



POLICY BRIEF

CARE ENVIRONMENTS IN JALISCO, MEXICO: RESULTS OF THE PILOT STUDY TO REFLECT ON THE NEEDS OF PRIMARY FEMALE CAREGIVERS

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“Initiatives to strengthen care policies in Latin America and the Caribbean”

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Care Environments in Jalisco, Mexico: Results of the Pilot Study to Reflect on the Needs of Primary Female Caregivers

Yasodhara Silva y Emiliano Barba

Introduction

According to a 2020 study conducted in the Metropolitan Area of Guadalajara (AMG), Jalisco, 85% of primary caregivers in households are women. These women provide care work seven days a week, with availability that can extend up to 24 hours a day to meet the needs of children, adolescents, elderly people, or people with disabilities. This caregiving burden significantly affects their time, reducing opportunities for rest, leisure, self-care, and access to personal income through paid employment with social protection.

The Care Environments Model in Jalisco was one of four projects selected in 2023 by the Fund for Applied and Collaborative Research for Latin America and the Caribbean on Innovations in Public Policy Related to the Care Economy. Inspired by Bogotá's Care Blocks (Manzanas del Cuidado), this model proposes a territorial strategy to strengthen the economic autonomy of unpaid caregivers, particularly women. It aims to coordinate training and physical and emotional well-being services, along with access to external care services for those who depend on their support. The model follows an inter-institutional approach—engaging subnational, state, and municipal governments—and an intersectoral perspective that includes public, social, and private sectors.

The pilot study was implemented in two municipalities of the AMG, each with different institutional frameworks regarding care. Zapopan was the first municipality to establish a care system and regulatory framework, whereas Tlajomulco had not yet implemented care-related programs or actions. Through a mixed-methods research design, the pilot enabled the identification of the needs of female caregivers and areas of opportunity to improve public care policies, aligned with the goals of the 5Rs: Recognize, Reduce, Redistribute, Reward, and Represent.

Study Description

The pilot study included the participation of female caregivers, state and municipal institutions, and civil society organizations. Both quantitative and qualitative methods were used to collect information, including pre- and post-surveys with treatment and control groups, focus groups, and interviews.

How was the implementation carried out?

The content of the program pathway was collaboratively defined with state and municipal institutions. The implementation structure at each site included a facilitator responsible for ensuring continuity between sessions, a community promoter to follow up with the group of participants, a person in charge

of caregiving replacement during the sessions, 29 public officials, and 3 members from social organizations.

Methodology

The Care Environments Model in the state of Jalisco was implemented as a pilot study in two municipalities of the Guadalajara Metropolitan Area (AMG): the Community

Development Center of DIF Hacienda Santa Fe in Tlajomulco de Zúñiga and Colmena Miramar in Zapopan. These locations were selected based on statistical information regarding populations in need of care and the concentration of available municipal infrastructure.

The model consists of a pathway structured into six modules, each with an average duration of one month:

Module 1: Introduction to Care. Aims to raise awareness about the rights of caregivers and introduce the Care Environments project, promoting recognition of care work.

Module 2: Pathways to Physical Well-being. Provides tools and knowledge on nutrition, food health, physical activity, first aid, and preventive health, addressing the physical well-being needs of caregivers.

Module 3: Pathways to Emotional Well-being. Focuses on mental health, emotional management, the “de-feminization” of care, and other key topics related to the emotional well-being of caregivers.

Module 4: Personal Life Plan and Economic Autonomy. Supports participants in planning their life projects and exploring alternatives for building economic autonomy.

Module 5: Socio-Productive Workshops. Offers training in productive skills aimed at generating entrepreneurship opportunities and personal income for female caregivers.

Module 6: Sustainability Plan – “Against All Odds.” This final module seeks to ensure the long-term continuity of program benefits by providing tools and strategies to sustain the well-being and autonomy achieved.

Closing Event: Families participate in activities designed

to promote co-responsibility and the redistribution of tasks through playful and reflective dynamics.

Key Findings

Through the six program modules, the model enabled a comprehensive understanding and approach to the needs of caregivers. These needs were identified through surveys and focus groups, whose findings helped define the module content.

- **Physical well-being:** The need for practical workshops with applicable daily knowledge was identified, covering topics such as nutrition, food health, physical activity, and first aid.
- **Emotional well-being:** The importance of validating the experiences of caregivers was highlighted, along with addressing issues such as caregiver syndrome, the de-feminization of care work, and emotional management.
- **Economic autonomy:** There was a need to adapt information on economic autonomy to the caregiving responsibilities of women, incorporating dynamics focused on task delegation, teamwork, and small practical projects.

What are the main findings in terms of the 5Rs regarding strengths and weaknesses of the Care Environments Model?

Strengths:

- **Recognize:** The model succeeded in raising awareness about the importance of care work and caregivers’ rights. Workshops and activities helped women to value themselves and their caregiving roles, which was also acknowledged by their families.
- **Reduce:** The provision of care support services (care relays) and workshops on physical and emotional well-being helped reduce caregiving

burdens and improve participants’ well-being. However, the care relays were limited to the duration of the sessions. Broader and more sustainable access to appropriate care services is needed..

Weaknesses:

- **Redistribute:** Despite efforts, the redistribution of caregiving responsibilities remains a challenge. The model promoted more equitable sharing through tools for setting boundaries, renegotiating, and delegating tasks within the home, which were well received by participants. However, low male participation—due to entrenched gender roles and the lack of measures such as flexible schedules or leave policies—hindered progress toward effective co-responsibility.
- **Reward:** The model did not directly address the economic dimension of caregiving. It only included monthly raffles of prepaid cards as a retention strategy. This initiative helped meet some immediate needs of caregivers and their families, generating positive recognition of their work. However, broader support mechanisms still need to be explored.
- **Represent:** While caregivers were involved in the program’s design and evaluation, their participation in decision-making processes at local and state levels needs to be strengthened.

What do the Theory of Change indicators reveal?

The Theory of Change indicators reveal several significant differences between the treatment and control groups from Colmena Miramar and DIF Tlajomulco in relation to the economic autonomy, physical well-being, and emotional well-being of women caregivers.

Economic Autonomy:

- **Personal income:** In the treatment group, there was a 9.3% increase in women with personal income, mainly in Zapopan. In contrast, the control group showed only a 2.4% overall increase, with a decrease observed in Tlajomulco.
- **Economic activity:** The proportion of economically active women remained stable in both groups, but with contrasting trends between locations. Zapopan showed increases, while Tlajomulco experienced decreases.
- **Difficulty finding paid employment:** In Zapopan, women in the treatment group reported fewer difficulties finding paid employment, while in Tlajomulco no such reduction was observed. The opposite occurred in the control group.

Physical Well-Being:

- **Care work seven days a week:** In the Zapopan treatment group, there was a reduction in the percentage of caregivers working seven days a week, while Tlajomulco saw an increase. In the control group, both locations showed increases.
- **Daily hours spent on care:** The data show an increase in time dedicated to care in the treatment group and a reduction in the control group. This could suggest greater recognition of care work among participants in the “Care Environments” program.

Emotional Well-Being:

- **Feelings of loneliness:** A decrease in the feeling of loneliness while performing care tasks was observed in both locations and groups.

- **Fatigue and stress:** There was a reduction in the percentage of caregivers who feel tired and stressed when carrying out care work in both locations and both groups.
- **Reduction in abandonment of leisure activities due to care responsibilities:** The percentage of women who gave up leisure activities decreased in both groups, with a greater reduction in the treatment group.

Government Support, Training, and Certification:

- **Government support:** There was a slight decrease in the proportion of caregivers receiving government support.
- **Training:** In the treatment group, the increase was 83.6%, while no increase was observed in the control group.
- **Certification:** Among women in the treatment group, this indicator increased by 86.9% between the two measurement periods, while no change was observed in the control group.

Summary:

The indicators suggest that the “Care Environments” Model had a positive impact on the economic autonomy and emotional well-being of women caregivers, particularly in Zapopan. However, areas for improvement were also identified, such as addressing difficulties in accessing employment in Tlajomulco and ensuring that women have more free time through the reduction and redistribution of care tasks.

To this end, it is important to strengthen connections with public care services and promote shared caregiving responsibilities within families. In the latter case, it would be

necessary to include activities on weekends and establish partnerships with companies to encourage the participation of men who are unable to engage during weekdays due to work commitments.

Reflections Based on the Findings

The reduction in time dedicated to caregiving was not an indicator that showed significantly favorable results following the implementation of the Model. This highlights the need to make visible the lack of public services and to involve all three levels of government to ensure guaranteed access, while also strengthening strategies for redistributing caregiving responsibilities within households.

In this latter case, shared responsibility and redistribution—which require the participation of men and the family as a whole—become essential. Therefore, the program, originally designed for primary female caregivers, must be adjusted to extend the model to entire families, with strategies specifically aimed at engaging men.

Regarding interinstitutional and intersectoral coordination, while its importance in building a Comprehensive Care System is recognized—and collaborations between state and municipal institutions as well as civil society organizations were achieved—the pilot study revealed differences between the municipalities of Tlajomulco and Zapopan.

These differences, mainly related to previous experience in the institutionalization of care, installed capacities, and institutional, regulatory, and budgetary conditions, confirm that local institutional capacity is a key condition for the implementation and scalability of the model.

This highlights significant challenges for effective governance of the care system at both the state and local levels, including the need to standardize the quality of program content and delivery, and to ensure the sustainability and continuity of services beyond administrative transitions. Strengthening coordination and sharing detailed information about local contexts and participant profiles are essential steps to improve implementation and outcomes. To this end, policy evaluation in diverse institutional and cultural contexts is necessary to adapt proposals to local realities and move toward fair and sustainable systems.

In both pilot locations, the Care Environments were established in peripheral areas with similar conditions of social vulnerability. Although initial tensions arose between mothers of people with and without disabilities—due to the diversity of challenges they faced—the Model provided

participants the opportunity to recognize the demands and challenges of caregiving across different populations.

At the DIF Tlajomulco site, more cases of domestic violence were detected than at Colmena Zapopan, where such cases were also reported but with lower frequency. Therefore, it is important to include a dedicated response track within the Program that ensures effective and monitorable referral to specialized care services.

The diversity of caregiver profiles (in terms of age and number of individuals under their care) enabled the creation of intergenerational networks of support and solidarity. However, some women were unable to participate because they lacked alternative care options for older adults or people with disabilities, due to the absence of substitute care services at the location.

Another essential aspect to increase the model's impact is to

include strategies that promote cultural transformation at the community level, challenging social norms that continue to naturalize caregiving as an exclusively female responsibility. Achieving shared responsibility within families and society requires involving the entire family—including men—and recognizing that the reorganization of care requires the autonomy of all parties involved.

This cultural shift is intrinsically linked to the relational dimension of care, which is based on the interdependence and mutual reciprocity between caregivers and care recipients, and is grounded in a care ethics framework with a human rights and gender perspective. Recognizing care recipients as active rights-holders rather than passive subjects, and ensuring that caregivers participate in decision-making processes, are essential elements in building a society that provides care in a just and equitable manner.

Policy Recommendations

- Expand the provision of care services as a right: A lack of access and limited services was observed, particularly for children and adolescents during after-school hours. There is also a need to include specialized care models for children with Attention Deficit Hyperactivity Disorder (ADHD), older adults with mobility challenges who cannot access institutional spaces without free adapted transportation, and adults with disabilities, including those with psychosocial disabilities.
- Strengthen interinstitutional and intersectoral coordination: Expand coordination spaces with relevant departments and stakeholders involved in the strategy to share detailed information about the contexts and participant profiles, as well as to standardize the use of content and dynamics that incorporate best practices.
- Integrate the strategy of shared caregiving responsibility throughout the Model's entire implementation: Develop activities targeting household members of caregivers to promote and monitor the redistribution of caregiving tasks.
- Engage companies to create conditions that support the labor inclusion of caregivers—both men and women— by offering care services, remote work options, and leave policies for caregiving-related activities.
- Adapt content and dynamics to the specific needs of caregivers: Take into account the characteristics of the populations targeted by the workshops, including age, education level, economic activity, and the types of individuals they care for.
- Ensure the sustainability of the services, programs, and support systems articulated through the Model: It is essential to disseminate and discuss the results of the pilot study with key stakeholders from the public, social, and private sectors to integrate strengths and address weaknesses in the planning of the State and Municipal Care Systems, incorporating the Model as a core component of public policy.