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University of Pisa, Italy

*CORRESPONDENCE
Inés Sánchez De Madariaga
✉ i.smadariaga@upm.es

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# Putting care on the map: gender mainstreaming, a policy approach to reduce inequalities in Latin American cities

Inés Sánchez De Madariaga[1]* and Carina Arvizu Machado[2]

[1]Real Colegio Complutense, Graduate School of Design, Harvard University, Cambridge, MA, United States, [2]Monterrey Institute of Technology and Higher Education (ITESM), Monterrey, Mexico

Rethinking, prioritizing and supporting the way care tasks are performed in urban and rural environments can contribute to reducing inequality in cities and territories, especially in Latin America and the Caribbean (LAC), the most unequal region in the world. To achieve this, gender mainstreaming must come to the forefront in urban policies, at all scales and phases of the policy cycle: from planning, regulation, and legislation, to design, construction and management of both cities and the services they provide. The concept of the "city of care" overcomes traditional visions of urban realities based on the dichotomy between the productive and reproductive spheres, by appropriately supporting care work, which is essential for the reproduction of society and for sustaining life and the economy. This article addresses gender mainstreaming in urban policies as a tool to shaping cities in ways that their physical, social, economic, cultural, and power dimensions can contribute to facilitating the realization of care work, by looking first into what the provision of care as a right can entail. Secondly, it looks at the spatial dimensions of care, particularly as mobility and facilities, also referred to as infrastructure, are concerned. Thirdly, it emphasizes the importance of gender mainstreaming in urban planning and legislation to achieve urban transformations that support care work. Fourthly, it showcases three examples from Latin America, two from Mexico City (*Utopías* and *Pilares*) and one in Bogotá (Manzanas del Cuidado), which have set out to advance access to rights in Latin America, including the right to care.

KEYWORDS

**gender mainstreaming, urban planning, Latin America, inequalities, care facilities, care infrastructures, everyday life, mobilities of care**

## 1 Introduction

Rethinking, prioritizing and facilitating the realization of reproductive and care activities in the urban environment can contribute to reducing inequality in cities and territories, especially in the Latin American and Caribbean region, which is the most unequal region in the world (ECLAC, 2024). Among the six sources of inequality identified by ECLAC, two of them have to do with gender inequality and socio-spatial segregation in cities, where 80% of the total population of the region lives. Given that gender inequality and socio-spatial segregation are two main factors of inequality, it is imperative to develop gender mainstreaming as a key approach to equality policies in urban development policies, planning, regulations, and legislation, as well as in the design, construction, and management of all urban systems (Juan Nadal et al., 2017; Sánchez de Madariaga, 2004a, 2009).

Research on women in the city and on the gender dimensions of urban planning is now more than four decades old. The first analysis of gender in the built environment dates to the

late 1970s and early 1980s, mainly from Anglo-Saxon countries. In the following two decades, studies on the built environment using a gender perspective were consolidated. Early authors writing in English include Hayden (1980), Reeves (1989), Roberts (1991), Moser (1993), and Greed (1994); in Spanish, Massolo (1991), Falú et al. (2002), and Sánchez de Madariaga (2004a,b).

These studies have shown how cities and territories, especially since the Industrial Revolution, have been built based on assumptions that some authors have described as androcentric, centered largely on male life experiences, which are configured as a universal reference. Since the Industrial Revolution, sexual divisions of labor and their spatial manifestations accentuated. In the public sphere, men carry out productive activities, related to the market and generating value in the economy, while in the private sphere, the home, women work on reproduction-related tasks, raising children and caring for others (Sánchez de Madariaga, 2004a,b). This body of research demonstrated how priority was given to the efficient realization of productive activities in the public sphere, that is, those that, under current capitalist economic models, generate economic value, growth, and development.

The contributions of the earlier generations of planning academics working in the late 1970s and 1980s were formulated in terms of women's realities and needs in the city, and did not rely on the concept of care as a key analytical approach. By the mid-1990s, "women and the city" was reformulated as "gender" and the city, highlighting the structural issues involved and the importance of overcoming traditional visions based on the dichotomy between the productive and reproductive spheres.

A significant starting point for the consideration of care activities in urban planning was their prior conceptualization as work by feminist economists. Feminist economists have shown how reproductive activities and unpaid domestic work remain invisible and fall disproportionately on women, adolescents and even girls, due to a socio-cultural construction, increasing gender bias, discrimination and gender inequality (Borderías et al., 1994; Torns, 2008; Esquivel, 2013).

In the early 2000s, Sánchez de Madariaga (2004a,b, 2009) translated into the sphere of urban and particularly in transportation planning the conceptualization of care as work that had been developed by feminist economists, by introducing the ideas of "mobility of care" and "urbanism of care," to refer to an approach to urban and transportation planning that would contribute to creating the spatial and physical conditions necessary to support care activities. Such conceptualizations of urbanism and mobility of care overcome traditional visions of urban realities based on the dichotomy between the productive and reproductive spheres, by appropriately supporting the care work essential for the reproduction of society and for sustaining life and the economy.

With a focus in the Latin American continent, and Mexico in particular, this article analyzes in the first place what the provision of care entails and how recent efforts are being made to frame care as a right. Secondly, it looks at the spatial dimensions of care, which require urban policies that shape cities in ways that physical infrastructure can contribute to facilitating the realization of care work. Thirdly, it looks at the possibilities and existing experiences of gender mainstreaming in urban planning to achieve urban transformations that support care work. Fourthly, it showcases three cases from Latin America, two from Mexico City (*Utopías* and *Pilares*) and one in Bogotá (Manzanas del Cuidado), which have set out to advance access to rights in Latin America, including the right to care.

## 2 The provision of care and care as a right

The care we receive through our individual lives is what sustains human life, society, and the economy. Care enables us to survive, grow, and flourish. Productive activities are carried out by people who, in turn, require care—provided by themselves, other people, or from institutions—from birth to death. This care is mostly provided by women. For example, as Figure 1 shows, while people in Mexico City spent in 2023 30.1 h per person per week of unpaid work (domestic and care tasks performed by the population aged 12 and over), women spent 39.2, and men spent 20.4 h (INEGI, 2023).

What do we understand by "care"? There is a wide range of scientific and institutional literature that addresses care from different disciplinary, theoretical and practical perspectives, and with different scopes and objectives. Care is an essential activity for the social well-being and development of people, which responds to their material, psychological, and physical needs. It encompasses tasks to assist dependent people in their daily lives, including children, the elderly, people with physical disabilities or neurodiverse people, and tasks required for the upkeeping of the home and the daily life of everyone, including healthy adult individuals. These activities can involve direct care activities for others and self, such as accompanying, cooking, cleaning, and resting; and indirect care, or pre-care activities, for example going to the market or pharmacy to shop, washing, or fetching water for washing or cooking. Both direct and indirect caregiving activities are considered caregiving work. In addition, caregiving includes organizational work related to all of these, and meeting the emotional and psychological needs of the people being cared for.

Care work can be paid in the formal or the informal economies, as in the case of domestic workers or nurses; or unpaid, generally

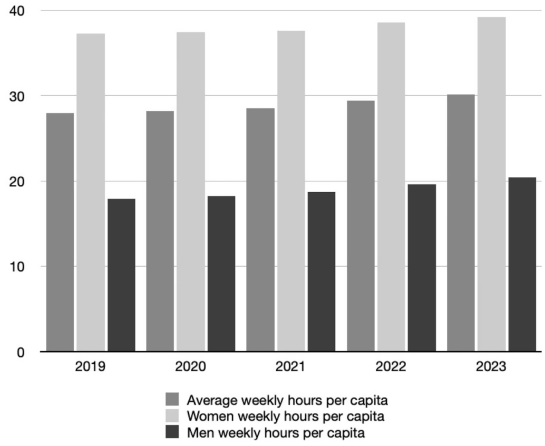


FIGURE 1
Hours of unpaid domestic and care work in households in Mexico City (population aged 12 and over, 2019–2023). Source: Own compilation with data from *Cuenta Satélite del Trabajo No Remunerado de los Hogares de México* (INEGI, 2023).

performed within families at home, normally by women; it can also take place within the framework of community networks with various degrees of informality. While care activities have been historically overlooked in urban planning, and even in housing policies and design, they all take place in urban space and require specific spatial conditions to be performed efficiently.

Ecofeminism, a particular strand of feminism, posits an additional approach to care, which includes care for nature. This involves activities that sustain and repair the conditions necessary for life, both of people and of the environment, or nature.

The term "care economy," originally developed by feminist economists, has been adopted by international organizations and NGOs. For example, Duvisac et al. (2024) states that the care economy "attempts to capture this relationship between care work and formal market production and encompasses the sectors central to the provision of unpaid and paid care: childcare, elder care, education, health care and domestic work." Care services can be provided by public entities, by the market, within communities, and within families (Horelli, 1997; Razavi, 2007). Most often, they are provided as unpaid labor or as very low-paid services, very often in the informal economy in the latter case. UN agencies including ILO and UN Women point out to the informal and precarious working conditions by millions of women providing paid care around the world. These agencies stress that care workers should have the same labor rights as workers in any other sector of the economy, in terms of contractual conditions, pensions, unemployment rights, and the like. They also refer to care as one of the four pillars of social protection, along with education, health, and social security.

Unpaid care work represents a significant share of the economy, as the system of satellite accounts helps highlight by presenting the economic value of unpaid household work and its equivalent percentage in national economies. The drive to quantify the economic value of care work in national public accounts was one of the important contributions of the 1995 Beijing World Conference on Women. Since then, different methodologies have been developed to quantify, recognize, make visible and value care work (Durán Heras, 2006).

For example, as illustrated in Figure 1, Mexican women spent an average of 39.2 h per week performing care and unpaid work (INEGI, 2023). Around two billion hours of care work are performed weekly; of these, only 6% are paid (Heatley, 2022). For the Latin American and Caribbean region, the economic value of these activities represents between 15.7 and 24.2% of regional GDP, and 75% of this value is contributed by women. These gaps are greater in the lowest income quintiles (ECLAC, 2021, 2022c). Figure 2 shows household and care work as percentage of the economy according to the Mexican Satellite Account for unpaid work over the last two decades. In Mexico it has been estimated that care activities and unpaid work represent 24.3% of GDP (INEGI, 2023). According to INEGI data, in 2023, women in Mexico performed 72.4% of these activities, compared to 27.5% that were performed by men.

While quantifying the value of care activities demonstrates their importance, in a second instance we must consider the mechanisms and forms that guarantee their effective provision. If, as the United Nations indicates, the State should be the guarantor, in co-responsibility with the market, families, and the community, one of the main challenges in the LAC region is that the model of care provision continues to be mainly family-based (Castilblanco, 2023). That is, care is relegated to the private sphere and is mainly provided by family members or community support networks, with women being mostly responsible for it. This is the result of socio-cultural and political contexts exacerbated by weakened states, with scarce resources, policies and programs that do not guarantee the universal provision of services, and particularly those aiming to meet care needs.

In addition, recent policies promoted under a neoliberal economic model sought to reconfigure care through a market logic, transferring it to the private sphere (Power and Mee, 2019; Smith, 2005; Lynch et al., 2009). As Power and Mee (2019) state:

> The relational nature of care is, however, invisible within hegemonic liberal and neoliberal philosophies. Neoliberal

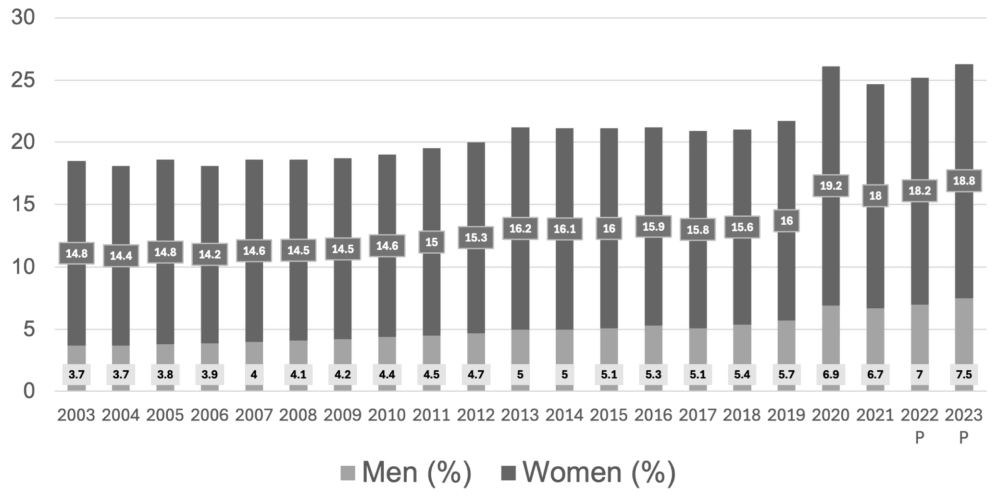


FIGURE 2
Household and care work as a percentage of the Mexican economy for unpaid work over the last two decades. Source: Own compilation with data from *Cuenta Satélite del Trabajo No Remunerado de los Hogares de México* (INEGI, 2023).

> philosophies of care understand care as a private practice for which autonomous, rational individuals are responsible and capable. These understandings have far-reaching implications for the visibility and valuation of relational care work, the formulation of social policy, and the organization of social welfare (Power and Mee, 2019).

In the LAC region, the neoliberal social organization of care has dominated the recent political agenda, exacerbating inequality of access to receiving and giving care and severely increasing the burden on the poorest households, especially on women. By commodifying care without the kind of State guarantees advocated within UN agencies, in precarious and exploitative conditions, caregivers are put at a greater disadvantage, and community care is made invisible. Many of these caregivers are women who are subject to additional forms of inequality, whether ethnic (indigenous women), place of origin (migrant or displaced women) or income level (poor women) (Ferreyra et al., 2022).

The agenda of care as a right is being advanced at the international level, notably since the pandemic, mainly through the work of UN Women but also of other institutions such as the Inter-American Development Bank and other international development and cooperation organizations. In this context, many Latin American countries have been developing emerging Care Systems programs. However, such Care Systems require the strengthening of public institutions, with programs and budgets that can guarantee the widest possible provision of services from an intersectional gender perspective. Failure to do so may reinforce gender biases and increase inequality gaps between men and women.

In Spain, health and education systems providing free universal coverage, even to undocumented immigrants, exist since the 1980s, while only in recent years the working conditions of domestic workers have been progressively equalized with those of any other sector of activity, as reclaimed by the ILO, in terms of minimum wage, vacation, and unemployment benefits. In the LAC region, countries such as Ecuador, Uruguay, Argentina and Mexico have made progress, some through national legislative frameworks, while others through programs at the national level or in local legislation. The Constitution of Mexico City (2017) recognizes care as a right in Articles 8, 9 and 10. For example, Article 9, section B, Right to care, states:

> "Every person has the right to care that sustains his or her life and provides him or her with the material and symbolic elements to live in society throughout his or her life. The authorities shall establish a care system that provides universal, accessible, relevant, sufficient and quality public services and develops public policies. The system will give priority attention to people in a situation of dependency due to illness, disability, life cycle, especially childhood and old age, and to those who, in an unpaid manner, are in charge of their care."

One useful way to look at the provision of care and the physical infrastructure it requires is through the lens of the structure of the welfare state (Sánchez de Madariaga, 2025). Esping-Andersen (1990) broadly categorized welfare states as either liberal, conservative, or social democratic. The liberal state promotes the market as the provider of welfare, and limits state intervention, examples of which are the United States and Australia. The conservative model is based on a principle of subsidiarity: the State intervenes only when the family is unable to provide care. The social-democratic model is based on a principle of universality or service provision, with the State providing a significant share of universal public social services, seeking to guarantee a high quality for all citizens.

Given that the LAC region has yet to consolidate a social democratic welfare state that guarantees rights based on the principle of universality, and that it continues to be the most unequal region in the world (ECLAC, 2024), the role of territorial planning and the spatial dimension of the provision of care services acquire even greater relevance to promote the guarantee of access to care (Sánchez de Madariaga and Novella Abril, 2021).

## 3 Spatial dimensions: urban structure, mobilities of care, and care infrastructures

Looking at the spatial dimensions of care involves three key broad issues: urban structure and land-use; mobilities of care; and care-specific infrastructures (or facilities). The spatial dimension of care, understood as the location, capillarity, affordability, and quality of the spaces where care takes place and how they are physically accessed, is a key aspect to guarantee the right to care. If these spaces, such as daycare or health centers for the elderly, are far from where those who need them live, or if they are only private and at a cost, or if they are only accessible by motorized transport, to give some examples, their access and provision is limited by the possibility, or rather impossibility, of physical access.

The lack of a gender perspective that brings care to the forefront in urban and architectural design makes life difficult for people who carry out care activities, and creates territorial, economic and social inequalities that disproportionately affect women. Too often housing is conceived as a space for rest that does not sufficiently consider the spatial implications of these tasks. However, for women, housing represents the space for domestic work, or care, and the overall reproduction of life.

In cities, land use segregation increases the number of trips (in number and distance) to carry out daily tasks, such as shopping, accompanying someone to the doctor, or going to the pharmacy. This has a greater impact on women, and on subgroups of women in which other potential traits of discrimination such as income levels, age, origin, ethnicity, functional ability, religion, among others, converge. For example, women with lower income levels who live on the outskirts of cities, and women who work in the domestic service, invest more time and resources in daily care-related travel. Many women face double workdays: one paid and the other unpaid in home-related work.

Urban structure also plays an important role. Cities with smaller blocks, mixed uses and good quality streets and sidewalks make it easier for caregivers to multitask, chaining trips. From disciplines such as geography, urban planning and architecture, the need for a multi-sectoral perspective that considers proximity to care services is argued. Location is key to facilitating access to these services.

To achieve this, we must reverse and intervene in cities that have been planned from a functional point of view, a legacy of the Modern Movement in architecture and urban planning. Since the publication of the Athens Charter (Le Corbusier, 1973), the priority to segment

the city in an efficient way, segregating residential, leisure and productive land uses, has been emphasized. This commitment to a "functional" city that facilitates productive activities makes invisible and hinders reproductive and care activities, which are vital to the functioning of the former (see Figure 3).

Improvement of data collection addressing gender biases and omissions, and development of gender indicators, have been key aspects supporting the development of all these policy innovations (Milosavljevic, 2007). The field of transportation is particularly relevant from the point of view of data and quantification.

However, travel patterns are conditioned by gender roles and gender divisions of labor, as evidenced by the work of Inés Sánchez de Madariaga (2009, 2013) through the conceptualization of "mobilities of care." This is both a conceptual framework allowing us to understand, in an appropriately contextualized manner, the qualitative characteristics of mobility (and immobility) linked to care, and a practical tool, as an umbrella category that makes visible and quantifies the trips made for caregiving purposes. In transport surveys conducted by transportation agencies around the world, care-related trips are regularly made invisible, not quantified, or hidden under other headings such as visits, escorting, strolling, or the "other" black box, all of them apparently of little importance because each of them represents a small percentage of total trips. The umbrella concept of "mobility of care" allows us to appreciate the importance of these trips in relation to the total volume of trips.

Care trips are mostly in a polygonal pattern, often multi-modal and partially on foot, and during off-peak hours (Figures 4, 7–10; Table 4). These characteristics are often less considered in urban design and in the design of public transport infrastructure and policy. For example: public transport frequencies tend to prioritize peak hours; fare policies in LAC rarely consider the possibility of chaining trips using different transport modes; the design of stations, public space or transport units does not sufficiently integrate elements that facilitate intermodality or the making of trips escorting other persons, which require spaces to sit down, put luggage, strollers, wheelchairs, or bags. All of this has negative repercussions on the quality of life and economic empowerment of women. In the Metropolitan Zone of the Valley of Mexico, for example, 75% of care-related trips are made by women, according to a CAF analysis based on the 2017 origin–destination survey. In Mexico, unfortunately, there is no disaggregated data at the national level on care mobility, which further makes invisible this reality (Figure 4).

In LAC, as in Spain, the term urban facilities refers to the buildings or spaces in the urban fabric that provide services to citizens: sports, education, culture, recreation, health, childcare, to mention a few. However, there is a growing literature that seeks to redefine facilities supporting care tasks as "care infrastructures," to highlight that they are a public good, with dynamic patterns that consolidate the basis of social organization and not only predefined objects (Power and Mee, 2019). While not always explicitly, this literature builds on earlier conceptualizations of "infrastructure for everyday life" put forward by Scandinavian feminists working in the 1970s and 1980s on the idea of a "new everyday life."

The term "infrastructures for everyday life" was intentionally proposed to consider the facilities and services necessary for the reproduction of life, i.e., care, as "infrastructure," rather than social facilities or services, purposefully assigning them the greater importance and priority in policy making that normally is attributed to the infrastructure managed by engineering and investment departments in government (Horelli and Vepsä, 1994; Sánchez de Madariaga, 2004b). As care became an issue of concern to policy makers and a popular topic of research for academics during the covid pandemic starting in 2020, the term "care infrastructure" became an *aggionamento* of the idea of "infrastructures for everyday life," by replacing "care" for "everyday life," without change of meaning. Care

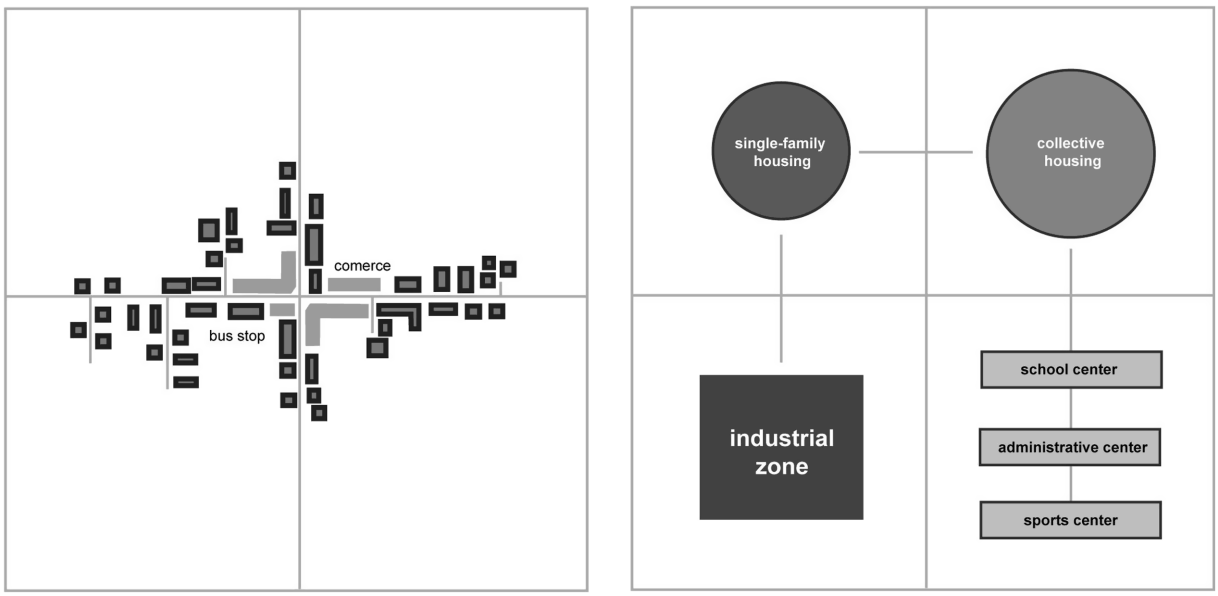


FIGURE 3
Impact of urban structure and land-use segregation on the experience of caregivers. Mixed-use compact city vs. sprawl and functional segregation. Source: Sánchez de Madariaga (2004a).

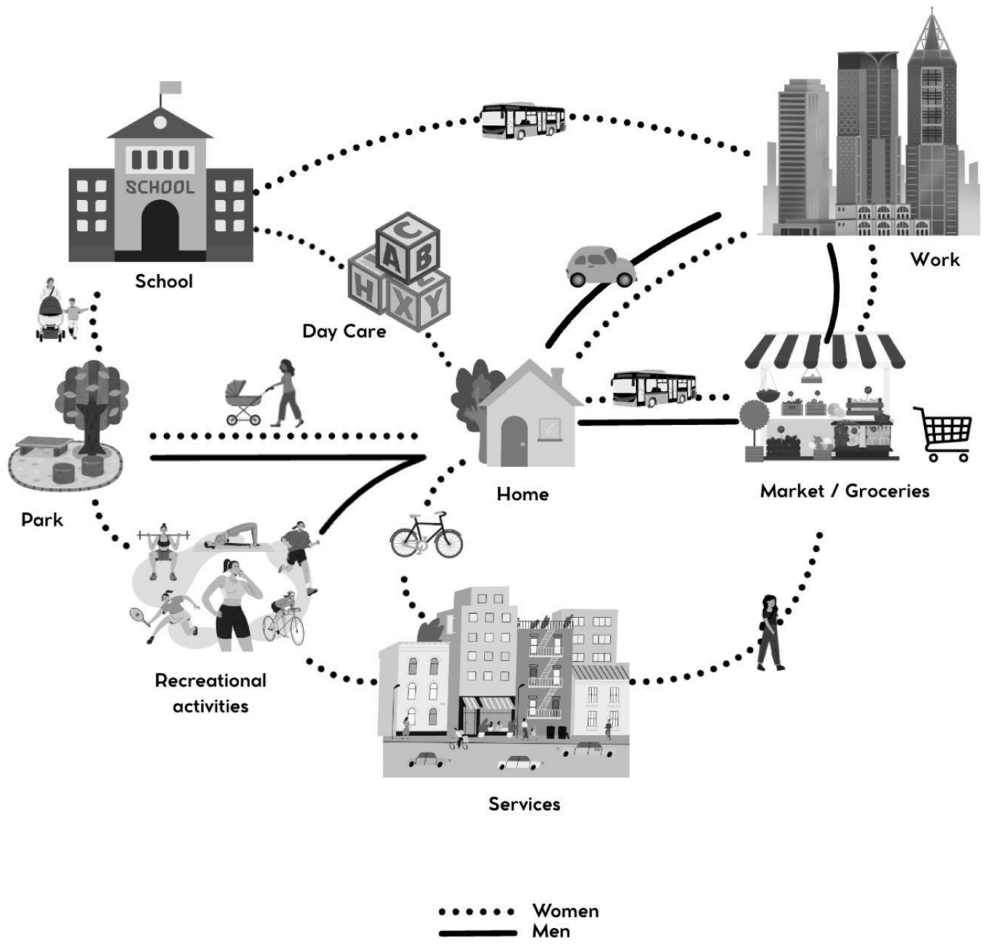


FIGURE 4
Differences in mobility between women and men. Source: Own compilation.

infrastructure structures social life in a continuous way (Latham and Wood, 2015).

For the purposes of this article, both terms, facilities and infrastructure are used interchangeably, to encompass both visions and the specificity of planning in LAC. Although examples of care facilities—infrastructures—have been given throughout the text, in the following table some examples are listed in more detail, being indicative but not limiting. Examples are given of direct formal services (aimed at providing care) and indirect services (such as schools), as well as services that support care activities (such as markets) and spaces to support self-care. They are mainly intended for: (1) children from 0 to 11 years of age; (2) older adults (65 years of age and older); (3) people with disabilities; and (4) caregivers (for self-care) whether they are professional caregivers, un-paid caregivers in their homes, or they hold a paid job in any other sector of the economy (see Table 1).

Mapping the existing distribution of care infrastructures—facilities—in the city is a previous step toward strengthening inclusive territorial planning with a gender perspective. New technologies, artificial intelligence, and geographical information systems provide new opportunities to create knowledge in this area. To this end, academia, NGOs and governments are developing various geospatial analysis tools that allow, in addition to locating them, to identify differences in access, or to detail the types of services they offer. It is important to note that new technologies such as AI, while amplifying capacity, also amplify bias, and need to be thoroughly reviewed for potential gender bias and omissions.

In the Mexican case, two specific tools can be highlighted: the Urban Inequality Index developed by the World Resources Institute in Mexico (WRI); and the Care Map, developed by the research team of the Center for Demographic, Urban and Environmental Studies of El Colegio de Mexico, in collaboration with UN Women and the Global Center of Excellence for Gender Statistics, for the Mexican National Institute of Women.

The first phase of the Urban Inequality Index was completed in 2021. Initially, this tool was intended to "analyze the differential access of the urban population to employment, education, health, food, public space, culture, and transit, by socioeconomic group, for the 74 metropolitan areas" existing in Mexico (World Resources Institute México, 2021). The Index shows the differences in access, in predefined time windows, either on foot or by public transportation, to the various urban facilities, depending on the location of households and income levels. In 2022, the methodology was improved to incorporate the care economy, starting this new gendered analysis in the Metropolitan Area of Guadalajara, Mexico's 3rd most populated city (see Figure 5) To this end, it added the following items: location of daycare centers and preschool (public and private), location of female-headed households (with income levels), among other new data. In addition, the impact on access was analyzed, based

TABLE 1 Examples of care infrastructures (or care facilities).

| Examples of care facilities (infrastructures) | | | | |
|---|---|---|---|---|
| Educational (direct and indirect) | Social assistance for the elderly (direct and indirect) | Provision and domestic work (direct and indirect) | Health care | Self-care |
| • Day care centers/nurseries pre-schools<br>• Play centers<br>• Early childhood stimulation centers<br>• Schools in general | • Nursing homes, homes for the elderly, nursing homes and/or residences<br>• Day care centers for senior citizens<br>• Specialized education schools for the neurodiverse or people with disabilities<br>• Residential care homes for neurodiverse people | • Markets or supply spaces<br>• Community kitchens<br>• Community laundries<br>• Commercial laundries<br>• Commercial food supply | • Health clinics<br>• Physical rehabilitation centers | • Therapeutic spaces<br>• Temazcal (Mexican traditional sauna)<br>• Sports and cultural spaces |

Own compilation.

on a new transit project (Bus Rapid Transit) "Mi Macro Periférico" and its stations.

One finding was that mothers in single-parent households with lower income levels seek to live near a public transportation station, even if this implies that rental costs may be higher. Conclusions such as these support the design of comprehensive public policies that make it possible to: (1) generate a housing policy with a gender perspective, including the public transportation component; (2) identify better locations for care facilities; (3) design mass public transportation with a gender perspective, considering not only the usual work/school-home as origin–destination, but also care trips and their chaining, the location of stops, the use of land around stations, among others.

The Care Map of Mexico is an interactive tool that geo-references the supply of care services and estimates their potential demand. It estimates 4 items: (1) the availability and location of care services; (2) the potential demand for care of three population groups: infants (0–11 years), the elderly (65 + years) and people with disabilities; (3) the relationship between the supply of services and the participation of women in the labor force; and (4) the accessibility of services, considering institutional (affiliation) and urban restrictions. It was designed to serve: (a) citizens looking for nearby and accessible care services; and (b) public administrations or social initiatives, which can use it to access statistics and maps useful for designing care policies. This information helps to identify areas lagging in the provision of services and to make informed decisions on the location of new care facilities, in order to reduce inequalities. Similar public efforts exist in other countries in the region, such as Chile's Care Map (see Table 2).

These examples show the relevance of care infrastructures as elements that promote social wellbeing and co-constitute urban social life (Amin, 2014). With the information they gather and analyze, evidence is generated, based on data, to support local governments in territorial decision-making (from where to invest, to how better plan spatially and programmatically the territory), to reduce inequality gaps for the population in conditions of greater vulnerability, and to make the right to care effective.

## 4 Territorial planning and urban regulations for an urbanism of care

In recent years, some cities and regions in the global North and South have initiated a variety of processes aimed at mainstreaming gender into different aspects of their urban policies. For example, in the global North: Vienna, Austria; Kokkola, Finland; the Basque Country, Barcelona, Extremadura, Valencia, among others, in Spain. In the global South: Montevideo, Uruguay; Mexico City, Mexico; San Salvador, El Salvador; Bogotá, Colombia; Asunción, Paraguay.

Making care accessible to the people who provide and receive it requires a mainstreaming approach throughout the policy cycle, from incorporating a care perspective into legislation, regulations, municipal urban plans, and development programs, to intervening in the existing urban fabric; from allocating land uses to specific spaces assigned to care facilities, to building facilities where they are needed; from creating new transit infrastructures, to improving public transportation services and micromobility options in neighborhoods.

In Latin America, gender approaches to urban policies have focused for decades on the central issue of violence and safety. The impact of safety in public space for women in Latin America puts a heavy toll on women's lives. In Mexico for example, after dark, 7 out of 10 women feel unsafe, in contrast to 5 out of 10 men (INEGI, 2021; in SEDATU, 2022). Also, women are the ones who in greater proportion gave up daily activities, such as the following: 60.5% using public transportation, 63% taking a cab, 62% going for a walk (INEGI, 2021).

Since the pandemic brought issues of care to the forefront, researchers and policy makers in LAC have reoriented, or, rather, expanded priorities, from safety, toward issues of care. Progress has been made, for example in the area of mobilities of care in LAC. In Mexico urban mobility has been recognized in the Mexican Constitution (2022) as a human right and considered as a pillar that enables access to other rights. Article 4° establishes that "Every person has the right to mobility in conditions of road safety, accessibility, efficiency, sustainability, quality, inclusion and equality." Reaching facilities such as schools, health centers and markets in a safe, inclusive and efficient way is crucial for the full exercise of citizenship.

Mexico's National Strategy for Mobility and Road Safety (Enamov) already incorporates the concept of care mobility, setting the foundation for future policy development in this area in Mexico (SEDATU (ENAMOV), 2023). While there are no national data on care mobility in Mexico, some origin–destination surveys such as the one of the Metropolitan Zone of the Valley of Mexico, or the Metropolitan Area of Guadalajara have integrated it a few years ago. With this data, it is possible to design: (1) better routes; (2) public transportation systems that counteract the usual reduction in frequency during off-peak hours; (3) subsidized, integrated fares, or fares that allow several trips to be made in one time window; and (4) even improve the design of the streets themselves, thinking about the needs of people who make care trips.

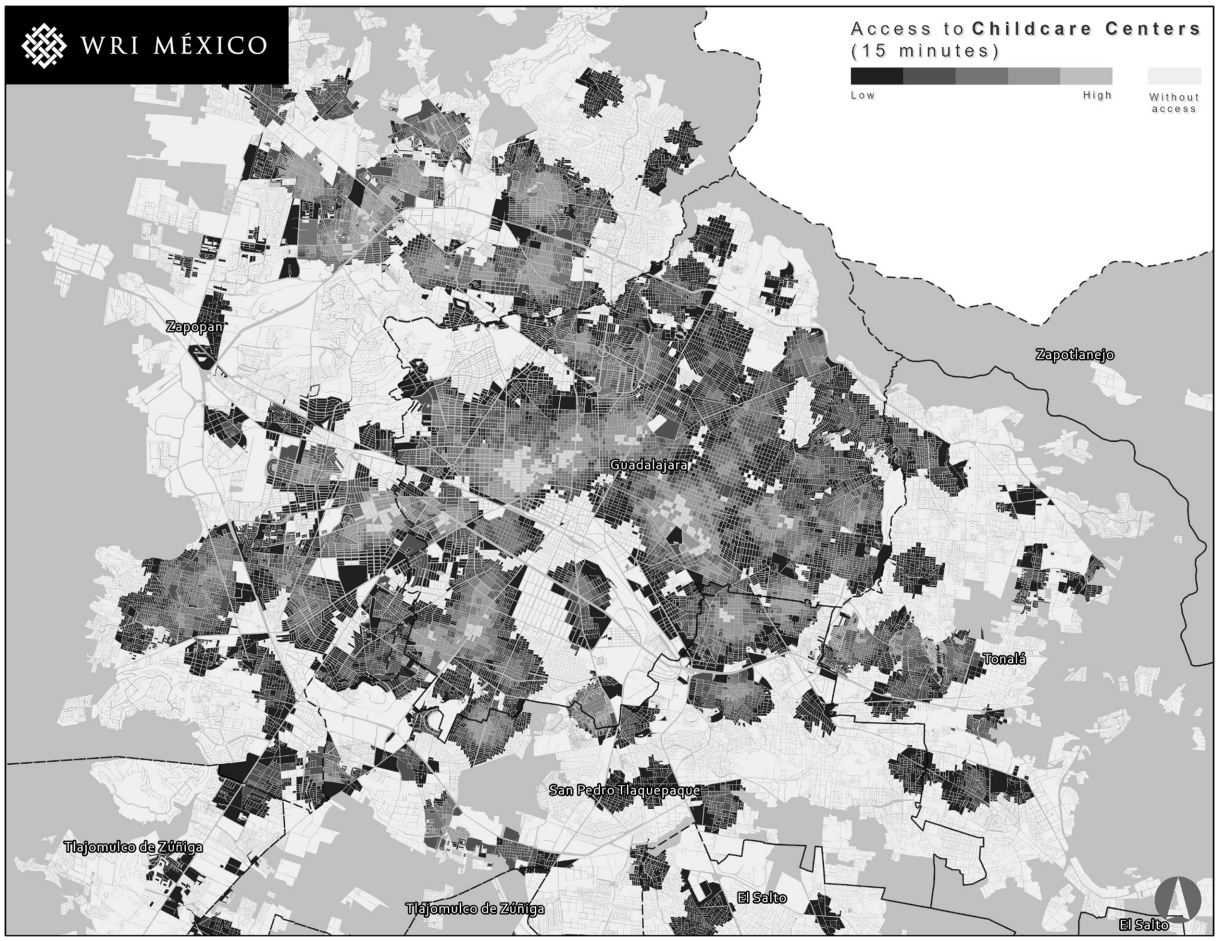


FIGURE 5
Access to childcare centers in Guadalajara metropolitan area, Mexico. Source: World Resources Institute Mexico (2021).

These diverse experiences address varying physical, social, economic, cultural, and power dimensions, aiming at facilitating the realization of care work (ECLAC, 2017). Examples in Latin America and the Caribbean (LAC) seeks to: (1) reduce inequality gaps in access to services that allow the full exercise of rights for the entire population, especially those who have been historically marginalized; (2) enable all people to develop freely with equal opportunities; and (3) facilitate the giving and receiving of care.

In Europe, the Spanish experience of the last 20 years stands out by the breadth and diversity of the scales, types of planning instruments, and topics addressed by a very significant number of initiatives developed at local, regional and national levels. A pioneering and particularly relevant experience of gender mainstreaming at the regional scale is the Spatial Planning Guidelines of the Basque Country (DOT) of 2016, which is explicitly based on the central idea of an urbanism of care (Sánchez de Madariaga, 2017). Other examples in Spain include the great urban initiative Madrid Nuevo Norte, which involves a new Central Business District, 1.500 new housing units, a new transportation hub and several new metro stations; the integration of gender dimensions in the procurement for the design of high-speed train stations, by the national railways' operator ADIF; or the redevelopment of the Brujas Square in Valencia.

In the Spanish case, legislative innovations addressing the intersection of gender and urban and territorial planning have been key since 2005. Such innovations have been made in two ways, according to the legislative opportunity of each region (autonomous community). Regions are the level of government with most legislative competence in urban planning matters, being within the Spanish administrative system the equivalent to the Mexican states. Some autonomous communities have addressed gender and planning issues within the laws of equality, while others have done it properly within the land-use and planning laws. One example of model legislation is the Law on Sustainable Land and Urban Planning of Extremadura (LOTUS) of 2018, which has pioneered gender mainstreaming into land and urban planning policies in a broad, detailed, and systematic manner through a Technical Annex to the Law (Sánchez de Madariaga and Novella Abril, 2021).

In a toolkit developed in parallel to the Technical Annex to the LOTUS of Extremadura, Sánchez de Madariaga and Novella Abril (2021) indicate key criteria, specific recommendations, and examples of good practice, at the various scales of planning and for the different substantive areas of planning. Priority should be given to the accessibility and proximity of homes, both to employment locations

TABLE 2 Classification of economic units that provide care-related services, as used in the Care Map of COLMEX, UN Women and INMUJERES.

| Establishments | Mexico National Statistical Directory of Economic Units Classification category | User population |
|---|---|---|
| 1. Day care centers | Health and social assistance services | Children from 0 to 2 years old |
| 2. Pre-schools | Educational services | Children from 3 to 5 years old |
| 3. Primary schools | Educational services | Children from 6 to 11 years old |
| 4. Nursing homes and other residences for the care of the elderly | Health and social assistance services | Seniors (65 and over) |
| 5. Centers dedicated to the care and day care of the elderly | Health and social assistance services | Seniors (65 and over) |
| 6. Special needs schools | Educational services | Persons with disabilities of all ages |
| 7. Residences for the care of persons with mental problems | Health and social assistance services | Persons with disabilities of all ages |
| 8. Job training services for handicapped persons | Health and social assistance services | People with disabilities of all ages |
| 9. Centers dedicated to the care and day care of the handicapped | Health and social assistance services | People with disabilities of all ages |

Own compilation based on the classification table of the Care Map (INMujeres, 2023).

(formal and informal) and to care facilities, sometimes referred to as "infrastructures" (e.g., daycare centers, play centers, preschools, schools in general, markets or supply spaces, health clinics, physical rehabilitation centers, care spaces for the elderly, among others). Key areas to address include: (1) Mixed land use and the principle of proximity, which affects the location of care facilities and infrastructures where these services are offered, in relation to housing, employment and the entire urban fabric; (2) Mobility and transportation, the way in which they are accessed; and (3) Quality and safety of public space, as it is women who are usually the most affected by unsafety and poor spatial quality.

## 5 Trends and case studies in LAC: *Pilares*, *Utopías* and Care Blocks

In recent years, innovative public policies and programs have emerged across Latin America and the Caribbean (LAC). The spatial dimension of care has been primarily driven by cities at the local level, through programs sometimes framed under an umbrella of care policies that provide services such as childhood or elderly care facilities (Jiménez Brito, 2022). In parallel national care policies and legislative frameworks at the country level are making significant progress toward the institutionalization of comprehensive Care Systems. It is essential to recognize that much of the progress in framing care as a right and placing it on the public agenda is the result of long-standing grassroots struggles and organized community movements. These movements have grown stronger and more coordinated through national and international coalitions, such as the *Coalición por el Derecho al Cuidado Digno y Tiempo Propio de las Mujeres*, and the recently created Global Alliance for Care (Colin Colin et al., 2024; De León, 2024; Lombera, 2024).

Table 3 provides a list of relevant strategies and legislation developed since the pandemic accross the continent, demonstrating a burgeoning activity in this area of policy and the variety of approaches to integrate care as a new area of policy developed by national and subnational levels of government.

To broaden and deepen the perspective, in this article we will present in more detail three cases promoted by the public sector that stand out in Latin America: two from Mexico City, *Pilares* and *Utopías*, and a third, the Manzanas del Cuidado, or Care Blocks, in Bogotá. These three experiences have been selected for the following reasons: (1) they involve the physical construction of facilities that either explicitly have been designed to provide a variety of care related services, or at least are having a clear impact in this area, even if not explicitly intended in their initial design; (2) they have integrated a significant degree of urban dimensions in their design; (3) they have been flagship political initiatives using feminist narratives developed by women local leaders seeking to increase their political impact at higher levels of government.

### 5.1 *Pilares*

In the LAC region, Mexico City (CDMX) stands out for its innovative approach to local policy making, especially since mayors began to be democratically elected in 1997, instead of appointed by the president of the country. Important advances have since been made in public programs, including the construction or rehabilitation of urban facilities, which seek to increase access to citizens' rights: educational, cultural, sports, environmental and economic empowerment. Examples of these are: (1) the Social Kitchens for Welfare, (2) the Factories of Arts and Crafts (FAROS), (3) the Points of Innovation, Freedom, Art, Education and Knowledge (*Pilares*), and (4) the *Utopías*, to mention a few.

Not all of these were conceptualized from their foundation to promote care or were designed with gender perspective principles. However, their spatial distribution in marginalized and underserved neighborhoods, as well as their programming and the services offered, promote the provision of direct and indirect care and self-care, free of charge for users.

*Pilares* is the Spanish acronym of Points of Innovation, Freedom, Art, Education, and Knowledge; this word game also refers to "Pillars." It is a Mexico City wide, community education strategy launched in January 2019 by former Mexico City mayor, Dr. Claudia Sheinbaum (current Mexico President). The program was set to support the population in greater vulnerable conditions: young people, women heads of household, and individuals living in areas with the lowest levels of social development in CMDX. As a social program, it aims to promote access to education, culture, sports, and employment.

TABLE 3 Public policies and programs aimed at advancing access to care in LAC, 2020–25.

| Country | Policy type | Name (if applicable) | Scale of implementation | Description | Year/status |
|---|---|---|---|---|---|
| Argentina | Provincial initiative | Cuidar Santa Fe | Subnational | Promotes shared care responsibility, gender equality | Ongoing |
| | Decree (National) | Registradas program (No. 89/2023) | National | Formalizes domestic work, recognizes care workers | 2023 |
| | Inter-ministerial roundtable | MIPC (Administrative Decision 1745/2020) | National | Coordinates national care strategy development | Active since 2020 |
| | Workplace Childcare Regulation | Article 179, Labor Law | National | Requires employer childcare over 100 employees | Regulated 2022 |
| | Comprehensive Care System Bill | SINCA Bill (Resolution 309/2020) | National | Legislative proposal for national care system | Submitted 2022 |
| Bolivia | Integrated Policy | Early Childhood Development Policy | National | Ensures optimal holistic development early life | Approved 2023 |
| | National Management System | National Children's Management System (SINNA) | National | Streamlines child protection care management | System created |
| | Municipal Law (Cochabamba) | Law 380 | Local | Promotes co-responsibility, improves women's access | 2019 |
| | National Decree | Supreme Decree No. 4589 | National | Regulates domestic work, mandates formal health coverage | Enacted 2021 |
| Brazil | National Law | Law N° 15.069 | National | Establishes National Care Policy, guarantees right | Approved 2024 |
| | Inter-ministerial roundtable | Decree N. 11.460 | | Develops National Care Policy and Plan | 2023 |
| | National pilot program | Cuidotecas | National | Pilot childcare centers alleviate parental burden | Pilot |
| Chile | General Rule | CVE 2280369 | National | Establishes a council to design national care policy | Enacted 2023 |
| Colombia | National Law | Law 2281 | National | Establishes National Care System, recognizes care | 2023 |
| | Bogotá Decree | Decree 237 | Local | Establishes District Care System, Care Blocks | 2020 |
| Costa Rica | National Law | Law No. 10192 (Sinca) | National | Optimizes care for dependent adults/older adults | 2022 |
| | National Care Policy | Decree No. 42878 (2021–2031) | National | Declares policy, promotes autonomy, supports caregivers | 2021 |
| Cuba | National System Decree | Decree 109/2024 | National | Creates a national system coordinating care policies | Issued 2024 |
| Ecuador | Organic Law | Right to Human Care | National | Protects care right for workers, regulates leave | 2023 |
| Mexico | State Law | Law of the Comprehensive Care System for the State of Jalisco | Subnational | Regulates, recognizes care work, promotes co-responsibility | Enacted 2024 |
| | System based on a legal framework | Care System for Well-being for Mexico City | Subnational | Shared responsibility system supports care and well-being | Launched 2024 |
| | Proposed General Law (National) | National Care System | | Establishes a national system, recognizes care right | Constitutional 2020, Law pending |
| Panama | National Law | Law 431 | National | Creates a National Care System, guarantees right | 2024 |

*(Continued)*

TABLE 3 (Continued)

| Country | Policy type | Name (if applicable) | Scale of implementation | Description | Year/status |
|---|---|---|---|---|---|
| Paraguay | Law | National System of Care (SINACUP) | National | Guarantees well-being dependent persons, caregiver rights | 2021 |
| Peru | National Law (Draft) | Draft Bill No. 2735 | National | Recognizes care work value, establishes a national system | Awaiting approval |
| | National Action Plan | Business and Human Rights (2021–2025) | National | Encourages private sector co-responsibility in care | Effective 2021 |
| | National Gender Equality Policy | Priority Objective #4 | National | Mandates National Care System gender approach | Effective |
| | Comprehensive Care System | Territorial Pilot Programs | National | Tests service models, improves access | Design phase, 2023 |
| Uruguay | National Integrated Care System Law | SNIC (Law N°19.553) | National | Establishes a universal integrated care system | Promulgated 2015 |
| | City Strategy (Montevideo) | Early Childhood Care Center (Migrant Families) | Subnational | First center for migrant/displaced families | Started 2023 |
| Venezuela | Law | Care System of Life | National | Recognizes care as indispensable, implements support | 2021 |

Source: Prepared by the authors based on government documents, academic publications, and publicly available data (Cardozo Delgado and Torre Nicolini, 2023; ECLAC, n.d.; Global Alliance for Care, 2022; Güezmes García and Vaeza, 2023).

A total of 300 *Pilares* centers have been built or renovated over a time span of 6 years, distributed across a city with a total population of 9.2 million (INEGI, 2020), primarily serving residents in underserved neighborhoods and providing free community education and vocational training for employment (see Figure 6).

The location of each *Pilares* center responds to a territorial, economic, social, and demographic analysis, which identified areas with low educational attainment, lower Social Development Index, underserved, with high degrees of marginalization, high population density, crime incidence and presence of youth population (ages 15–29) (Benlliure, 2024). The selection process also considered proposals from local municipalities and community requests, involving participatory design processes through which boroughs and community leaders played a key role in identifying local needs and submitting proposals for new centers. This participatory approach ensured strategic site selection and responsiveness to community demands, strengthening local ownership of the *Pilares* model.

Originally, the *Pilares* strategy was set to be a community education network grounded in four core pillars: Economic Autonomy, Community Sports, Arts and Crafts, and Community Education. Implicitly, it was responding to serve primarily youth and women heads of household. Before formal spaces were available, the initiative began with 20 brigades working to reclaim public spaces, which soon expanded to 145 brigades across 340 priority neighborhoods. While permanent infrastructure was being constructed or renovated, educators and project coordinators delivered free workshops in parks and kiosks. Of the currently 300 *Pilares*, 117 were built specifically for this purpose, of which 16 were designed by renowned architects. The remaining 183 are rehabilitated structures of former public facilities such as community cultural spaces.

The size of the facilities is between 300 and 2000 sqm. Some *Pilares* have evolved into community spaces that also provide care services and infrastructures and are used by entire families (Damián, 2025). Initially not conceived as care infrastructure, the program gradually integrated care-related functions in response to users' needs. Young mothers began bringing their children, prompting the creation of early childhood spaces (*bebetecas*), while older adults found socialization opportunities, contributing to intergenerational interaction and informal support networks.

The *Pilares* vary their programming depending on their location and the needs of the surrounding community. For example, they offer spaces such as: (1) children's play for early childhood development; (2) vocational training in dressmaking, plumbing, electricity, robotics, gastronomy, computers and programming, for economic empowerment; (3) yoga, dance and martial arts classes, for the promotion of self-care, to give some examples (see Image 1). Although this program was not designed from a care perspective, field visits showed that it provides services to two population groups that generally require care: children and the elderly; they have also promoted mental health care. For example, on a field visit, we witnessed one user that had schizophrenia and previously lived isolated in her house.

Some of them are located near consolidated public transportation stations, such as Cablebus (in the case of Gustavo A. Madero and Iztapalapa, two of the most deprived municipalities in Mexico City), Metro and Metrobus (BRT), facilitating access to these facilities. The estimated number of users in 2024 was over 600,000 participants that benefited from *Pilares* programs. Of this total: 64% were women, and 36% men; 30% were children (0–15), 30% youth (15–30), 30% adults (30–60), and 10% older adults (60+). Funding for this program comes from Mexico City's public infrastructure program. In 2020, 264 million MXN (approx. 14 million USD) were allocated for the construction of 25 new *Pilares* centers, as part of a broader strategy totaling 1.6 billion MXN (approx. 85 million USD) for the construction or rehabilitation of 274 facilities. The ongoing operation of the program is managed and funded by the Mexico City Ministry of Education.

Their normative and regulatory framework is explicitly aligned with the UN Sustainable Development Goals (SDGs) and the Political Constitution of Mexico City, with an emphasis on

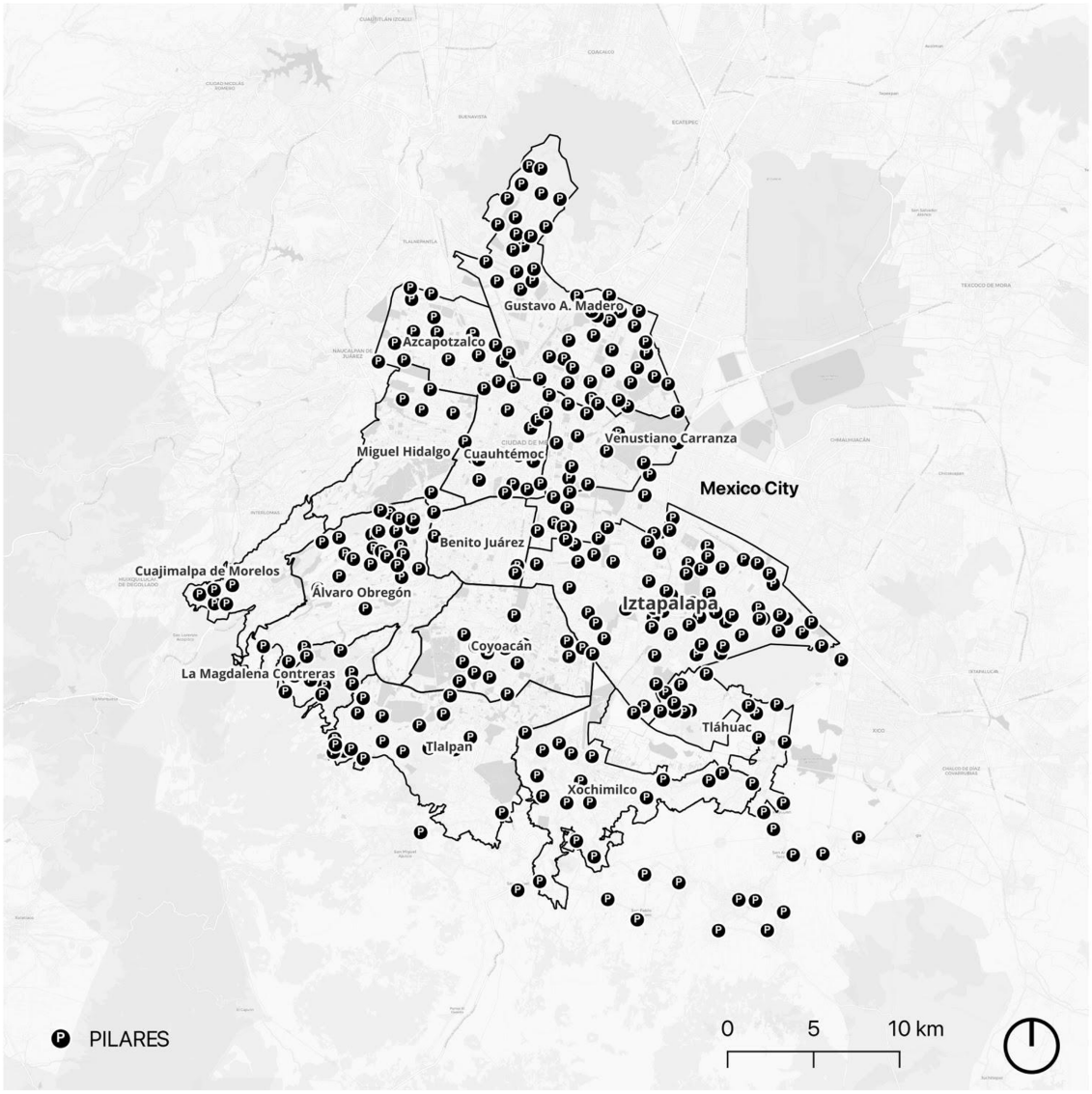


FIGURE 6
Distribution of *Pilares* in Mexico City. Own elaboration with data from INEGI (2023).

human rights, sustainability, and social equality, with a dedicated law enacted to institutionalize community education in the city. Some of the long-term operational and sustainability challenges derive from their mode of operation in pre-existing or rehabilitated buildings, which limits the capacity to expand services or integrate full care infrastructure. The model's future depends on continued institutional support, stable public investment, and its ability to remain a political priority amid shifting government agendas.

## 5.2 *Utopías*

The *Utopías* program was launched in 2018 in Iztapalapa, one of the 16 municipalities that make up the CDMX, and one of its poorest. The targeted neighborhoods are areas marked by socio-territorial inequality, high levels of urban and social conflict, limited access to green spaces and basic services, and a high proportion of informal settlements. These are social infrastructures that seek to facilitate access to rights, formulated in terms of "the right to the city," in the most populated municipality of the Mexico City, with 1.8 million inhabitants (INEGI, 2020). The *Utopías* offer sports, cultural and recreational spaces, including semi-Olympic-sized swimming pools, free of charge. In the time span of 6 years, 16 facilities were built, some of them rehabilitating existing deteriorated or disused parks and public facilities, and others built from scratch and designed for that purpose. More than 100,000 sqm of facilities were built, including care facilities, with a total of 609,000 sqm distributed in 25 properties (Lombera, 2024).

A key aspect of the planning of these spaces is that they are carried out with processes of citizen participation, which has allowed their programming to respond to the actual needs of users. The participatory design process for *Utopías* engaged communities in three phases: (1) self-diagnosis and awareness workshops; (2)


IMAGE 1
*Pilares*. Source: Own images.

submission, evaluation, and integration of community proposals into unified spatial plans; and (3) public assemblies for project presentation, with feedback incorporated and local monitoring committees established to ensure long-term engagement. Each *Utopía* has its own strong visual identity, using colors and imagery such as a dinosaur park, a library inside an airplane shell, or one with a ship shape, asserting their presence in urban space, and creating a sense of meaning and belonging. This program represents a social bet, under an innovative model of addressing the public sphere and city-making, which aims at building citizenship and pride in urban peripheries (Figure 7).

Six years after the launching of the program, a review of the services provided shows the diversity of care-related facilities existing in several *Utopías*, particularly the most recent ones, including community canteens and laundries, libraries for children, physical rehabilitation spaces, homes for the elderly, and services related to prevention and response to gender violence (legal and psycho-emotional). The most recent *Utopías* address explicitly the needs of caregivers, facilitating care tasks and as a result giving them the time for personal care, leisure, or education. By supporting high-quality education and vocational training, *Utopías* have allowed people living in a very poor neighborhood to become pianists or high-performance athletes, which can be interpreted as a way of redefining what living in the eastern part of the city means.

It purposefully seeks to open horizons and create life possibilities previously unthinkable, by offering nearby access to high quality services without economic barriers. Its location, architecture and programming have been key to its rapid consolidation as a public program. After the last elections of 2004, in which Clara Brugada, former mayor of Iztapalapa became mayor of the whole of Mexico City, this program is being absorbed by the Government of CMDX with the intention of expanding it to the city level and reaching the construction of 100 of these facilities in the next 6 years.

The estimated number of users is approximately 15,000 per day, increasing to 25,000 on weekends, across the 15 facilities. As of November 2024, the program was exclusively funded by the annual public budget of the Iztapalapa local government, approved by the local Congress (approx. 6 billion MXN / 300 million USD annually). Each *Utopía* center required an initial investment of around 100 million MXN (approx. 5.3 million USD), with annual maintenance and staffing costs of approximately 8.4 million MXN (445,000 USD) per center. The program has since been transferred to Mexico City's Ministry of Social Development and Egalitarian Welfare (Damián, 2025). Their normative and regulatory framework is grounded in the Political Constitution of Mexico City, particularly Article 12, which guarantees the right to the city for all inhabitants and is supported by the Iztapalapa Borough's Public Care System and the Mexico City Charter for the Right to the City.

Long-term operational and sustainability challenges include high maintenance costs and full reliance on public funding. Despite inclusive design principles, the large size and peripheral location of some *Utopías* limit physical accessibility and walkability, particularly for people with disabilities and limited access to efficient public

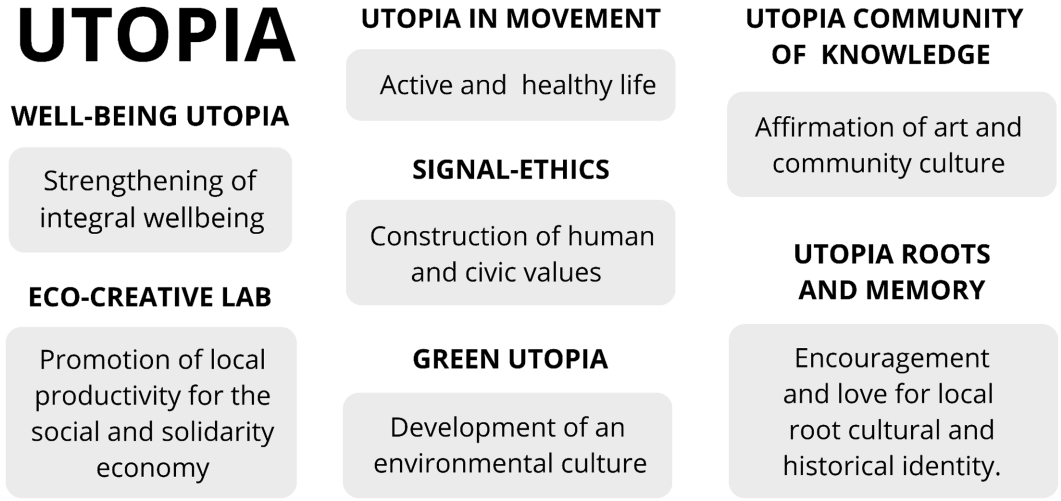


FIGURE 7
*Utopías* conceptual framework. Source: Lombera (2024).

transportation (Colin Colin et al., 2024). Future political shifts could deprioritize the model, affecting funding and continuity. The ambition of the planned expansion to 100 facilities might also create additional sustainability and operational challenges.

## 5.3 Bogotá's Care Blocks

The program of the Care Blocks or *Manzanas del Cuidado* in the original Spanish, in Bogotá, Colombia, a city with a total population of 10.5 million in 2021, was designed during the Covid 19 pandemic. This program aims at bringing together in a relatively close space different free public services: childcare, education, social services, public spaces, mobility and employment opportunities. The services are provided in mostly existing underused municipal facilities. The idea is to create a district-level system of inter-sectoral supply of a variety of public services, which articulated the operation of these facilities. The Care Blocks were planned and designed under principles of simultaneity, flexibility, and proximity (accessible within a 20-min walk), in neighborhoods with a high concentration of caregivers, mostly women, in conditions of poor living conditions and marginalization (Jaramillo, 2023).

They mainly consist of one or several interconnected facilities, with two main areas: one building for services aimed at caregivers, and another for care receivers. In some cases, they can act as neighborhood centers, where services are offered within 20 min walking distance. The Care Blocks were designed considering the 3 "R's" of care, suggested by the International Labor Organization (ILO) following the theoretical work of Nancy Fraser and others: recognize, redistribute and reduce the overload of care (Figures 8–10).

Another innovation of the Care Blocks Program was their integration into Bogotá's Land Use Plan (POT) published in 2023, which distributes them throughout the city considering geostatistical information, and links them to key mobility and public transportation projects. The POT projects to consolidate 25 Care Blocks by 2023, with the goal of reaching 45 by 2025. For example, the Altamira and La Gloria Care Blocks are part of the Integral Revitalization Project in the area of the San Cristóbal Aerial Cable (CASC), under the responsibility of the Bogotá Urban Renewal and Development Company (Empresa de Renovación y Desarrollo Urbano de Bogotá). The Care Blocks are part of a planning instrument, with legal value, which offers a greater guarantee of a long-term territorial vision of the public care system in the territory. However, these kinds of policies, in countries with welfare states in consolidation, as is the case of LAC, are highly dependent on political contingencies, including budgetary, policy priorities and the programming of spaces and facilities. Their continuity is fragile as they depend on continued political will to maintain their operation.

Care Blocks were developed through a participatory process led by the Secretariat for Women, involving 13 city agencies, civil society actors, and community input. An interdepartmental commission, chaired by Mayor Claudia López, guided strategic decisions, while a technical unit provided user's feedback. This inclusive governance fostered co-responsibility, women's empowerment, and drove institutional and cultural change around gender and care. The estimated number of users as of June 2022 was of more than 130,000 care-related services delivered to caregivers through the whole system. They primary funding comes through Bogotá's four-year general budget approved by the City Council. During the COVID-19 pandemic, the initiative received complementary funding from international donors such as Open Society Foundation and UN Women (Table 4).

# 6 Conclusion and lessons learned

This article has argued that placing care at the center of urban policy is key for reducing inequalities and promoting greater inclusion in cities, especially in Latin America and the Caribbean (LAC), the most unequal region in the world. By analyzing how

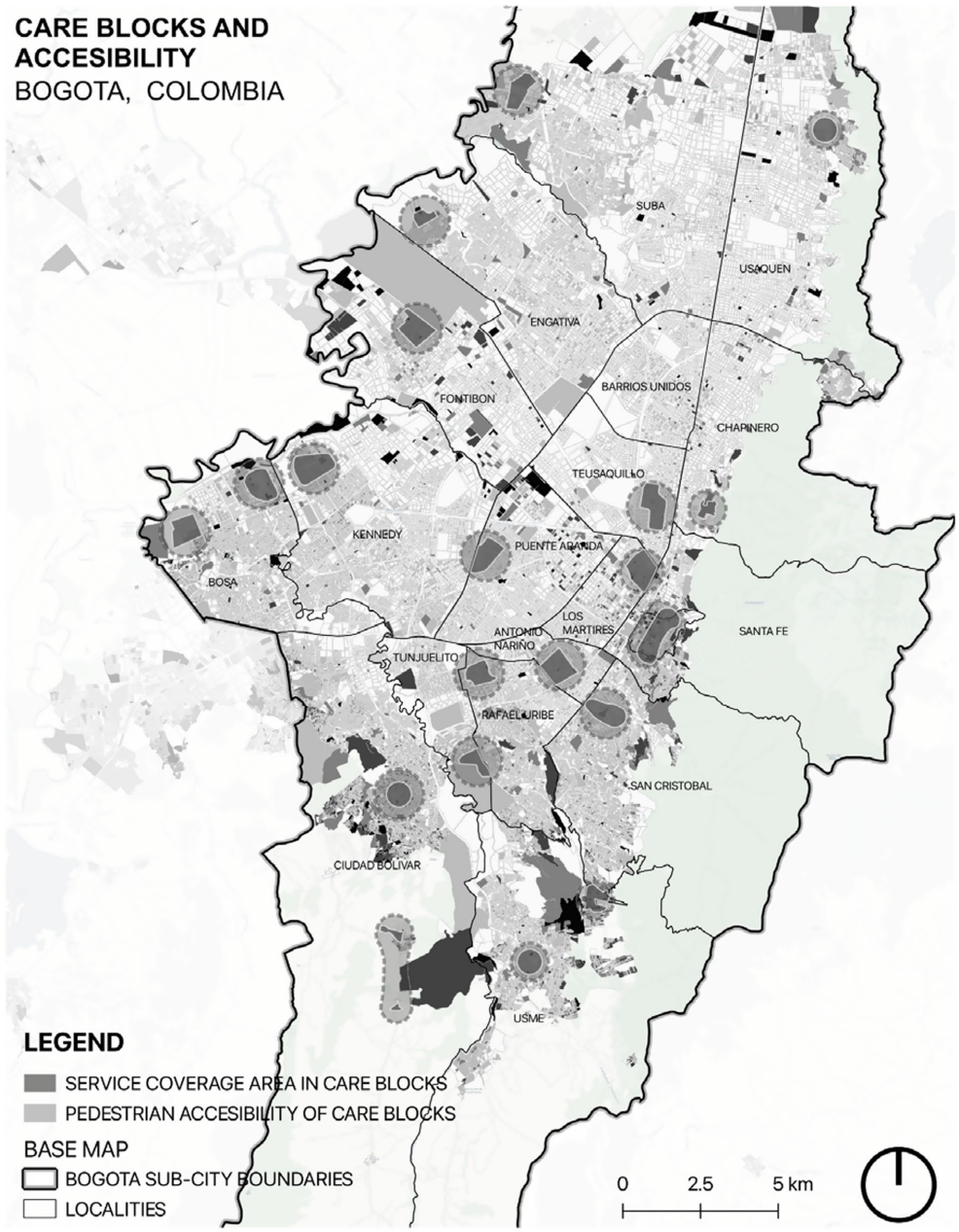


FIGURE 8
Bogota's Care Blocks. Source: Own elaboration based on Council on Urban Initiatives, 2022.

gender mainstreaming, and daily life activities, can reshape spatial planning, it has shown that integrating care into urban policy—particularly through urban planning and the provision of care infrastructure—can contribute to the recognition, redistribution, and reduction of the care burden, which is disproportionately shouldered by women. The three case studies presented—*Utopías*, *Pilares*, and Care Blocks—demonstrate the potential of local governments to reimagine cities through innovative narratives and programs, each showing a strong commitment to addressing socio-spatial inequalities and expanding access to rights for historically excluded communities, including the emerging concept of the "right to care." Notably, all three initiatives were led by women mayors, whose leadership remains closely associated with their development and implementation.

Although gender mainstreaming has been present in urban planning academic debates for about two decades, its formal integration into urban planning instruments and legislation remains limited in the LAC region. The COVID-19 pandemic, which underscored the centrality of care in urban life, has brought significant academic and policy interest to conceptualizations of care that are at the center of gender analysis of cities. These cases portray that, in practice, programs and infrastructure projects have often served as the first entry points for institutionalizing care-related

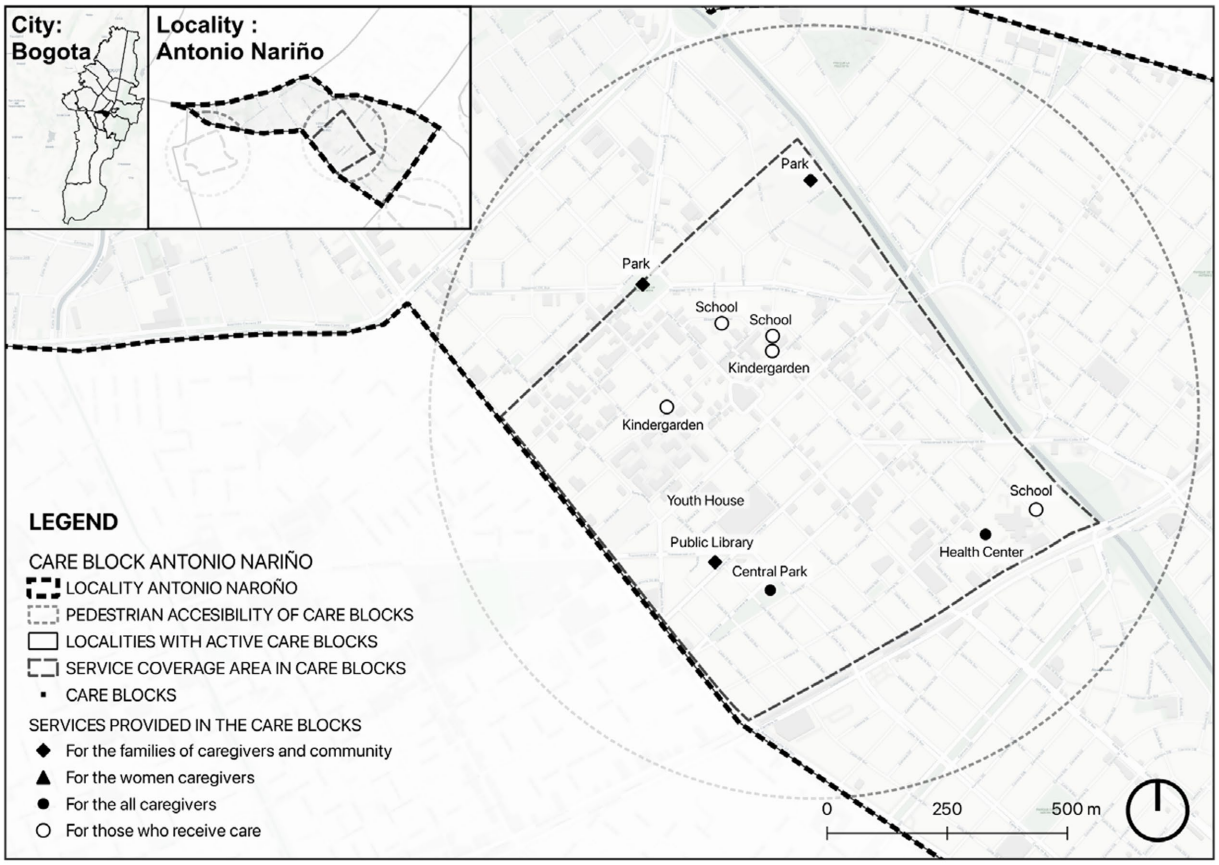


FIGURE 9
Example of urban insertion of Care Blocks. Source: Council on Urban Initiatives (2022).

strategies. While not all were initially conceived with a clear gender or care focus, these dimensions were progressively incorporated as the programs evolved. For example, in the case of *Pilares*, young women began arriving with their babies, prompting the creation of dedicated early childhood spaces in some centers.

Two important lessons learned relate to the flexibility of physical space—so that public infrastructure can be adaptable—and to how the size and integration of facilities into the urban fabric can promote greater access to these spaces. The scale and design of these infrastructures also differ: while some operate at the neighborhood level (*Pilares*), others function at a broader urban scale (*Utopías*), which directly impacts their accessibility. *Pilares* is more locally embedded and offers greater pedestrian and public transit connectivity compared to the larger and more peripheral *Utopías*. Care Blocks use former buildings or infrastructure of different public entities to integrate the services. Facilities that allow for flexible programming have proven effective in accommodating evolving needs—such as integrating early childhood spaces or expanding community services—without requiring major structural changes. This flexibility can serve as a strategic design principle for scaling up.

Among the three, only Care Blocks were embedded from the outset within a comprehensive care system and aligned with the city's territorial planning instruments—explicitly integrating care into urban policy and spatial strategy of Bogotá. This institutionalization might give Care Blocks a structural advantage that is not present in the other two cases, although this potential advantage might be overshadowed by political change. The three case studies offer distinct models with varying degrees of institutionalization, scale, and integration with spatial planning instruments. While Care Blocks were conceived within a broader care system, *Pilares* and *Utopías* evolved through experience and user demand, rapidly adapting and expanding to become a core part of Mexico City's emerging care system.

One characteristic that is both a strength and a risk, is the critical role of political will and leadership. All three initiatives were driven by committed local leadership, particularly women mayors, who played a decisive role in shaping both the vision and implementation of these policies. Nonetheless, the progress made remains fragile. In all three cases, long-term sustainability is at risk due to high maintenance costs, full reliance on public funding, and vulnerability to political shifts.

The scalability and adaptability of this case studies, to other cities (not capitals) in LAC region and beyond depend on several factors: the degree of intersectoral coordination, the flexibility of physical and programmatic design, the availability of long-term funding, community support and engagement, the normative framework that supports such initiatives, among others. Contextual differences—such as governance models, welfare regimes, and institutional capacities—may pose barriers to implementation, for

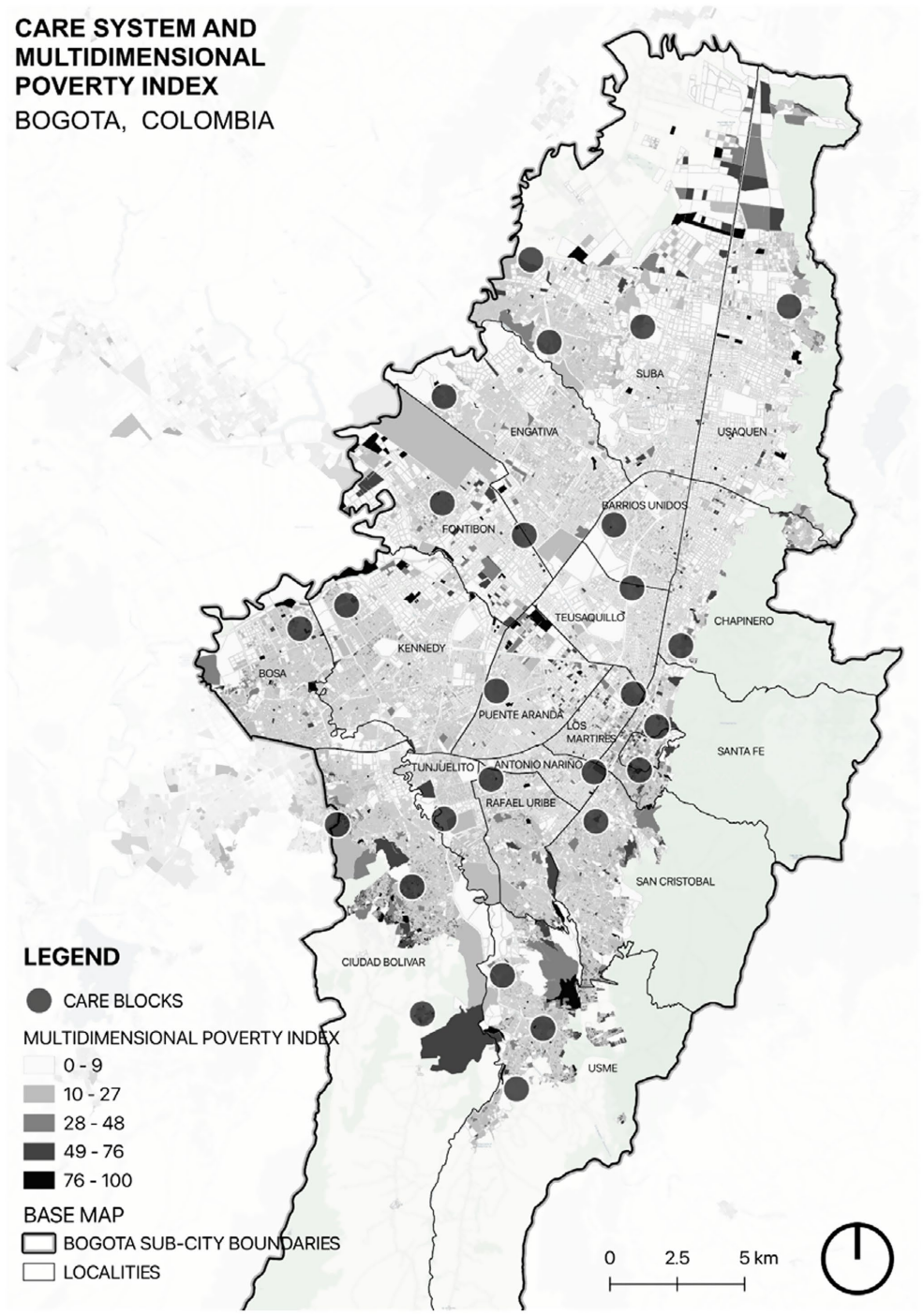


FIGURE 10
The Bogotá Care System, by programed stage of development and degree of social deprivation. Source: Council on Urban Initiatives (2022).

example, in cities with reduced public funding. Nonetheless, the core principle remains transferable: rethinking cities with a focus on gender and care. This approach advocates for more democratic cities and for accessibility in cities, addressing the challenges faced by women and other historically marginalized groups in their daily lives. In Latin American cities this involves particularly addressing the structural causes of urban sprawl and its concomitant spatial segregation.

Overcoming the sexual division of labor and guaranteeing substantive equality for women, girls and adolescents requires a cultural and structural change that turns care into a collective responsibility. This implies not only recognizing its centrality for social and economic reproduction but also redesigning cities putting gender on the map, through the following key policy areas: (1) territorial and urban planning; (2) mobility and public transportation; (3) provision of infrastructure and care services,

TABLE 4 Comparative chart of the three case studies: *Pilares*, *Utopías*, and Care Blocks.

| Case study | *Utopías* | *Pilares* | Care Blocks |
|---|---|---|---|
| Location (level) | Iztapalapa (local) | Mexico City (subnational) | Bogotá (local) |
| Primary goal | Rights, infrastructure, public space | Education, culture, empowerment | Reduce care burden, caregiver rights |
| Launched | 2019 | 2018 | 2019 |
| Facilities | 15 multi-functional centers | 300 community centers | 25 + integrated network |
| Care focus | Integrated (second phase) | Integrated gradually (informal) | Explicit core/system purpose |
| Gender focus | Inclusive design, reduce care work burden | Prioritize women-led households | Explicit, norm transformation |
| Location criteria | Socio-territorial inequality, urban-social conflict areas, limited access to green and public spaces | Low social development indicators, high rates of violence, population density, youth with incomplete education, existing structures | Urban zones (in 20-min walk) offering proximity to essential services, areas with high care needs and accessibility |
| Available spatial city planning instruments | N. A. | N. A. | City's 2022–2035 Masterplan (Plan de Ordenamiento Territorial – POT) |
| Key challenges | High costs, accessibility, political risk | Facility limits, sustainability, political transitions | Fiscal, coordination, political transitions |

* Mexico City is divided into 16 boroughs. Iztapalapa is the most populous, accounting for nearly 20% of the city's total population.
Source: Prepared by the authors based on interviews, government documents, academic publications, and publicly available data (Agência Brasil, 2025; ArchDaily, 2020; Fuentes Morales, 2023; Gobierno de Bogotá, 2024; López Hernández, 2023; Navarro, 2024; Rodríguez, 2024; Rojas, 2023; Secretaría De Las Mujeres, Dirección General De Igualdad Y Atención A La Violencia De Género, Ciudad De México, 2024).

as well as housing; and (4) social security. Thus, care is assumed as a collective task, where the State assumes a leading role.

This article presented a conceptual framework of care as rights, the spatial dimensions of care including geospatial tools, technical and legislative advances in LAC and in Spain, and Latin American cases, where innovations are being made in the provision of care facilities and regulatory instruments. Cities should meet the needs of caregivers and give care activities a greater priority in decision making, throughout the territory. Gender and care approaches provide innovative perspectives that are redefining urban planning by guiding cities toward more humane urban models.

## Author contributions

ISM: Conceptualization, Investigation, Methodology, Supervision, Validation, Writing – original draft, Writing – review & editing. CA: Conceptualization, Data curation, Investigation, Methodology, Supervision, Validation, Writing – original draft, Writing – review & editing.

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The authors declare that no Gen AI was used in the creation of this manuscript.

## Publisher's note



## Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/frsc.2025.1556795/full#supplementary-material

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