differentiating state actions on care from governmental initiatives that relate to health, labor rights, or social security. They point out that clearly defining which state public policies can be classified as state actions on care is essential in the context of the country's current discussion on the implementation of a National Care System. Furthermore, the study concludes that although the direct state efforts and public financing for care are limited, there is an opportunity to organize and give more consistency to a number of peripheral care activities that the Mexican state is implementing.

## PERU<sup>n</sup>

### BACKGROUND, RESEARCH OBJECTIVES, AND METHODOLOGY



The case study focuses on the urban informal settlement of Santa Rosa de Comas, located in one of the most populous districts of Lima. It was founded by internal migrants who occupied the territory in 1959 and claimed their right to be part of the city, even before Comas was officially a district of Lima. Like many other communities and neighborhoods in Lima, in the absence of the state, the community of Santa Rosa managed the provision of healthcare autonomously, without regulation, and based on the resources of the community members and its families. In the context of the COVID-19 pandemic, the few precarious public services collapsed, increasing the burden on families, who were already assuming most of the responsibilities and burdens of care.

The Peru case study explores the conceptualization of care infrastructure and care investment through community care and health infrastructure in urban contexts by focusing on the community Anti-COVID-19 Committee of Santa Rosa in Comas (Anti-COVID-19 Committee), which is a subcommittee of the Santa Rosa Committee that was founded in 1959 by residents of Santa

Rosa in Lima. By doing so, this case study seeks to characterize the role that organized civil society (community-based actors) and community social networks, in particular women leaders, played in generating care infrastructures to attend to the effects of the COVID-19 pandemic. Furthermore, the case study examines the ways in which women leaders reconcile their leadership role with other areas of their lives and their own care responsibilities.

The case study conducted a literature review and collected firsthand data through in-depth interviews with three members of the Anti-COVID-19 Committee and two representatives of the Directorate of Health of Northern Lima, as well as conducting participant observation in the community of Santa Rosa and a focus group with members of the Anti-COVID-19 Committee.

The research was carried out by the research consultants Chakakuna with the cooperation of local leaders and the Anti-COVID-19 Committee, with which Oxfam in Peru had previously collaborated.

### CARE AND CARE INFRASTRUCTURE

The case study defines care as a way “to sustain life,” recognizing the central function care has for society. It examines care from a social responsibility and right-based approach that sees care being valued, recognized, and promoted by society as a whole and by the state. Furthermore, care is understood through the prism of community care as meeting the needs of the population through the use of community resources such as collective organizing, local ties, and communal knowledge and practices for the fulfillment of life. Community care implies the collaboration and active participation of members of the community to promote community members’ well-being. These activities contribute to central aspects of life such as care for children, elderly people, and the sick, mental health care, nutrition and food management, and disease prevention.

<sup>n</sup> This summary is based on the published case study, L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria: estudio de caso del Comité Comunitario Anti-COVID-19 de Santa Rosa de Comas (Lima, Perú)*. Lima: Oxfam Perú and Chakakuna. <https://peru.oxfam.org/lo-%C3%BAltimo/publicaciones/infraestructuras-de-cuidados-y-salud-comunitaria-de-santa-rosa-de-comas>. The summary contains citations as well as textual references to this country case study.

Care infrastructure in the case study refers to “the network of resources, services, and systems that are available to meet the care needs of people, including with special priority girls, boys, and adolescents, older adults, people with disabilities, and sick people.”<sup>129o</sup> A sustainable and strong care infrastructure demands a co-responsibility approach with the participation of all care stakeholders: the state, as guarantor of the right to care; the private sector; communities; and families.<sup>130</sup>

## SOCIAL ORGANIZATION OF CARE

Although the social organization of care has traditionally been family oriented, with families, and primarily women within families, holding the main care responsibilities, the authors of the case study articulate a co-responsibility approach, where all stakeholders have a responsibility as providers of care. They also describe the regional and national context, in which some actors have been working toward the adoption of a rights-based approach, demanding implementation of regulatory frameworks that define the role of the state, and calling for implementation of National Care Systems.

That being said, the Peru case study focuses on the role of community organizers (*agentes comunitarios*)—in particular, women community organizers—in providing integrated services to meet health, care, and economic needs in the context of the COVID-19 pandemic. This focus acknowledges the important role communities played during the pandemic and the resulting care crisis as well as the important function community leaders play as a bridge between the state, communities, and families as these leaders demand and implement care activities.

## COMMUNITY CARE AND COMMUNITY ORGANIZATIONS AS PART OF CARE INFRASTRUCTURE

The study understands care infrastructure as the communal fabric of society in relation to its leaders and organization. Community organizations serve as care infrastructure for, among other purposes, strengthening well-being (in terms of health) by building bridges between the state and the community. These organizations can identify and make visible the community’s needs and advocate for them to the state.

### Activities and Approaches Taken by the Santa Rosa Community Anti-COVID-19 Committee

The case study presents a brief history of the Anti-COVID-19 Committee and describes the main activities and approaches taken by this committee during the pandemic. A main milestone was the official formation of the committee, which was recognized by the Peruvian Ministry of Health (MINSA) in July 2020. The decision to form the committee was a direct response to the high number of people dying in the urban settlement, including an important community organizer and leader.

Among the first committee’s activities were two “rallies for life” to make visible the situation of the community’s residents. Their slogan was “We Are Dying in Santa Rosa.” In this context, the committee formalized its work plan, including a first overview of the health situation that revealed that between 150 and 200 people had died within their community. With the increased visibility resulting from media attention, MINSA provided community organizers with direct contacts (via WhatsApp) as a way to refer health cases directly to MINSA. Besides public campaigns for visibility and direct demands to health officials, the committee carried out activities to slow the virus spread by carrying out spraying (fumigation) campaigns, health campaigns, and testing and diagnosis campaigns. To support the most-affected families, the committee delivered care baskets, and it provided specific support to community members experiencing challenging situations (such as facing eviction after losing their source of income). It also sold basic food items at low prices, distributed oximeters, and trained

<sup>o</sup> The case acknowledges that care infrastructure was coined by Nancy Folbre in *The Invisible Heart*, op. cit.

people in their use. Additionally, a professional with expertise in psychology led a mental health campaign.

After focusing on making visible the crisis, gathering evidence to understand the status of the health crisis, and taking immediate actions to slow the spread and support the most vulnerable families, in 2021 the Anti-COVID-19 Committee put all its effort into demanding and supporting the state, which was carrying out national-level COVID-19 vaccination campaigns.

By 2022 the Anti-COVID-19 Committee had established contact with the Ministry of Economy and Finance (MEF) to request that an unused physical infrastructure in Santa Rosa be converted to a health center with an emphasis on mental health. In May 2022 symbolic tribute was paid to the residents of Santa Rosa who had died of COVID-19, and in the same year, the Anti-COVID-19 Committee revised its objectives and was renamed the Committee for Life and Health. As of July 2022, according to the leaders, approximately 100 neighbors participated, according to their needs and their capabilities.

### **Women's Leadership**

The community organizers are mainly older adults, age 60 and over, most of whom are women. Many of these women joined after seeing relatives die from COVID-19. The authors of the case study characterized their leadership along four dimensions: "commitment to the community; knowledge of public management; honesty; and experience of activism/militancy"<sup>131</sup> that allows them to know how to relate to other people as key actors. However, the women of the committee described the challenges they faced in balancing their paid jobs, their community work, and their care work responsibilities. The women found themselves facing a dilemma in which some dimension of their lives must be "sacrificed." The case study argues that they incurred heavy costs in their personal relationships and self-care (understood as invisible costs). For example, some of the women leaders reported being called a "bad mother."

Looking toward the future, the case study identifies the greatest challenge for the community of Santa Rosa as the sustainability of the community work. Young people will need to assume leadership tasks and positions and be willing to learn from the experiences of other community leaders. Community members' decisions about whether to become involved with the committee may be impacted by individual factors (such as the age of their children, the state of their mental health, or mistrust) and structural factors (such as socioeconomic status, long working hours, and heavy load of unpaid care work). Thus it will be important to consider community members' characteristics and experiences when promoting community participation, especially considering that it is women who contribute to a greater extent to these activities<sup>132</sup> and also face structural inequality (in the form of, for example, a heavy load of care work and higher rates of poverty) that may limit their participation.

## **CARE INVESTMENTS**

The case study documents a high level of investment carried out by the committee, its members, and the organized community of Santa Rosa to form the committee and carry out its activities. These investments were mostly not economic, although they did demand economic resources from their members. They mainly included the time, effort, and leadership knowledge required to strengthen social ties and organize community work as well as investments in leadership to develop connections and formal relations with different levels of government in order to transfer and implement the care demands of the community. The case study strongly recommends public investments in community leadership to form the next generation of leaders in Santa Rosa.

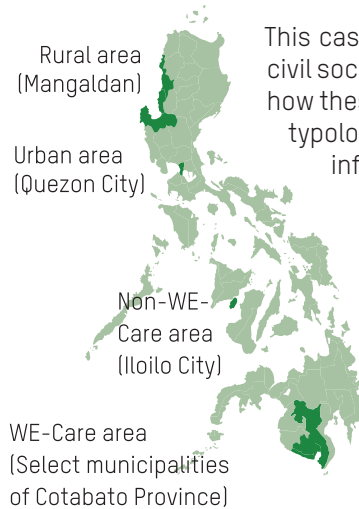
The case study also identifies the existence of more tangible investments that the committee implemented both on its own, such as the economic relief efforts they carried out for families in need, and through the government, such as COVID-19 tests, oximeters, and vaccines. In terms of major physical infrastructure, the committee is demanding the construction of a health center in the community.

## **CONCLUSION**

The case study illustrates an example of community care and the important role that community networks play in providing critical care services and in serving as a bridge between families, communities, and the state. It also highlights that community networks are filling a vital gap left by the state and that the state should support and invest in community care. In particular, so that community leaders do not increase their own care work responsibilities and negatively impact their own well-being, it also highlights the importance of ensuring that community care does not reproduce the typical unequal gendered distribution of care work.

# THE PHILIPPINES<sup>p</sup>

## BACKGROUND, RESEARCH OBJECTIVES, AND METHODOLOGY



This case study examines the salience of care infrastructure as a concept in civil society, communities, local governments, and the federal government and how these actors define what constitutes care infrastructure. It puts forward a typology of care infrastructure investments in the Philippines: physical care infrastructure, care services, care policies and regulations, employment-related care provision, and norm-reorienting investments.

The case study uses a review of policies and documents from the government, civil society, and businesses. It also draws on 31 key informant interviews with local leaders and community members to build case stories on how investments (or non-investment) in care infrastructure have affected women's lives and livelihoods across four types of pre-selected communities: (1) WE-Care program areas, (2) non-WE-Care program areas, (3) urban communities, and (4) rural communities.

## SOCIAL ORGANIZATION OF CARE

The case study finds that families, and mainly women within them, are the main providers of care and considered by other social actors as the main providers of care. State policies reinforce the family as the main provider of care while giving some support for care provision for poor and marginalized people. The case study examines the role of local governments and their responsibilities and flexibility in supporting and providing care. It notes that the private sector is a stakeholder, tasked primarily with ensuring the provision of care services such as childcare and nurseries and providing state-mandated rights such as breastfeeding areas in workplaces and places of leisure. However, affordable, high-quality, and accessible care infrastructure is not uniformly present in all the regions, and those with higher incomes access care services in the private market, especially for domestic work.

## DEFINITIONS AND DEBATES AROUND CARE INFRASTRUCTURE

The case study broadly situates care as the "the provision of services, time or effort, and money to meet the physical and emotional requirements of an individual, and the normative, economic, and social frameworks within which these are assigned and carried out."<sup>133</sup> The case study also elaborates on the specific Philippines context of care: *Pag-aalaga* is taking care of a "person because you need to or you provide for their basic needs." *Pag-aaruga* is "a deeper variation of care, where you are not only providing for their basic needs, but you are also showing them concern." *Pag-kandili* is "where you are nourishing, caring, and supporting them."<sup>134</sup>

In the Philippines infrastructure has been at the forefront of the government agenda as it is considered a vital driver of economic growth because it creates jobs and connects households to the market. The government recognizes that infrastructure promotes access to basic services and expands economic opportunities, which improve the quality of life of the households. The importance of infrastructure in the national development agenda is underlined by significant public budget

<sup>p</sup> This summary is based on the published case study report, J. Angelo, E. Bata, and M. Quiogue (2023). *Care Is Essential Infrastructure: The Case of the Philippines*. Quezon City: Oxfam Pilipinas and Fieldwork PH. <https://oxfam.org.ph/download/care-is-essential-infrastructure-the-case-of-the-philippines/>. The summary contains citations as well as textual references to this country case study.

allocations and private sector participation in the past few years, as in the case of the Build Build Build Program. However, care-related infrastructure is not considered to be a part of this policy framework. The case study notes that the role of care in supporting the development and well-being of society remains obscured.

Interviews with stakeholders revealed that the phrase “care infrastructure” is not salient in the Philippines. In interviews, the term “care infrastructure” prompted “hazy definitions”<sup>135</sup> or an articulation of how it may differentiate or overlap with social protection and healthcare infrastructure. One reason for this response could be that unpaid care work is still considered to be within the ambit of the private sphere. Over the course of the interviews, respondents’ understanding of care infrastructure moved beyond care-supporting physical infrastructure, and they noted that such care infrastructure has positively impacted the lives of women.

The study defines care infrastructure as a network of structures, frameworks, and systems that enables and supports the delivery of, access to, and provision of care to a wide segment of the population that is necessary for survival and well-being, particularly to those who have less in life. These care infrastructures include social norms; high-quality, affordable, and accessible childcare services; healthcare services; long-term care for people with disabilities, sick people, and elderly people; insurance and other forms of social protection; and paid medical, parental, and vacation leave. In other words, care infrastructure includes not only physical care-related infrastructure but also services and regulations geared toward providing high-quality, affordable, and accessible care.

## COMPONENTS OF CARE INFRASTRUCTURE

### Care-Supporting Physical Infrastructure

For both community and government respondents, care infrastructure was at first understood as physical infrastructure (such as daycare centers, health centers, evacuation centers, farm-to-market roads, community (*barangay*) halls, water systems, and even streetlights). When prompted, however, respondents were able to expand their perceptions of care beyond the physical.

### Social Protection and Care Infrastructure

The case study identifies a number of social protection policies as a part of care infrastructure: the Pantawid Pamilyang Pilipino Program (4Ps), a conditional cash transfer program conditioned on parents’ investments in their children’s health and education; government social security services, including the national pension scheme; the national insurance program (PhilHealth); and the Sustainable Livelihood Program. Respondents noted that these programs provide baseline protection for meeting everyday expenses.

### Knowledge and Care Infrastructure

The Philippines case study also highlights how trainings and seminars can shift community norms in regard to unpaid care work. In the WE-Care Program in Libungan Torreta in 2019, seminars laid a foundation for shifting community practices around the unequal distribution of unpaid care work. Interview respondents noted that such trainings helped women articulate the importance of the care work they provide and the ways in which their husbands could support their work. As a result, community norms, especially of men, shifted.

### Community Networks and Care Infrastructure

Respondents in WE-Care areas of the study mentioned *dagyaw* or *dayum* as a form of community-led care infrastructure.<sup>136</sup> In this practice, community members help each other by providing needed labor, giving neighbors crops or food items, or pooling monetary contributions to help pay for hospital or burial expenses. Community respondents in all four areas of the study identified the *barangay*

(smallest/local administrative division) and *barangay* captains as having responsibility for care: “respondents view their immediate community as an extension of their family life, and they trust their *barangay* captain to look out for them.”<sup>137</sup> Respondents also highlighted community-related care infrastructure in the form of shared laundry areas in communities that have obstacles with piped water and community sharing of childcare responsibilities.

## INVESTMENTS

Investments in care infrastructure exist in the Philippines, although they are often inadequate or not directly and explicitly related to care work. These care infrastructure investments are often by-products of other programs and initiatives. Communities demand increased investment.

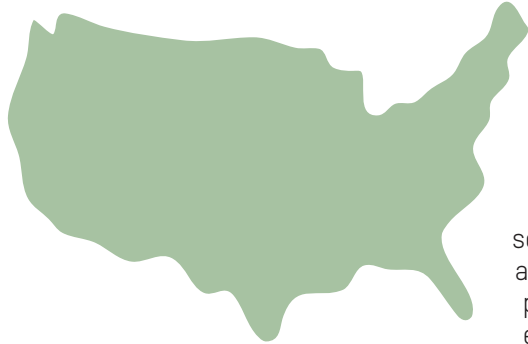
In most cases, the government categorizes care infrastructure under social welfare programs. At the local government level, investments are tied to the gender and development (GAD) budget. The study argues that local government units seem to be stuck with programs and policies prescribed by the national government and have little flexibility to use GAD funds for direct care-related services. Often local governments cannot propose new programs or spending as it is considered “redundant with existing policies such as the gender and development (GAD) policy and health policies.”<sup>138</sup> The case study notes that there is no clear differentiation between care-related programs and GAD programs, a situation that reduces investments in care-related programs.

## CONCLUSION

The case study finds a public-private divide, with care located in the private sphere (that is, within households and families). Public care provisions treat the family as the basic unit of intervention; thus the state’s role is to support care provision for those who are poor and marginalized. Additionally, government policies on gender equality do not explicitly link care and gender equality. To ensure that care is on the public agenda, care work should be central to the government’s development, poverty alleviation, and gender equality frameworks.

# UNITED STATES<sup>9</sup>

## BACKGROUND, RESEARCH OBJECTIVES, AND METHODOLOGY



The COVID-19 pandemic resulted in unprecedented pressures on systems of care, which informed a public debate on care infrastructure in the US between March 2020 and July 2022.

This case study examines how the US federal government (executive and legislative branches), civil society, and the media defined “care infrastructure” and care infrastructure investments in the context of a public debate surrounding the Biden administration’s efforts to pass the Build Back Better (BBB) Act in 2021. Additionally, this case study extends its framework

to understand whether LGBTQ+ issues are considered in mainstream conceptualizations of care infrastructure.

In their methodology, the authors of this case study conducted content analysis of secondary sources on the public and national debate around “care infrastructure” and “care as infrastructure” that occurred in the US during the pandemic between March 2020 and July 2022. Secondary sources analyzed included policy and legislation documents, civil society organization reports, news stories, op-eds, social media messages, and public statements.

## SOCIAL ORGANIZATION OF CARE

The study identifies different stakeholders in the national public debate around care infrastructure. Among them are the US federal government (executive and legislative branches, presided over by the Democratic and Republican Parties), civil society organizations, and the private sector. The primary civil society organization that the case study focuses on is the Care Can’t Wait Coalition, which includes care worker organizations. It is important to mention that the public debate focused on the role of the federal government as the primary stakeholder in providing care and supporting care provision.

## DEBATES AROUND CARE INFRASTRUCTURE

### Executive Branch of the Government

The Biden administration’s (2021–present) efforts to pass care-related policies were significant and without precedent, although these efforts were not able to reach final consensus in Congress. The case study notes that Joe Biden was the first president in US history to release a proposal on caregiving while he was still on the campaign trail.<sup>139</sup> Within weeks of being inaugurated, President Biden worked with the Democratic majority in Congress to pass the American Rescue Plan Act (ARPA), which included the biggest investment in childcare since World War II, an extension of the paid leave benefits introduced in the Families First Coronavirus Response Act (FFCRA),<sup>140</sup> and an expansion of both the child tax credit<sup>141</sup> and the child and dependent care tax credit.<sup>142</sup> The BBB framework included provisions on childcare, care for the elderly and those with disabilities, and an expanded child tax credit, although many of these provisions did not make it into the last version of BBB that passed the House of Representatives. The subsequent American Families Plan and American Jobs

<sup>9</sup> This summary has been developed based on the internal case study, R. Rewald and L. Pascarella (2022). “United States: Debates and Discussion around Care during COVID-19.” Internal document. Boston: Oxfam America. The summary contains citations as well as textual references to this country case study.

Plan from the Biden administration included the same care-related provisions, plus an expanded child and dependent care tax credit and a plan to provide all workers with 12 weeks of family and medical leave.<sup>143</sup> Additionally, Biden's agenda included efforts to increase pay and strengthen labor rights for paid care workers.

### **Congressional Debate**

Because the initial version of the BBB Act that passed the Democrat-controlled House of Representatives included all the of the care-related provisions proposed by Biden, the authors of the case study find it difficult to distinguish large differences between the Biden administration's and the Democratic lawmakers' conceptualization of care infrastructure, with the exception of a few individual members of Congress.

In an attempt to dampen opposition to the bill, paid family and medical leave were ultimately dropped from the bill. The authors argue that the fact that paid family and medical leave was sacrificed while other care-related provisions were not might shed light on different Democrats' conceptualization of care infrastructure. Additionally, while the Biden administration initially proposed \$400 billion for home-and community-based care services for elderly people and people with disabilities, the BBB Act included only \$150 billion for this provision, perhaps indicating that this issue is less of a priority for Democratic lawmakers. The case study discusses more deeply the internal discussion and opposition from a few Democratic senators that led to the passage of a final reconciliation bill without any care provisions in it.

On the Republican side of the debate, the case study finds no examples of lawmakers explicitly supporting the framing of care as infrastructure. Furthermore, the authors argue that the Republican framing of infrastructure means that Republicans are less likely to support an investment in "care infrastructure," or even use the term. Senior Republican Party leaders directly opposed framing government support for care services as infrastructure spending. During the COVID-19 pandemic, Republicans did support individual care-related policies, often agreeing to enact these policies for short periods of time, but they tended to view care measures as one-off policies.

Specifically, the immediate federal response to the pandemic, the first year of which happened during the Trump administration, heavily centered on supporting care, albeit in the short term. For example, the Coronavirus Aid, Relief, and Economic Security (CARES) Act,<sup>144</sup> passed during the Trump administration in 2020, included emergency funding to childcare providers to help stabilize the childcare industry. The FFCRA included temporary emergency paid sick leave and paid family medical leave provisions for millions of employees who otherwise did not have access to these benefits.<sup>145</sup> However, subsequent legislation to permanently codify paid family leave resulted in significant Republican backlash.<sup>146</sup>

The authors of the case study argue that Republican officials recognize the need for care policies in emergency situations (such as COVID-19) but do not necessarily recognize the lack of care support as an ongoing problem of infrastructure and as requiring long-term public investment. Some Republican Party members frame care, and specifically childcare, as a private rather than a public responsibility. At the same time, the case study observes that childcare-related policies gained the support of some Republicans due their alignment with conservative values.<sup>f</sup>

Later Republicans introduced the Protecting Worker Paychecks and Family Choice Act, which addressed childcare as well as paid family and medical leave. Among other things, the childcare portion of the bill focused on "leveraging" the \$50 billion already passed for childcare funding through the various COVID-19 relief packages rather than issuing any new funding. Rather than have the

---

<sup>f</sup> Republican Senators Joni Ernst and Maggie Hassan introduced a bill in March 2021 called the Improving Child Care for Working Families Act, and as a response to the childcare provisions in BBB, Senator Richard Burr and Senator Tim Scott co-sponsored the Child Care and Development Block Grant Reauthorization Act of 2022 (CCDBG). The biggest differences between the two bills are that the Republican bill does not include a funding commitment, does not address childcare workers' pay, and limits the number of families that would receive financial subsidies for childcare.

federal government pay for family and medical leave benefits for workers, this bill would incentivize the private sector to offer and pay for this leave.<sup>147</sup> This Republican childcare proposal underscores a framing that does not view care as infrastructure but approaches care through narrow policies that limit public investment and rely on incentivizing the private sector to invest.

### **Civil Society Approaches**

While the debate around the federal government's role in care continued, there was also a heated debate taking place within civil society spaces. The authors argue that care-focused civil society organizations provided an integrated vision of care infrastructure that included framing care as a public good or as a part of a national agenda. For instance, the advocacy group Caring Across Generations called for a "national care agenda" that treats care like "a public good that requires collective, public policy-supported solutions."<sup>148</sup> From their point of view, care infrastructure should include (1) universal long-term services and support, mainly for elderly people and people with disabilities; (2) universal childcare; (3) paid sick and safe days and paid family and medical leave policies; (4) support for "sandwich generation" caregivers, including provision of training, financial compensation, and health assistance; (5) assurance of dignity for domestic workers and all care workers; and (6) mechanisms for people to better access care benefits.<sup>149</sup> Similarly, the Care Can't Wait Coalition, which includes Caring Across Generations and 15 other organizations, adopted a broad definition and conceptualization of care infrastructure.<sup>150</sup> In 2021 the coalition introduced a separate policy agenda that includes the narrower list of policies that appeared in the Build Back Better agenda: childcare and early learning, home- and community-based services, and paid family and medical leave.<sup>151</sup>

### **LGBTQ+ Communities**

The case study argues that discussions on care infrastructure must consider the care needs of and discrimination faced by LGBTQ+ communities, an issue that typically receives little attention. Drawing on the work of Sage, a national-level organization drawing attention to intersections of LGBTQ+ populations and care infrastructure, the case study notes that that LGBTQ+ children encounter exclusion in care settings (particularly schools) and LGBTQ+ elders face discrimination in care settings. Given the risks faced by LGBTQ+ youth, the need for better childcare support for families is critical. Additionally, LGBTQ+ elders are much more likely to live alone than are cisgender heterosexual people and as a result are heavily reliant on paid caregivers. LGBTQ+ elders report fears over discrimination in their care and describe discrimination in care settings, with minimal legal protections against discrimination.<sup>152</sup>

## **CONCLUSION**

The US case study highlights an important and unprecedented debate regarding the state's role in care and care infrastructure, despite the fact that the BBB bill did not become law and many of the visionary changes related to public care services did not become a reality. On one side of the debate was an understanding of care as a "system" critical to the functioning of an economy and society. This conceptualization goes beyond pure economic framing since it includes the well-being of communities. Civil society, the executive branch of the government, and much of the Democratic Party understood and pushed for a set of care policies and large financial public investments as part of the national infrastructure that supports the functioning of society. On the other side of the debate were individuals, organizations, and the majority of the Republican Party in the legislative branch advocating a much narrower understanding of infrastructure that excludes care. A number of senior Republican leaders understood infrastructure more narrowly as referring only to physical infrastructure and largely excluding care services, with exception of one-off, short-term policies related to some spheres of care—namely, childcare. Moreover, this framing does not view care as a public good for which the state provides large-scale investments.

# ZIMBABWE<sup>s</sup>

## BACKGROUND, RESEARCH OBJECTIVES, AND METHODOLOGY



The objectives of the case study of Zimbabwe are to (1) explore the definitions, experiences, and debates related to care infrastructure across different social actors and across urban and rural settings; (2) understand how unpaid care work impacts women's lives; and (3) understand how infrastructure can address women's unpaid care work.

The research is based on a review of relevant policy documents, 27 key informant interviews, and eight focus group discussions. Interviews were conducted with community and local leaders, government actors, and members of civil society organizations (CSOs). Interview subjects were identified through a stakeholder mapping exercise with a focus on communities in which Oxfam and Oxfam partners are implementing projects related to care work. The focus group discussions had between 15 and 20 participants selected from individuals participating in Oxfam programming; the focus groups were conducted in three districts.

## DEFINITIONS AND DEMANDS OF CARE INFRASTRUCTURE

The case study presents the perspectives of CSO, state, and community actors on how to define care infrastructure. Study participants defined care work as activities "done to give care/support to family or community without any recognition and or remuneration whatsoever." CSO actors see care infrastructure as encompassing physical infrastructure, norms, and practices that support care work, but the CSO actors interviewed did not immediately identify policies and laws as a part of care infrastructure. In the course of the interviews, urban CSO actors did identify policies such as maternity leave as part of care infrastructure, but rural CSO actors did not.

State actors defined care infrastructure as physical infrastructure that can alleviate and redistribute care work responsibilities. Such care-supporting physical infrastructure encompasses "structures and innovations such as the immovable physical, visible structures and devices that support care delivery work such as obtaining water and sanitation, conducting reproductive chores, and procuring energy as well as the general mental well-being of women."<sup>153</sup>

Community actors also focused on physical infrastructure, in large part because of the importance of this infrastructure for meeting the challenges of daily life. Initially, neither urban nor rural community actors included policies, knowledge, or initiatives as a part of care infrastructure. Over the course of the interviews, however, community actors began to identify practices and community networks and initiatives as a part of care infrastructure.

## COMPONENTS OF CARE INFRASTRUCTURE

### Physical Infrastructure

Through interviews and focus group discussions, the case study identifies the following types of physical infrastructure as a core part of care infrastructure in Zimbabwe: water infrastructure, roads,

<sup>s</sup> This summary has been developed based on the internal case study report commissioned by Cowen Dziva (2022), "Understanding Care Infrastructure by Civil Society Groups in Rural Areas and Government Actors in Zimbabwe." Harare: Oxfam in Zimbabwe. The summary contains citations as well as textual references to this case study.

schools, and health facilities. In rural communities, respondents most strongly identified water infrastructure, owing to the significant amount of time women spend collecting water. This water infrastructure includes the refurbishment of water wells, solar-powered water pumps, the building of water tanks, and piped water infrastructure. These types of infrastructure can reduce the time women spend collecting water and thereby reduce their care duties.

Respondents in rural areas also highlighted the importance of having an adequate density of rural health facilities and school buildings in helping reduce care workloads. Respondents identified the need for good roads and proper transportation in order to ensure that women can reduce the amount of time they spend taking their children to schools and health facilities.

Another type of physical infrastructure that respondents identified is the Tsotso stove, which reduces the labor and time required for cooking. These stoves allow cooking to take place inside the kitchen, reduce the amount of firewood needed, and allow for cooking while standing. This innovation not only makes it easier for women to cook but also encourages men to take on cooking activities.

### **Laws and Policies**

As noted, research participants did not emphasize policies when discussing care infrastructure. However, urban-based respondents, particularly those in civil society, highlighted labor policies such as maternity leave and protections for pregnancy, birth, and lactation. Some respondents also noted the need for parental leave for both men and women, although some civil society actors interviewed were worried that fathers may not use parental leave to share care responsibilities. Participants in Bubi and Zvishavane districts also lauded local authorities' efforts to hold monthly clinics to immunize children. This policy reduced the amount of time mothers had to spend to travel to the nearest clinic for medical checkups.

### **Knowledge, Social Norms, and Practices**

CSOs noted the importance of building and sharing knowledge around care and care work as a part of care infrastructure. Civil society participants highlighted, in particular, Oxfam- and partner-supported WE-Care programs that raised awareness of how care work responsibilities are distributed. Respondents also noted the critical role that WE-Care programming plays in educating state actors on the importance of care infrastructure; state actors who had not participated in WE-Care programming were less knowledgeable about care.

One of Oxfam's WE-Care partners, Bethany, noted that they have worked to train and educate communities to embrace a more gender-equal division of care work. Bethany staff reported that 20 CARE Champions work in communities to explain the gendered dynamics of care work and the importance of shifting responsibility for care work so that it falls on both men and women. These initiatives have resulted in measurable changes, with men in the household taking on some care duties.

Community respondents also highlighted the impacts of cooking competitions. Men participated in the cooking competitions and in the process debunked social norms that men are "bad cooks" or that "the kitchen is a women's place."<sup>154</sup> The competitions also impacted women's social norms around the role of men and cooking.

Participants spoke of community practices that promote shared labor as important to care infrastructure. In the practice of *Nhimbe*, rural people come together to harvest crops. This practice has an impact on women as they contribute between 60% and 70% of agricultural labor. There are also cooperatives through which women can get assistance in completing unpaid care work. These cooperatives and the practice of *Nhimbe* help redistribute care work from women to men and youth in the community.

In another example of community networks, through the income-generating activities in WE-Care programming, women community members raised money to invest in the community's water infrastructure.

## **CARE INVESTMENTS**

Civil society and community actors are investing in building knowledge-related care infrastructure. In addition, community networks have used care-related programming to raise funds for investment in physical water infrastructure. Although the state has invested in some forms of care infrastructure, particularly water infrastructure and mobile clinics, interviews and focus group discussions highlighted the demand for increased investments. Respondents noted that the state needs to improve transportation, roads, and density of school and health facilities.

## **CONCLUSION**

The case study describes how care infrastructure is defined by different social actors. While all actors had some understanding of care infrastructure, they perceived it largely as physical infrastructure. At the same time, the case study highlights other components of care infrastructure, including community networks, social norms, and care-related policies. There is a need for increased investments in care infrastructure such as investments in the care-related capacity of civil society actors, communities, and policymakers.

# ENDNOTES

- 1 A. Parvez Butt, M.R. Castro Bernardini, A. Parkes, V. Paz, R. Seghaier, and S. Nanda. (2021). *Care Policy Scorecard: A Tool for Assessing Country Progress towards an Enabling Policy Environment on Care*. Oxford: Oxfam International, p. 6. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621287/bp-care-policy-scorecard-240921-en.pdf;jsessionid=797FEF7CDD0D59C519144F4895435BAC?sequence=17>
- 2 International Labour Organization (ILO). (2018). *Care Work and Care Jobs for the Future of Decent Work*. Geneva: ILO, pp. 72, 13, 142. [https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms\\_633135.pdf](https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf)
- 3 Ibid.
- 4 A. Parvez Butt, A. Parkes, C. Veiceli, and M.R. Castro Bernardini. (2021). *Care Policy Evidence Review: Evidence of Effective Policy Measures and Programme Interventions to Address Unpaid and Paid Care Work*. Oxford: Oxfam International. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621287/bp-evidence-effective-policy-measures-240921-en.pdf?sequence=11>
- 5 S. Valiani. (2022). *The Africa Care Economy Index*. Nairobi: African Women's Development and Communication Network (FEMNET), p. vi.
- 6 L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria: estudio de caso del Comité Comunitario Anti-COVID-19 de Santa Rosa de Comas*. Lima, Peru: Oxfam in Peru and Chakakuna. <https://peru.oxfam.org/lo-%C3%BAltimo/publicaciones/infraestructuras-de-cuidados-y-salud-comunitaria-de-santa-rosa-de-comas>
- 7 Ibid., p. 21.
- 8 Comisión Económica para América Latina y el Caribe (CEPAL) and ONU Mujeres. (2020). *Cuidados en América Latina y el Caribe en tiempos de COVID-19: hacia sistemas integrales para fortalecer la respuesta y la recuperación*. <https://repositorio.cepal.org/server/api/core/bitstreams/1c41fa60-37ab-4f2f-80a6-3e15320aa08e/content>
- 9 Inter-American Court of Human Rights. (2023). Request for an Advisory Opinion submitted by Argentina before the Inter-American Court of Human Rights of January 20, 2023. [https://www.corteidh.or.cr/solicitud\\_opiniones\\_consultivas.cfm?lang=en](https://www.corteidh.or.cr/solicitud_opiniones_consultivas.cfm?lang=en). Accessed 15 January 2024.
- 10 F. Marco and M. Rico. (2013). *Cuidado y políticas públicas: debates y estado de situación a nivel regional*, p. 3. In L. Pautassi and C. Zibecchi, eds., *Las fronteras del cuidado: Agenda, derechos e infraestructura*, pp. 27–58. Buenos Aires: Editorial Biblos.
- 11 J. Tronto. (2013). *Caring Democracy: Markets, Equality, and Justice*. New York: NYU Press.
- 12 C. Ferreyra. (2022). *Los cuidados en Latinoamérica y El Caribe: entre las crisis y las redes comunitarias*. Ecofeminita and Oxfam. [https://oi-files-cng-v2-prod.s3.eu-west-2.amazonaws.com/lac.oxfam.org/s3fs-public/file\\_attachments/Informe\\_Los%20cuidados%20en%20LAC%2C%20entre%20la%20crisis%20y%20las%20redes%20comunitarias.pdf](https://oi-files-cng-v2-prod.s3.eu-west-2.amazonaws.com/lac.oxfam.org/s3fs-public/file_attachments/Informe_Los%20cuidados%20en%20LAC%2C%20entre%20la%20crisis%20y%20las%20redes%20comunitarias.pdf)
- 13 The Care Collective. (2020). *The Care Manifesto: The Politics of Interdependence*. London: Verso.
- 14 Economic Commission for Latin America and the Caribbean (ECLAC). (2023). *Buenos Aires Commitment (LC/CRM.15/6/Rev.1)*. Santiago: ECLAC, p. 6.
- 15 The Care Collective (2020). *The Care Manifesto*, op. cit.
- 16 R. Aguirre, K. Batthyány, N. Genta, and V. Perrotta. (2014). "Los cuidados en la agenda de investigación y en las políticas públicas en Uruguay." *Íconos, Revista de Ciencias Sociales*, 18(50), p. 49.
- 17 ILO. (2018). *Care Work and Care Jobs for the Future of Decent Work*, op. cit., p. 6.
- 18 Ibid.
- 19 A. Parvez Butt et al. (2021). *Care Policy Scorecard*, op. cit., p. 6.
- 20 J. Tronto. (2013). *Caring Democracy*, op. cit.
- 21 V. Esquivel. (2014). "What Is a Transformative Approach to Care, and Why Do We Need It?" *Gender and Development*, 22(3), 423–439. <https://doi.org/10.1080/13552074.2014.963303>

- 22 A. Parvez Butt et al. (2021). *Care Policy Scorecard*, op. cit., p. 6.
- 23 Oxfam America. (2021). "Oxfam America Unpaid and Underpaid Care Work Strategy: 2021–2024." Internal document. Boston: Oxfam America, p. 2.
- 24 Ibid.
- 25 The Care Collective. (2020). *The Care Manifesto*, op. cit.
- 26 ECLAC. (2023). *Buenos Aires Commitment*, op. cit.
- 27 ECLAC. (2022). *The Care Society: A Horizon for Sustainable Recovery with Gender Equality*. LC/CRM.15/3. Santiago: ECLAC. <https://repositorio.cepal.org/items/aa7173cb-8473-43af-ba65-7777706c2b0>
- 28 N. Folbre. (2006). "Measuring Care: Gender, Empowerment, and the Care Economy." *Journal of Human Development*, 7(2), p. 185. <https://doi.org/10.1080/14649880600768512>
- 29 D. Elson. (2005). *Unpaid Work: Creating Social Wealth of Subsiding Patriarchy and Private Profit?* Presentation to Forum on Social Wealth, Political Economic Research Institute, University of Massachusetts, Amherst.
- 30 Ibid.
- 31 I. Peng. (April 2, 2021). *What Is the Care Economy and Why Should We Care?* Care Work and the Economy. <https://research.american.edu/careworkeconomy/blog/tag/care-economy/>
- 32 T. Bhattacharya. (2017). "Introduction: Mapping Social Reproduction Theory." In T. Bhattacharya, ed., *Social Reproduction Theory: Remapping Class, Recentering Oppression*. London: Pluto Press.
- 33 Ibid.
- 34 L. Ossome. (2021). "The Care Economy and the State in Africa's Covid-19 Responses." *Canadian Journal of Development Studies*, 42(1–2), p. 71. <https://doi.org/10.1080/02255189.2020.1831448>
- 35 L. Ossome and S. Naidu. (2021). "The Agrarian Question of Gendered Labour." In P. Jha, L. Ossome, and W. Chambati, eds., *Labour Questions in the Global South*. New Delhi: Springer.
- 36 N. Folbre (2021). *The Rise and Decline of Patriarchal Systems: An Intersectional Political Economy*. United Kingdom: Verso.
- 37 Ibid.
- 38 C. Ferreyra. (2022). *Los cuidados en Latinoamérica y El Caribe*, op. cit., p. 7.
- 39 S. Razavi. (2007). *The Political and Social Economy of Care in the Development Context: Conceptual Issues, Research Questions, and Policy Options*. Gender and Development Paper Number 3. Geneva: United Nations Research Institute for Social Development, p. 21.
- 40 V. Esquivel. (2014). "What Is a Transformative Approach to Care, and Why Do We Need It?" op. cit.
- 41 Ibid.
- 42 S. Razavi. (2007). *The Political and Social Economy of Care in the Development Context*, op. cit., p. 22.
- 43 J. Martínez Franzoni. (2008). *¿Arañando Bienestar?: Trabajo Remunerado, Protección Social y Familias en América Central*, 1st ed. Buenos Aires: Consejo Latinoamericano de Ciencias Sociales (CLACSO).
- 44 ILO. (2018). *Care Work and Care Jobs for the Future of Decent Work*, op. cit.
- 45 C. Ferreyra. (2022). *Los cuidados en Latinoamérica y El Caribe*, op. cit.
- 46 M.B. Aliaga. (2021). "Gender Inequality during the Pandemic: Perspectives of Women Workers in Latin America and the Caribbean." *International Journal of Labour Research*, 10(1–2), p. 93. [https://labordoc.ilo.org/discovery/fulldisplay/alma995340933602676/41ILO\\_INST:41ILO\\_V2](https://labordoc.ilo.org/discovery/fulldisplay/alma995340933602676/41ILO_INST:41ILO_V2)
- 47 J. Rogero-García. (2012). *Regions Over-burdened with Care: Continental Differences in Attention for Dependent Adults*. Documentos de Trabajo 5. Bilbao: Fundación BBVA.
- 48 R. Oloo and A. Parkes. (2021). *Addressing Unpaid Care and Domestic Work for a Gender-Equal and Inclusive Kenya*. WE-Care policy briefing. Oxford: Oxfam. <https://policy-practice.oxfam.org/resources/addressing-unpaid-care-and-domestic-work-for-a-gender-equal-and-inclusive-kenya-621179/>

- 49 C. Hess, T. Ahmed, and J. Hayes. (2020). *Providing Unpaid Household and Care Work in the United States: Uncovering Inequality*. Washington, DC: Institute for Women's Policy Research and Oxfam. <https://iwpr.org/wp-content/uploads/2020/01/IWPR-Providing-Unpaid-Household-and-Care-Work-in-the-United-States-Uncovering-Inequality.pdf>
- 50 B. Heilman, M.R. Castro Bernardini, and K. Pfeifer. (2020). *Caring under COVID-19: How the Pandemic Is and Is Not Changing Unpaid Care and Domestic Work Responsibilities in the United States*. Boston: Oxfam; Washington, DC: Promundo-US. <https://policy-practice.oxfam.org/resources/caring-under-covid-19-how-the-pandemic-is-and-is-not-changing-unpaid-care-and-621084/>
- 51 L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria*, op. cit.
- 52 Ibid.
- 53 C. Ferreyra. (2022). *Los cuidados en Latinoamérica y El Caribe*, op. cit., p. 38.
- 54 V. Esquivel. (2014). "What Is a Transformative Approach to Care, and Why Do We Need It?" op. cit.
- 55 A. Parvez Butt et al. (2021). *Care Policy Scorecard*, op. cit., pp. 16–17.
- 56 Oxfam. (2020). *Time to Care: Unpaid and Underpaid Care Work and the Global Inequality Crisis*. Oxford: Oxfam International, p. 9. <https://policy-practice.oxfam.org/resources/time-to-care-unpaid-and-underpaid-care-work-and-the-global-inequality-crisis-620928/>
- 57 L. Rost and S. Koissy-Kpein. (2017). *Infrastructure and Equipment for Unpaid Care Work: Household Survey Findings from the Philippines, Uganda, and Zimbabwe: Household Care Survey Report*. Oxford: Oxfam International. <https://policy-practice.oxfam.org/resources/infrastructure-and-equipment-for-unpaid-care-work-household-survey-findings-fro-620431/>
- 58 Oxfam. (2020). *Time to Care*, op. cit.
- 59 K. Piaget, C. Coffey, S. Molano, and M.J. Moreno Ruiz. (2020). *Feminist Futures: Caring for People, Caring for Justice and Rights*. Oxford: Oxfam International. <https://policy-practice.oxfam.org/resources/feminist-futures-caring-for-people-caring-for-justice-and-rights-621046/>
- 60 A. Parvez Butt et al. (2021). *Care Policy Scorecard*, op. cit.
- 61 Oxfam. (2021). *The Inequality Virus: Bringing Together a World Torn Apart by Coronavirus through a Fair, Just, and Sustainable Economy*. Oxford: Oxfam International. <https://oxfamlibrary.openrepository.com/bitstream/handle/10546/621149/bp-the-inequality-virus-summ-250121-en.pdf?sequence=23>
- 62 D. Chauhan and S. Bist Joshi. (2021). *Care Principles and Care-Responsiveness Barometer: Guidelines and Toolkit for International Financial Institutions (IFIs)*. Oxford: Oxfam International. <https://policy-practice.oxfam.org/resources/care-principles-and-care-responsive-barometer-guidelines-and-toolkit-for-intern-621303/>
- 63 C. Ferreyra. (2022). *Los cuidados en Latinoamérica y El Caribe*, op. cit.
- 64 D. Chauhan and S. Bist Joshi. (2021). *Care Principles and Care-Responsiveness Barometer*, op. cit.
- 65 A. Parvez Butt et al. (2021). *Care Policy Scorecard*, op. cit., p. 20.
- 66 Oxfam. (2021). "Increasing Investments in the IDA20 Replenishment Process." Boston: Oxfam. [https://webassets.oxfamamerica.org/media/documents/IDA\\_and\\_Care\\_Final\\_July\\_2021.pdf](https://webassets.oxfamamerica.org/media/documents/IDA_and_Care_Final_July_2021.pdf)
- 67 D. Chauhan and S. Bist Joshi. (2021). *Care Principles and Care-Responsiveness Barometer*, op. cit.
- 68 Oxfam in Bolivia. (2019). *Time to Care: Sharing Care for Sustainable Living*. Executive Summary. [https://actions.oxfam.org/media/assets/file/Time\\_to\\_Care-Ingl%C3%A9s\\_2WyeDA8.pdf](https://actions.oxfam.org/media/assets/file/Time_to_Care-Ingl%C3%A9s_2WyeDA8.pdf)
- 69 L. Pautassi. (2023). *The Right to Care: From Recognition to Its Effective Exercise*. Mexico City: Friedrich Ebert Foundation in Mexico. <https://library.fes.de/pdf-files/bueros/mexiko/20270.pdf>
- 70 V. Esquivel. (2017). "The Rights-Based Approach to Care Policies: Latin American Experience." *International Social Security Review*, 70(4), p. 90. <https://doi.org/10.1111/issr.12154>
- 71 ECLAC. (2022). *The Care Society*, op. cit.
- 72 L. Pautassi. (2023). *The Right to Care*, op. cit.
- 73 Republic of Argentina. (2023). "Request for an Advisory Opinion to the Inter-American Court of Human Rights: The Content and Scope of Care As a Human Right, and Its Interrelationship with Other Rights." [https://www.corteidh.or.cr/docs/opiniones/soc\\_2\\_2023\\_en.pdf](https://www.corteidh.or.cr/docs/opiniones/soc_2_2023_en.pdf)

- 74 Oxfam LAC. (2023). "Comentarios relativos a la opinión consultiva sobre 'El contenido y el alcance del derecho al cuidado y su interrelación con otros derechos.'" Internal document.
- 75 Ibid.
- 76 Ibid., p. 5.
- 77 Ibid., p. 5.
- 78 N. Folbre. (2001). *The Invisible Heart: Economics and Family Values*. New York: New Press
- 79 L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria*, op. cit.
- 80 H. Jarvis. (2015). "Towards a Deeper Understanding of the Social Architecture of Co-Housing: Evidence from the UK, USA and Australia." *Urban Research and Practice*, 8(1), 93–105. <https://doi.org/10.1080/17535069.2015.1011429>
- 81 A. Parvez Butt et al. (2021). *Care Policy Scorecard*, op. cit., p. 32.
- 82 Ibid.
- 83 Ibid., p. 12.
- 84 Oxfam. (2021). Increasing Investments in the IDA20 Replenishment Process, op. cit., p. 9.
- 85 Oxfam. (2023). WE-Care Programme. <https://policy-practice.oxfam.org/we-care/>
- 86 L. Cuba Varas, E. Goñez Fernández, F. Encalada Yong, C. Oviedo, and C. Navarro Lopez. (2024). *Santa Rosa de Comas y la crisis de cuidados: Aprendizajes desde la organización comunitaria durante la pandemia de COVID-19*. Brief. Lima: Oxfam in Peru. <https://peru.oxfam.org/lo-%C3%BAltimo/publicaciones/brief-santa-rosa-de-comas-y-la-crisis-de-cuidados>
- 87 H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). "State, Public Policy, and Care: A Methodology for the Analysis of State Policy on Care." *International Journal of Care and Caring*, p. 6. <https://doi.org/10.1332/239788221X16890895484088>
- 88 Ibid., p. 7.
- 89 J. Angelo, E. Bata, and M. Quiogue (2023). *Care Is Essential Infrastructure: The Case of the Philippines*. Quezon City: Oxfam Pilipinas and Fieldwork PH, p. 22. <https://oxfam.org.ph/download/care-is-essential-infrastructure-the-case-of-the-philippines/>
- 90 Ibid., p. 2.
- 91 L. Cuba Vargas et al. (2024). *Santa Rosa de Comas y la crisis de cuidados*, op. cit, p. 8.
- 92 J. Kalipeni and J. Kashen. (September 1, 2020). "Building Our Care Infrastructure: For Equity, Economic Recovery, and Beyond." *Caring Across Generations*, p. 7. <https://caringacross.flywheelsites.com/carepaper/>
- 93 C. Dziva. (2022). "Understanding Care Infrastructure by Civil Society Groups in Rural Areas and Government Actors in Zimbabwe." Internal document. Harare: Oxfam in Zimbabwe, p. 8.
- 94 N. Chehade, N. Fahmy, A. Holmstrom, P. Iyer, R. Rewald, and M.R. Castro Bernardini. (2023). *US Care Policy Scorecard: Assessing Federal Unpaid and Underpaid Care Policies in the US*. Boston: Oxfam America, p. 19. [https://webassets.oxfamamerica.org/media/documents/US\\_Care\\_Policy\\_Scorecard\\_FINAL\\_Xi0f557.pdf?\\_gl=1\\*1ihnye0\\*\\_ga\\*NTQxNzQ3MTUxLjE2OTU2NzA5MzI.\\*\\_ga\\_R58YETD6XK\\*MTcwODYzNTgxMC4yOC4xLjE3MDg2MzU4MjQUNDYuMC4w](https://webassets.oxfamamerica.org/media/documents/US_Care_Policy_Scorecard_FINAL_Xi0f557.pdf?_gl=1*1ihnye0*_ga*NTQxNzQ3MTUxLjE2OTU2NzA5MzI.*_ga_R58YETD6XK*MTcwODYzNTgxMC4yOC4xLjE3MDg2MzU4MjQUNDYuMC4w)
- 95 J. Angelo, E. Bata, and M. Quiogue. (2023). *Care Is Essential Infrastructure*, op. cit., p. 39.
- 96 N. Folbre. (2014). "The Care Economy in Africa: Subsistence Production and Unpaid Care." *Journal of African Economies*, 23(supplement 1), i128–i156. <https://doi.org/10.1093/jae/ejt026>
- 97 S. Hall. (2020). *Addressing Unpaid Care to Close the Gender Gap in the Philippines and Zimbabwe: The Women's Economic Empowerment and Care Project Report, 2016–2019*. Oxford: Oxfam International, pp. 19–21. <https://policy-practice.oxfam.org/resources/addressing-unpaid-care-to-close-the-gender-gap-in-the-philippines-and-zimbabwe-620933/>
- 98 H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). "State, Public Policy, and Care," op. cit., p. 7.
- 99 L. Marcos Barba et al. (2020). *Shelter from the Storm: The Global Need for Universal Social Protection in Times of COVID-19*. Oxford: Oxfam International. <https://policy-practice.oxfam.org/resources/shelter-from-the-storm-the-global-need-for-universal-social-protection-in-times-621132/>

- 100 S. Kidd and D. Athias. (2019). *Hit and Miss: An Assessment of Targeting Effectiveness in Social Protection*. Working Paper. Orpington, UK: Development Pathways. <https://www.developmentpathways.co.uk/wp-content/uploads/2019/03/Hit-and-Miss-March13-1.pdf>
- 101 H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). "State, Public Policy, and Care," op. cit., p. 11.
- 102 L. Pautassi. (2023). *The Right to Care*, op. cit.
- 103 L. Marcos Barba et al. (2020). *Shelter from the Storm*, op. cit.
- 104 National Council for Children Services and Republic of Kenya. (2020). *Kenya National Care System Assessment: A Participatory Self-Assessment of the Formal Care System of Children Living outside of Family Care and for the Prevention of Unnecessary Separation of Children from Families*. Nairobi: National Council for Children Services and Republic of Kenya
- 105 B. Khawaja and R. Riddell. (May 20, 2022). *Stealth Privatization: Kenya's Approach to Universal Health Coverage Is a Private Sector Giveaway*. Open Global Rights. <https://www.openglobalrights.org/stealth-privatization-kenyas-approach-to-universal-health-coverage-is-a-private-sector-giveaway/>
- 106 University of Nairobi Women Economic Empowerment Hub. (2021). Care Economy Budget Brief, 2021. Unpublished document.
- 107 B. Khawaja and R. Riddell. (May 20, 2022). *Stealth Privatization*, op. cit.
- 108 L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria*, op. cit., p. 77.
- 109 H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). "State, Public Policy, and Care," op. cit., p. 11.
- 110 L. Pautassi. (2023). *The Right to Care*, op. cit.
- 111 J. Angelo, E. Bata, and M. Quiogue. (2023). *Care Is Essential Infrastructure*, op. cit., p. 2.
- 112 Kenya, Ministry of Public Service and Gender, State Department for Gender. (2020). Women Economic Empowerment Strategy 2020–2025. <https://gender.go.ke/wp-content/uploads/2021/04/Women-Economic-Empowerment-Strategy-2020-2025-REVISED-10th-march.pdf>
- 113 L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria*, op. cit., p. 18.
- 114 M. Lawson et al. (2019). *Public Good or Private Wealth?* Oxfam Briefing Paper. Oxford: Oxfam and Even It Up. <https://policy-practice.oxfam.org/resources/private-wealth-or-public-good-620599/>
- 115 K. Malouf Bous and J. Farr. (2019). *False Promises: How Delivering Education through Private Schools and Public-Private Partnerships Risks Fueling Inequality instead of Achieving Quality Education for All*. Oxford: Oxfam GB. <https://policy-practice.oxfam.org/resources/false-promises-how-delivering-education-through-private-schools-and-public-priv-620720/>
- 116 R. Jalipa. (Forthcoming, 2024). *Oxfam Care Infrastructure: A Kenya Case Study Policy Brief*. Nairobi: Oxfam Kenya.
- 117 Ibid., p. 4.
- 118 Ibid., p. 5.
- 119 Kenya. (2020). Women Economic Empowerment Strategy 2020–2025, op. cit.
- 120 G. Cejudo, C. Michel, S. Ortiz, A. Sobrino, H. Trujillo, and M. Vázquez. (2017). "Diagnóstico sobre el problema público en materia de cuidados en México" [Diagnosis of the public issue of care in Mexico]. Mexico City: CIDE.
- 121 A. Heatley. (2022). "Sostener la vida: las redes de cuidados en México" [Sustaining life: care networks in Mexico]. Foro "La Sociedad del Cuidado y Políticas de la Vida," 9th Conferencia Latinoamericana y Caribeña de Ciencias Sociales. [https://conferenciaclacso.org/programa/actividades\\_por\\_participante.php?p=8288](https://conferenciaclacso.org/programa/actividades_por_participante.php?p=8288)
- 122 A. Giglia. (2012). *El habitar y la cultura: perspectivas teóricas y de investigación* [Habitating and culture: theoretical and research perspectives]. Mexico City: Anthropos Editorial.
- 123 H.A. Garciamarín Hernández and A. Heatley Tejada. (2023). "State, Public Policy, and Care," op. cit., p. 3.
- 124 Ibid., p. 3.
- 125 Ibid., p. 6.
- 126 Ibid., pp. 9–10.
- 127 Ibid., pp. 10–11.

- 128 Ibid., p. 11.
- 129 L. Cuba, E. Goñez, and F. Encalada. (2024). *Infraestructura de cuidados y salud comunitaria*, op. cit., p. 19.
- 130 Ibid., p. 4.
- 131 Ibid., p. 56.
- 132 L. López-Bolaños, M. Campos-Rivera, and M.A. Villanueva-Borbolla. (2018). "Compromiso y participación comunitaria en salud: aprendizajes desde la sistematización de experiencias sociales." *Salud Pública de México*, 60(2): 192–201.
- 133 J. Angelo, E. Bata, and M. Quiogue. (2023). *Care Is Essential Infrastructure*, op. cit., p. 6.
- 134 Ibid., p. 10.
- 135 Ibid., p. 11.
- 136 Ibid., p. 39.
- 137 Ibid., p. 46.
- 138 Ibid., p. 4.
- 139 Joe Biden for President: Official Campaign Website. *The Biden Plan for Mobilizing American Talent and Heart to Create a 21st Century Caregiving and Education Workforce*. Accessed November 21, 2022. <https://joebiden.com/caregiving/>
- 140 US Internal Revenue Service. (2022). *Tax Credits for Paid Leave Under the American Rescue Plan Act of 2021: Overview*. Accessed November 21, 2022. <https://www.irs.gov/newsroom/tax-credits-for-paid-leave-under-the-american-rescue-plan-act-of-2021-overview>
- 141 US Department of the Treasury. (March 18, 2021). *Fact Sheet: The American Rescue Plan Will Deliver Immediate Economic Relief to Families*. Accessed November 21, 2022. <https://home.treasury.gov/news/featured-stories/fact-sheet-the-american-rescue-plan-will-deliver-immediate-economic-relief-to-families>.
- 142 American Rescue Plan of 2021. (2022). H.R. 2617, 117th Congress. <https://www.govinfo.gov/app/details/COMPS-16472>
- 143 White House. (April 28, 2021). *Fact Sheet: The American Families Plan*. <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/>
- 144 Coronavirus Aid, Relief, and Economic Security Act (CARES Act). (2020). S. 3548, 116th Congress. <https://www.congress.gov/bill/116th-congress/senate-bill/3548/text>
- 145 Families First Coronavirus Response Act. (2020). H.R. 6201, 116th Congress. <https://www.congress.gov/bill/116th-congress/house-bill/6201/text>
- 146 J. Pramuk. (April 22, 2021). "Senate Republicans Outline Their Own Infrastructure Plan—Here's What's in It." CNBC. <https://www.cnbc.com/2021/04/22/senate-republicans-release-infrastructure-plan-in-counter-to-biden-proposal.html>
- 147 Committee on Ways and Means, Republicans. (May 2021). "Discussion Draft: Protecting Worker Paychecks and Family Choice Act." <https://gop-waysandmeans.house.gov/wp-content/uploads/2021/05/PWPFCA-Section-by-Section-052721-FINAL.pdf>
- 148 J. Kalipeni and J. Kashen. (September 1, 2020). "Building Our Care Infrastructure," op. cit., p. 7.
- 149 Ibid.
- 150 Care Can't Wait. *About*. <https://www.carecantwait.org/about>.
- 151 Care Can't Wait. (March 26, 2021). "Care Can't Wait Coalition's Jobs and Economic Recovery Agenda: Building a Durable and Equitable Care Infrastructure." [https://nwlc.org/wp-content/uploads/2021/04/PolicyAgenda\\_CareCantWait\\_20210330a.pdf](https://nwlc.org/wp-content/uploads/2021/04/PolicyAgenda_CareCantWait_20210330a.pdf)
- 152 Sage. (2021). *Uplift LGBT Carework in the American Jobs Plan*. Movement Advancement Project. <https://www.lgbtmap.org/file/2021-brief-sage-lgbt-carework.pdf>
- 153 C. Dziva. (2022). "Understanding Care Infrastructure by Civil Society Groups in Rural Areas and Government Actors in Zimbabwe," op. cit., p. 3.
- 154 Ibid., p. 25.

© Oxfam International 2024

This publication is copyrighted, but the text may be used free of charge for the purposes of advocacy, campaigning, education, and research, provided that the source is acknowledged in full. The copyright holder requests that all such use be registered with them for impact assessment purposes. For copying in any other circumstances, or for re-use in other publications, or for translation or adaptation, permission must be secured, and a fee may be charged. Email [policyandpractice@oxfam.org.uk](mailto:policyandpractice@oxfam.org.uk).

The information in this publication is correct at the time of going to press.

Published by Oxfam GB for Oxfam International in June, 2024. DOI: 10.21201/2024.000031

Oxfam GB, Oxfam House, John Smith Drive, Cowley, Oxford, OX4 2JY, UK.

## OXFAM

Oxfam is an international confederation of 21 organizations, working with its partners and allies, reaching out to millions of people around the world. Together, we tackle inequalities to end poverty and injustice, now and in the long term – for an equal future. Please write to any of the agencies for further information or visit [www.oxfam.org](http://www.oxfam.org).

Oxfam America ([www.oxfamamerica.org](http://www.oxfamamerica.org))  
Oxfam Aotearoa ([www.oxfam.org.nz](http://www.oxfam.org.nz))  
Oxfam Australia ([www.oxfam.org.au](http://www.oxfam.org.au))  
Oxfam-in-Belgium ([www.oxfamsol.be](http://www.oxfamsol.be))  
Oxfam Brasil ([www.oxfam.org.br](http://www.oxfam.org.br))  
Oxfam Canada ([www.oxfam.ca](http://www.oxfam.ca))  
Oxfam Colombia ([www.oxfamcolombia.org](http://www.oxfamcolombia.org))  
Oxfam France ([www.oxfamfrance.org](http://www.oxfamfrance.org))  
Oxfam Germany ([www.oxfam.de](http://www.oxfam.de))  
Oxfam GB ([www.oxfam.org.uk](http://www.oxfam.org.uk))  
Oxfam Hong Kong ([www.oxfam.org.hk](http://www.oxfam.org.hk))

Oxfam Denmark ([Oxfam.dk](http://www.oxfam.dk))  
Oxfam India ([www.oxfamindia.org](http://www.oxfamindia.org))  
Oxfam Intermón (Spain) ([www.oxfamintermon.org](http://www.oxfamintermon.org))  
Oxfam Ireland ([www.oxfamireland.org](http://www.oxfamireland.org))  
Oxfam Italy ([www.oxfamitalia.org](http://www.oxfamitalia.org))  
Oxfam Mexico ([www.oxfamMexico.org](http://www.oxfamMexico.org))  
Oxfam Novib (Netherlands) ([www.oxfamnovib.nl](http://www.oxfamnovib.nl))  
Oxfam Québec ([www.oxfam.qc.ca](http://www.oxfam.qc.ca))  
Oxfam South Africa ([www.oxfam.org.za](http://www.oxfam.org.za))  
KEDV ([www.kedv.org.tr](http://www.kedv.org.tr))

The confederation also includes three prospective affiliates (organizations on their way to full affiliation). As a part of our commitment to global balance and to developing Oxfam as a diversified network, we are working to grow the number of Oxfam affiliates in the Global South over the coming years. The three prospective affiliates are national organisations based in Pilipinas, Indonesia (Penabulu) and Pacific.

### Cover photos:

Residents of Libungan Town in Cotabato, Philippines, share water supply in the pipeline built through the project of WE-Care. Cotabato, Philippines. 2109. ©Jed Regala/Oxfam.

Women and men care champions in Zimbabwe's Bubi District pose behind the water tanks that store the water they use for laundry and gardening, among others. Bubi District, Zimbabwe. 2019. ©Ian Nyasha Gadzayi/Oxfam.

National Care Conference, "The Future of Care in Mexico," May 25 and 26, Mexico City. 2023. © Oxfam Mexico.

Janet Fuentes talks about the Anti-COVID-19 Committee she leads in her community. The group is walking through the community talking about the situation with the neighbors. Santa Rosa de Comas, Lima. 2022. ©Miguel Villalobos/Oxfam in Peru.

[www.oxfam.org](http://www.oxfam.org)

