

POLICY BRIEF

COMMUNITY CO-RESPONSIBILITY IN CARE: EVIDENCE FROM THE “CHILE CUIDA” COMMUNITY CARE CENTERS

AUTHORS

Antonia Asenjo |
Camilo Sembler |



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

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Antonia Asenjo | Camilo Sembler

1. Introduction

Care work constitutes a fundamental economic activity. In Chile, a recent study estimates that unpaid domestic and care work is equivalent to 19.2% of the expanded GDP in 2023, making it the country's largest economic sector (Comunidad Mujer and Ministry of Finance, 2025). This figure not only reveals the economic significance of care work but also the depth of a structural inequality. Women contribute 65% of this value, dedicating an average of almost 5 hours a day to caregiving, compared to less than 3 hours for men (NIS, 2025). This inequality has direct consequences for the well-being, health, and employment opportunities of caregivers. More than 32% of caregivers experience intense time burden, with significant effects on their mental and physical health (Ministry of Women and Gender Equity, 2025). The feminization of care work has concrete consequences for women's position in the labor market. Of all those who are economically inactive due to permanent family responsibilities, 94.8% are women (Undersecretariat of Labor, 2024b), with a female labor force participation rate that reached 51.9% in 2024, compared to 70.7% for men (Undersecretariat of Labor, 2024a). This gap is also reflected in the working conditions available to those who do participate in the labor market. Women are disproportionately concentrated in lower-paying sectors, with a higher proportion of informal employment, earning, on average, 25% less than men (NIS, 2024). In this context, a fairer organization of care is a fundamental condition for gender equality and the country's sustainable development. This requires understanding care as a shared responsibility among families, the State, the market, and the community.

In Chile, progress has been made in recognizing, redistributing, and progressively reducing care work. The implementation of the Caregiver Credential, the expansion of the Local Support and Care Network (*Red Local de Apoyos y Cuidados*, RLAC), and, most recently, the approval in January 2026 of the Law creating the National Support and Care System (*Sistema Nacional de Apoyos y Cuidados*, SNAC) represent concrete steps in that direction. This law marks a turning point by recognizing care as a fundamental human right and establishing it as the fourth pillar of social protection, promoting a universal and integrated approach to care grounded in gender equality and community co-responsibility.

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The Community Care Centers (CCCs) are the main territorial infrastructures of the SNAC, operating since late 2024. What sets them apart from previous interventions is their focus on unpaid caregivers rather than those receiving care, with the goal of promoting caregivers' well-being, improving their access to services, and fostering community co-responsibility. The centers are directed at unpaid caregivers of people with functional dependencies and/or children and adolescents that reside in the municipalities where they operate². Their governance model represents an innovation in Chilean social policy, centering community participation and adaptation to local conditions as defining features of the program. By early 2026, 62 centers had opened across the country.

This policy brief presents the main findings of a study conducted in 2025 aimed at identifying the conditions that promote or hinder community co-responsibility in the CCCs across four territorial contexts. The research was conducted by the Faculty of Social Sciences at the University of Chile, with the active collaboration of the Undersecretariat of Social Services of the Ministry of Social Development and Family, and the *Kuidadores CAM Foundation* and the *Yo Cuido Association*, both representing caregiver organizations. The findings reveal substantial gains in emotional well-being, reduced isolation, and recognition of care work, while community co-responsibility remains in its early stages and is shaped by territorial conditions that the program cannot always guarantee.

2. Study description and methodology

Using a Participatory Action Research (PAR) approach, the study aimed to understand how community co-responsibility is promoted in the territorial implementation of Community Care Centers (CCCs) across four socio-territorial contexts: a densely populated urban environment (Cerro Navia), a rural area with a markedly aging population (Monte Patria), a border city with a high migrant population (Arica), and a rural territory with a significant Mapuche indigenous population (Puerto Saavedra). These sites were selected based on a criterion of maximum territorial variation, with the aim of capturing the diversity of contexts in which the program operates. The study addressed

four specific objectives: describing the influence of socio-territorial dynamics on community co-responsibility; analyzing the normative and institutional factors shaping its promotion; proposing adjustments to the intervention strategy; and co-designing, together with caregiver organizations, community action plans with a gender and intersectional approach.

The study adopted a mixed-methods approach with a qualitative predominance, grounded in a participatory research strategy. Data collection was organized into three phases: a territorial diagnosis and literature review phase; a primary data collection phase in the four CCCs; and a collaborative analysis and interpretation phase.

Data collection instruments included in-depth interviews (n=67) with caregivers, territorial teams, members of community councils, and representatives of local organizations; a survey administered to caregivers attending the centers (n=62); participatory workshops based on social mapping conducted in three of the four territories; and field notes. The methodological design was co-developed with the inter-institutional working group, which actively participated in defining analytical dimensions, developing instruments, and validating results.

The study prioritized understanding the experiences of caregivers over representativeness, consistent with the early stage of program implementation. The findings

² To identify the target population, the presence of an unpaid caregiver is estimated in those households of two or more people that have at least one person with mild, moderate, or severe functional dependence and/or a child or adolescent (up to 14 years old) in the communes with a center (1,901,791 people by the year 2025).

should therefore be understood as situated evidence from the four selected centers. The analysis, while potentially illuminating broader patterns, is not representative of all centers in the program.

3. Main Findings

Drawing on the collected evidence, we propose a two-stage interpretation of the program. The first stage focuses on consolidating caregivers' well-being and strengthening support networks within the centers. The second, longer-term stage, aims to build community social capital and deepen the ties between the CCCs and the organizational fabric of their territories. This distinction matters because it allows us to situate the program's current achievements in their proper perspective, without overstating progress that is still in its early stages or underestimating transformations that require different conditions and timeframes. Advancing toward the second stage demands concrete material conditions. Without effective care relief services and sustained institutional support, calls for community participation of caregivers risk becoming an additional burden on a population that already faces severe time constraints.

Characterization of caregivers

93.5% of respondents identified as women (n=62), confirming the structural feminization of care work. Although the program is designed to serve caregivers with diverse needs and profiles, the majority of the participants provide full-

time care to individuals with severe functional dependency, primarily children, but also mothers, fathers, or partners, under conditions of high economic vulnerability, caregiver burden, and social isolation. The lack of time is not a choice, but a direct consequence of caregiving demands, which makes it impossible to maintain continuous employment. Moreover, caregiving responsibilities are distributed unequally within families: even when other family members are present, care work falls exclusively on women. This is a group that has historically been invisible within public policy, with little access to spaces for socialization or community life. This social isolation is paradoxical, given that caregiving is an experience that affects the vast majority of people at some point in their lives.

"I don't know how I survive. I used to sell things at the front of a fair that was dismantled; I had a stall. They let me go from the fair for the same reason, for constant absences, and I lost my job because of my daughter's diagnosis" (Caregiver).

"I spent a year with her (daughter) in the hospital. A year going to the hospital every day (...) I lost everything, everything, everything." (Caregiver).

"As a caregiver, you live in isolation, it's a real issue. You live, and that's it, you live alone without help." (Caregiver).

Subjective well-being, mental health, and reduced isolation

Participation in the CCCs demonstrates a positive and consistent impact on the subjective well-being of caregivers, expressed in two related but distinct dimensions. The first is access to mental health services and self-care. Interviews reveal that individual psychological support and group therapy sessions are the most valued components of the program. For most caregivers, this is the first time they have accessed therapy and recognized their own mental health as a priority. This is particularly relevant in areas with limited mental health services, where the center becomes the only accessible source of psychological support. 88% of respondents reported that their participation improved their mood and mental health (n=62). Interviews also reveal the physical impact of providing continuous care, including assistance with hygiene, mobility, and constant attention to individuals with severe dependency. This leads to physical injuries and exhaustion among caregivers performing these tasks without formal training. The center provides a space to identify these physical consequences and equips caregivers with tools to perform these tasks more safely. In this sense, subjective well-being is not expressed solely as an individual improvement, but as a collective process activated when institutions recognize, sustain, and at least temporarily reduce the burden of care.

"I cried with the psychologist then; she gave me very insightful advice and therapy, and it helped me a lot, a lot, yes, a great deal" (Caregiver).

"Before coming here, I was like in a deep well... [it has been] a super enriching experience, both intellectually and emotionally. They support us when we're sad, they help us." (Caregiver).

The second dimension is the reduction of social isolation. Caregivers describe lives shaped by loneliness and a chronic lack of time for themselves, where self-care is neglected. Many caregivers forgo their own medical appointments or treatments because there is no one to look after the person they care for. The center offers a space for emotional relief where the anxieties associated with caregiving, including exhaustion, fear, and loneliness, are not experienced in isolation but recognized as part of a collective condition. This allows caregivers to reframe their work as something with real consequences for their own health, rather than a naturalized family obligation. 80.6% report feeling more supported in their caregiving tasks, and 83.9% feel part of their community through participation in the center (n=62). Many caregivers describe having found a space to breathe, a relief from their caregiving duties, particularly through the opportunity to meet and talk with others who share similar daily experiences.

"The work of a caregiver is very demanding, very emotionally, psychologically, and physically demanding. There are times when they break down, they just break down... They were so alone in their own little corner, within their four walls, that they thought that was all there was to it" (Territorial Team).

"They are always looking out for us, the workshops, both psychological and practical, which for me are all therapy. Everything there is therapy. The positive thing is meeting people who speak on the same wavelength as you. That is very beautiful." (Caregiver).

It is important to clarify, however, that these changes occur mainly on the emotional and relational level. While this could represent a first step towards building greater agency among caregivers, enabling them to recognize and articulate their needs and demand change, they do not necessarily imply transformations in the structural conditions that generate caregiver overload.

Networks and collective organizing capacity

The CCCs foster bonds of trust and friendship among caregivers, which, for many, constitute their first sustained connection with others in similar situations. The presence of empathetic professionals, such as psychologists and facilitators, has also enabled the development of trusting relationships with local teams, creating an environment conducive to interaction. Through regular attendance at a shared space with common routines, caregivers come to know one another, provide mutual support, and build solidarity networks. These everyday encounters lay the foundation for collective organizing. The center becomes a space where caregivers identify shared needs, strengthen their

collective voice, and develop an emerging capacity for joint action. 77.4% report having gotten to know their neighbors better and made new friends, and 67.7% found concrete ways to contribute to their community (survey, n=62). In rural areas, where access to institutional services is more limited, these bonds take on an even greater significance as a source of support in the absence of services.

"Back then, there wasn't that support network, so it was difficult for me. But they were there, the Center was there" (Caregiver).

"We share the same situations... we advise each other, and that frees us up" (Caregiver).

Recognition

One of the most transformative aspects of the participation in the CCCs is the recognition of care work as labor with social, economic, and human value. For most caregivers, the center is the first space where their daily work is collectively named as work, validated in its multiple dimensions and complexities, including its physical, emotional, and relational demands, and treated as a shared social responsibility rather than an exclusively familial or female one. This process of recognition is not merely symbolic. By identifying themselves as caregivers and situating their experience within a broader collective condition, participants develop greater self-esteem and agency. This translates into a growing willingness to demand

support, set boundaries, and advocate for better conditions both within the household and in relation to public institutions. In this sense, recognition constitutes a necessary condition for advancing toward more effective forms of co-responsibility.

"Here we've been taught that we have to be well... we've learned to value ourselves first in order to be able to care for others" (Caregiver).

"They can now see themselves as having a role that society values. So they feel valued in this" (Territorial Team).

Emerging Forms of Co-responsibility

Participation in the CCCs fosters emerging forms of co-responsibility, expressed in two dimensions. The first unfolds within the household, where self-care practices and processes of recognition generate a growing willingness to delegate tasks and establish boundaries with other family members. The changes reported are specific and do not imply a structural transformation of the sexual division of labor, but they suggest a meaningful redistributive potential in contexts where care has historically been assumed as an exclusively female responsibility.

"I talked to him (her brother) several times; he cried and was angry with my mother (whom he cares for). But he just listened and did nothing else. And that's when, in one of the therapy sessions, they talked to me about delegating roles." (Caregiver)

"Last night I finished making a poster board where I wrote down the tasks that each of us has to do every day of the week... I thought, okay, a way to make everything clear here. So yesterday I finished sticking the paper with the tasks on the board." (Caregiver)

"Here, we're both parents, so you also have to be part of this." (Caregiver)

The second dimension points toward a more equitable social co-responsibility, where caregiving ceases to be an exclusively family responsibility and is progressively assumed by both the community and the State. The CCCs contribute to this process through inter-institutional coordination: by identifying shared needs among caregivers and mediating between them and local public services, the centers work to ensure that public provision adapts to the needs of both caregivers and those under their care. In Arica, for example, extended hours were arranged at the Local Family Health Center for registered caregivers, institutionally recognizing their time constraints. This was complemented by the coordination of health outreach programs and physical stimulation workshops for dependent individuals, conducted by community health professionals. These advances remain fragmented and largely dependent on the initiative of local teams, but they illustrate the program's potential to reduce access gaps and contribute to a gradual redistribution of caregiving responsibilities from families

to public institutions.

The study supports the conclusion that the CCCs are effective in improving the emotional and relational well-being of caregivers. Their contribution to emotional relief, recognition, and reduced isolation is consistent across all four territories. Their contribution to the reduction and redistribution of care work, particularly at the community level, remains in its early stages and is shaped by material and social conditions that the study identifies. The promotion of community co-responsibility is thus conditioned by factors operating at multiple levels.

At the individual level, caregiver burden and time poverty limit sustained participation, particularly in cases of severe dependency. At the territorial level, geographic isolation and lack of public transportation are the main barriers in rural areas, while in urban contexts, insecurity and the deterioration of public spaces condition attendance at the centers. At the institutional level, the stability of local teams emerges as a key enabling factor: in centers where teams have maintained continuity, caregivers report greater trust and community processes with neighborhood organizations are more consolidated. Staff turnover, by contrast, fragments these processes. When collaboration with local public services is strong and fluid, it expands the community presence of the centers and constrains it when it is weak. Finally, more structural social and cultural factors persist. Familialist norms and the strong feminization of caregiving limit expectations

that this responsibility can be shared with community actors, while the density of the local organizational network, which varies significantly across territories, shapes the foundations upon which co-responsibility can be built.

4. Policy Recommendations

The following recommendations emerge from the analysis of interviews, surveys, and participatory workshops conducted in the four territories, and were developed collaboratively with caregiver organizations and representatives of the Ministry of Social Development and Family. Given the territorial heterogeneity identified in the study, these recommendations should be understood as general guidelines requiring adaptation to the specific conditions of each implementation context. This is consistent with the program's technical guidelines and governance model, which recognize community participation in decision-making as a key mechanism for adapting to local conditions.

Advance the recognition of caregivers as a target population of public policy. The CCCs address concrete social needs related to mental health, caregiver burden, and isolation, all of which are structural to the organization of care in Chile. The findings suggest that a dedicated support program for caregivers, offering both individual and group therapy and conditions for building networks among caregivers, is essential for improving their well-being and lays the foundation for collective agency

and the capacity to articulate demands to institutions. This recognition also implies guaranteeing the material conditions that enable their participation in the centers. What has already been achieved represents a minimum floor of rights for caregivers that should be protected. This is not only a matter of equity, but a condition for advancing towards more effective forms of shared social responsibility of care.

Adopt a sequenced and territorially differentiated intervention approach. The findings show that the CCCs operate across diverse socio-territorial contexts, with heterogeneous caregiver profiles, community structures, and institutional capacities that create distinct opportunities and constraints for promoting community co-responsibility. The program therefore requires a two-stage intervention logic: an initial phase centered on well-being and network-building within the centers, followed by a second, longer-term phase, oriented toward community co-responsibility. Given the territorial heterogeneity, objectives, expectations, and indicators must be differentiated according to local conditions rather than applied uniformly across contexts

Strengthening inter-institutional coordination as a mechanism for shared social responsibility. The findings illustrate that the CCCs have the potential to act as spaces of articulation between caregivers' needs and local public services. This was demonstrated by concrete outcomes such as extended health service hours and coordinated outreach programs

in the territories studied. Formalizing and systematizing these coordination mechanisms across health, education, and social protection services represents a tangible pathway for public services to adapt to their provision to the needs of caregivers and those under their care.

Guarantee institutional continuity and the stability of territorial teams. The evidence suggests that building trust between territorial teams and caregivers is a fundamental condition for the program's operation and for advancing toward new forms of community co-responsibility. Staff turnover undermines caregiver participation and weakens the capacity to coordinate with local stakeholders, fragmenting processes that take considerable time to consolidate. This also requires strengthening the institutional commitment of the implementing municipalities, whose territorial position is central to the program, but whose dependence on political cycles represents a risk to its long-term sustainability

Scaling the program based on evidence and territorial relevance. The CCCs represent a minimum support infrastructure for caregivers, establishing the initial conditions for a more equitable distribution of caregiving responsibilities in society. Dismantling or weakening these centers would constitute a setback in the rights of both caregivers and those under their care. Scaling up requires moving towards territorial differentiation rather than design standardization. To this end, a more systematic use

of available administrative data is recommended, enabling a more precise characterization of the population participating in each center and a more context-specific approach to the services provided. Finally, developing a detailed theory of change for the community co-responsibility component is a necessary condition for rigorously evaluating the program's performance and informing future public policy decisions.

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