

Providing Care through Cooperatives

Literature Review and Case Studies

2



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International Labour Organization

Cooperatives Unit (COOP)
Gender, Equality and Diversity Branch (GED)

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Preface

Today, care is provided in myriad forms, from childcare and eldercare to care for persons living with a disability or illness. What is more, the need for care is growing worldwide, driven by demographic shifts including the growing ageing population and the rising number of persons living with illnesses. Both research and practice provide evidence that innovative enterprise models are emerging as players in the provision of care. One such model is the cooperative enterprise.

In an effort to map the ways in which cooperatives manifest in the care sector worldwide, ILO produced the 2016 study, *Providing Care through Cooperatives 1: Survey and Interview Findings*. This first report set forth fresh evidence of the ways in which the cooperative model manifests itself in the care economy as both an employer and service provider.

This second report, *Providing Care through Cooperatives 2: Literature Review and Case Studies*, complements the previous one by setting forth a thorough review of the literature on cooperatives that provide care, as well as an assessment of 16 relevant Case Studies from around the world. This report has the following three objectives: to compare, synthesise and identify discrepancies among previous studies; to draw broad conclusions about the ways in which cooperatives manifest in care and vice versa; and to identify potential areas for research and policy development.

It presents how cooperatives are addressing care needs among diverse populations, including children, elderly, and persons living with developmental, mental and other health needs. What is more, cooperatives are meeting these persons' needs through a variety of service types and solutions, including housing, daycare services and foster care, among others. This second report presents how cooperatives that provide care vary in terms of members, stakeholders, financial security and nature of membership. Still, all cooperatives that provide care aim to do so using a membership-based democratic decision making model while improving the health, well-being and autonomy of individuals, families and communities they serve, and providing access to decent and gainful employment opportunities to workers across the care chain.

While the present report expands findings set forth in the earlier mapping of the provision of care through cooperatives, it also builds on complementary ILO initiatives relating to cooperatives, gender equity and decent work. Such efforts include *Advancing Gender Equality: The Cooperative Way*, which assesses the impact and interplay between cooperatives and gender equality, and the mapping of domestic worker cooperatives, which identified over 40 domestic worker cooperatives worldwide.

Furthermore, the present study speaks to the broader framework of the ILO Director General's *Future of Work Centenary Initiative*, a forward-looking initiative which challenges policymakers, practitioners and researchers alike to consider innovative ways in addressing the changes world of work. The ILO Director-General's *Women at Work Centenary Initiative* focuses on the care economy as one of its primary areas of work. This present review of the literature speaks to these calls by focusing on one emerging approach: cooperative enterprises that provide care.

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Executive Summary

In 2016, ILO produced the study, *Providing Care through Cooperatives 1: Survey and Interview Findings*, a pioneering primary investigation of cooperatives that provide care services. This present report, a review of current literature and assessment of case studies from the field, complements that previous study by addressing three objectives: comparing, synthesising and identifying discrepancies across the broad literature base; drawing broad conclusions about cooperatives as care providers and employers in the care sector; and identifying potential areas for research and policy development.

Employing a global perspective, the report explores themes such as cooperative models prevalent in the care sector, the type of care services that they provide, contributions of the model for care workers and beneficiaries, and potential ways forward for cooperatives in the sector. To illustrate these and other themes, 16 brief case studies from across the world are set forth, all of which highlight the unique practices of a given cooperative in the care sector. The study aims to set forth specific, practical examples on the diverse ways in which cooperative enterprises (1) provide care to a multitude of populations and (2) provide decent work opportunities across the care chain.

Key findings from this report include the following:

- **Evidence suggests that cooperatives may provide access to improved wages, working conditions and benefits and reduce employee turnover.** This particularly impacts women, who comprise the majority of care workers coming from low socio-economic status and ethnic minorities.
- While cooperatives provide care in various ways throughout the world, **there are regional differences in the types of care provided through the cooperative model that are shaped by local contexts and care needs.** For example, cooperatives in Sub-Saharan Africa, including Rwanda and Zimbabwe, have emerged to meet the housing and health needs of persons living with HIV and AIDS. Across North America, cooperatives targeting youth with developmental needs are common. Eldercare cooperatives which provide housing and/or home-based care are prevalent across Asia (e.g. Japan), Western Europe (e.g. France and the UK), North America (e.g. the US and Canada), and parts of the Southern Cone (e.g. Uruguay).
- **Commonly cited cooperative models in the care sector include worker, user and multistakeholder cooperatives,** based on their membership structure. There is no one-size-fits-all model as local contexts, beneficiary care needs and worker conditions and characteristics shape the model adopted by members of cooperative enterprise.
- **Cooperatives in the care sector are often *multipurpose*—beneficiaries' care needs are not singular, nor are the services that cooperatives provide.** Cooperatives provide multiple services to distinct populations, including elders, children and adolescent youth, persons living with disabilities (mental and/or physical) and persons living with physical illness. Furthermore, these populations' needs may overlap. For example, a child living with a developmental disability may require day care as well as specific developmental assistance services. Multipurpose cooperatives are a response to care needs through care and other types of services.

- **Cooperatives that provide care services can often take on a *multistakeholder* nature.** Such stakeholders include care providers and other workers, beneficiaries and service users, families of service users, governments and community agents, among others. The multistakeholder model is a unique trend emerging from cooperatives' involvement in the care sector.
- **Cooperatives that provide care services may grow out of other types of cooperatives.** Most often this takes the form of care services added on to existing cooperatives. For example, in UPAVIM cooperative in Guatemala, childcare and education programmes were added on to a women's artisanal producer cooperative. Add-on care services were prompted by women worker-members' care needs.
- **Cooperatives providing care may also prompt an inverse outgrowth of other types of cooperatives.** In this model, other forms of cooperatives emerge from what started as a care cooperative. Such is the case with Sungmisan Village in South Korea, in which a consumer cooperative and cooperative school grew out of a cooperative day care centre.
- **There is room for building and fostering collaboration to support cooperatives providing care.** Such relationships are needed across the care sector as well in partnership with other stakeholders from within the cooperative movement.

Acronyms

CASA	Care and Share Associates
CBO	Community-based organization
CHCA	Cooperative Homecare Associates
CICOPA	International Organisation of Industrial, Artisanal and Service Producers' Co-operatives (a sectoral organization of the International Co-operative Alliance)
COOP	ILO Cooperatives Unit
GED	ILO Gender, Equality and Diversity Branch
ICA	International Co-operative Alliance
ILO	International Labour Organization
NGO	Non-governmental organization
UPAVIM	<i>Unidas para Vivir Mejor</i> (United for a Better Life)
ZINAHCO	Zimbabwe National Association of Housing Cooperatives

Introduction

The provision of care is found in a variety of forms, including childcare, eldercare, and care for persons living with developmental disabilities or illness, among others (ILO, 2016; Munn-Giddings & Winter, 2013). The need for care goes across class, ethnic or national boundaries—every individual across the globe requires care at some point in time, regardless of nationality, gender, race, ethnicity or class (Ehrenreich & Hochschild, 2002; Pearson & Kusakabe, 2012; UN Women, 2015).

Despite the ubiquitous need for care, deep disparities in who provides it persist. Compared to men, women across the world spend two to ten times the amount of time on care work, an unbalanced allocation which leads to a 'double burden' that working women everywhere navigate (Ferrant, Pesando & Nowacka, 2014). In Australia, for example, women make up 70 per cent of all primary caregivers, and in Canada, 22.9 per cent of the total adult population provides care, most of whom are women (Family Caregiver Alliance, 2002; Paraprofessional Healthcare Institute, 2014). In the United States, women contribute an estimated USD 148-188 billion annually in informal care work; this labour, however, reduces paid work hours for middle-aged women by about 41 per cent (Family Caregiver Alliance, 2002; Paraprofessional Healthcare Institute, 2014).

For the purposes of this report, care is:

Looking after the physical, psychological, emotional and developmental needs of one or more other people, namely the elderly, children and people living with disabilities, physical illness and/or mental illness.

Adapted from ILO (2015), *Women and the Future of Work: Taking Care of the Caregivers*.

Recent demographic shifts, such as the growing ageing population and the increasing number of people living with chronic disease, are pushing the bounds of care. As care needs expand and diversify across the globe, new work opportunities in the care sector are expected to arise, particularly for women. In the United States, for example, the direct care industry is expected to add approximately 1.6 million jobs by 2020 (Paraprofessional Healthcare Institute, 2014).

Despite this anticipated growth, exploitative conditions continue to characterise paid care work. Wages in the care sector tend to be low (or, as in many informal arrangements, not remunerated at all) and benefits such as paid sick-leave are all too often lacking. Women employed in the care sector are more likely than men to work in jobs that fall outside of labour legislation and work above the legal hours of work per week (Antonopoulos, 2009; Ferrant et al., 2014). In care work across all countries, women migrant workers are the least likely to earn equitable wages, enjoy time off and receive benefits (Ehrenreich & Hochschild, 2002).

Recent research suggests that cooperatives are emerging to address key concerns in both labour practices and service provision in the care sector (e.g., Gosling, 2002; ILO, 2016; Keregero, & Allen, 2011). Such research suggests that cooperatives, rooted in values of social justice, equity, democracy and decent work for all: (1) serve as vehicles that generate access to the labour market and (2) are responsive, community-based providers of care. Despite such broad conclusions, the landscape of

the literature remains fragmented and disjointed. This review aims to systematise this body of literature by consolidating key findings on the ways in which cooperatives manifest in the care sector.

A cooperative is:

An autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly owned and democratically controlled enterprise.

International Co-operative Alliance and ILO R193: Promotion of Cooperatives Recommendation, 2002 (No.193)

Taking a global approach, the review sets forth key findings from literature as well as 16 brief case studies on cooperatives that provide care. Drawing on insights from Italy to Rwanda, Japan to Guatemala and beyond, the report sets forth snapshots of practices and lessons learned from cooperatives that provide care. Broad conclusions about the diversity of the cooperative model in the care sector, as well as the opportunities and challenges faced and avenues for ways forward, are also discussed.

Chapter 1: Cooperatives in Care: A Diverse Model

1.1 Cooperatives in the Care Sector: An Overview

While cooperatives have long existed in sectors such as financial services, housing, retail and agriculture, research contends that cooperatives in the care sector are a relatively recent phenomenon in many – although not all (e.g., Italy, Canada, France) – countries (Birchall, 2014; Conaty, 2014; Fisher et al., 2011; Girard, 2014). Cooperatives in the care sector address care needs as diverse as youth and elder foster care, developmental and mental health needs, physical health, senior housing, childcare, and personal assistance with daily needs (e.g. bathing, toileting, cooking) (Conaty, 2014; Girard, 2014). Within these service types, individuals at different points across the life cycle are served, from infants to adolescents to adults to the elderly (Conaty, 2014; Fisher et al., 2014).

What is common across the various types of care provided and populations served by cooperatives, is that all beneficiaries are in need of some sort of care and support that they are unable to obtain on their own. Cooperatives providing care also vary in the nature of membership, types of stakeholders and financial security. Nevertheless, all cooperatives in the care sector aim to both support the health, well-being and autonomy of individuals, families and communities they serve, as well as provide access to decent and gainful work opportunities to workers across the care chain (ILO, 2014).

There are differences in the classification of cooperatives that provide care. In the literature, cooperatives in the care sector are often broadly referred to as ‘social cooperatives’¹ as well as cooperatives referring to the population served or service type provided (e.g. ‘childcare cooperatives’, ‘senior housing cooperatives’ and so on) (e.g. Birchall, 2014; Conaty, 2014; Ellingsæter, & Gulbrandsen, 2007; Girard, 2014). Contributing to the differences in classification is the relative newness of these cooperatives, both as care providers and as players in the cooperative movement. Further complicating the terrain is that in many countries, the legal provisions do not provide coverage for cooperatives in the care sector.

While such differences in classification have surfaced in the literature and in practice, it is important to note that the term ‘care cooperative’ has not been defined as such by the cooperative movement. Thus the term as used thus far in the present report is an informal nomenclature, not an officially coined term or a type of cooperative recognized through democratic processes from within the cooperative movement.

1.2 Cooperative Models in the Care Sector

The models through which cooperatives provide care are numerous and diverse. The literature stresses that there is no single ‘right way’ to structure a cooperative (e.g. Salvatori, 2012; University of Wisconsin Centre for Cooperatives, 2015). Instead, local contexts (e.g., regulatory environment, local cooperation

¹ For the definition and further discussion of social cooperatives, see the *World Standards of Social Cooperatives* (CICOPA, 2011).

and support), beneficiary care needs, and worker conditions and characteristics shape the model which each cooperative enterprise adopts (University of Wisconsin Centre for Cooperatives, 2015).

The most cited models used by cooperatives in the care sector are as follows. It is important to note that some of the following categories may overlap.

Care Services Provided by Worker Cooperatives

Worker cooperatives are democratically owned, operated and governed by their worker-members. As a key defining characteristic of worker-owned cooperatives, the majority of workers are members, and vice versa, and their relation with the cooperative is different from conventional wage-based labour (CICOPA, 2005). In the care sector, worker cooperatives are found in childcare, home-based care, and domestic work, among others, in which the workers maintain cooperative ownership (ILO, 2014).

Care Services Provided by User Cooperatives

User cooperatives are owned by their members who are users of the cooperatives' services. Examples include senior housing cooperatives (e.g., Altus & Mathews, 2002) and child care or elder care provided by consumer cooperatives.

Care Services Provided by Multistakeholder Cooperatives

Multistakeholder cooperatives bring together numerous stakeholders involved in the provision of care services (Conaty, 2014). Stakeholders may include beneficiaries and their families, care workers, other community members and government representatives, among others. Examples of multistakeholder cooperatives in the care sector include eldercare cooperatives with diverse services and certain types of health care cooperatives. The multistakeholder model is a unique characteristic of cooperatives that provide care.

1.3 Populations Served

Cooperatives serve various populations with a multitude of diverse care needs. This diversity of care is driven in part by demographic shifts such as the growing ageing population across several regions of the world, efforts to increase birth rates in some regions, and a rising number of people living with non-communicable diseases. Explored in detail through the case studies set forth in the next chapter, the populations which cooperatives tend to serve include the following.

Children

Cooperatives serve children and youth in a variety of ways. Cooperative forms of childcare include day care centres, after-school care and home-based childcare (e.g., Chang-bok, 2012). Service users include worker-members, non-worker members, and paying service users who are neither workers nor members of the cooperative. Childcare has also emerged as a critical service type addressed by domestic worker cooperatives (ILO, 2014).

Reflecting the multipurpose nature of service provision, some cooperatives specialise in providing services to children and youth with disabilities, or those who or whose families have been affected by illness and disease. In addition, in a growing number of cases with multistakeholder cooperatives, local and national governments have been involved as regulators, co-funders and decision makers in the provision of childcare services.

Elders

Like childcare, eldercare manifests in various ways in the cooperative movement, crossing over into several service types including home-based care and cooperative housing or recreational centres for the elderly (Marshall, 2014). Whether formed by care workers, community members or elders themselves or their families, cooperatives have emerged to meet diverse health and social needs, including housing, physical and mental health concerns, and social integration of elders.

Rather than prioritize treatment of illness, cooperatives involved in eldercare emphasize elders' democratic involvement in their ageing experiences. This in turn shifts the ageing narrative from a focus on illness to an emphasis on autonomy, interdependence, agency and inclusion (Grove Seniors Cooperative, n.d.; ILO, 2016). Through this approach, cooperatives aim to not only meet ageing adults' physical care needs, but also include them in the decision-making processes related to their well-being.

Persons Living with Disabilities

Cooperatives serving persons living with disabilities work with children, adults or both, providing services to persons with both physical and developmental disabilities. Services are broad and range from physical care and rehabilitation to social services, such as job preparation in and beyond the cooperative, and life skills training (ILO, 2015a; Health Coops Canada, n.d.).

Persons Living with Illness or Disease

Cooperatives serving persons living with illness or disease provide physical services, such as home-based or clinic-based health services and care, as well as social and support services to beneficiaries and their families. Illnesses around which the cooperative movement has emerged include HIV and AIDS, particularly in Sub-Saharan Africa (Keregero & Allen, 2011; Nadeau, 2010).

1.4 Overlapping Approach to Care

It is critical to note that the populations that access care services through a cooperative model are diverse yet overlapping (Girard, 2014). For example, a child with a developmental disability may need not only day care but also personal assistance, in order to ensure positive, healthy functioning, development and growth. As another example, an elder person may have an acute illness or disease which requires around-the-clock medical attention and care, as well as housing. Cooperatives may also serve multiple populations with overlapping needs by providing services that reach a variety of populations. One such example is home-based auxiliary care provided to youth and adults, as well as persons with varying intensity of care need.

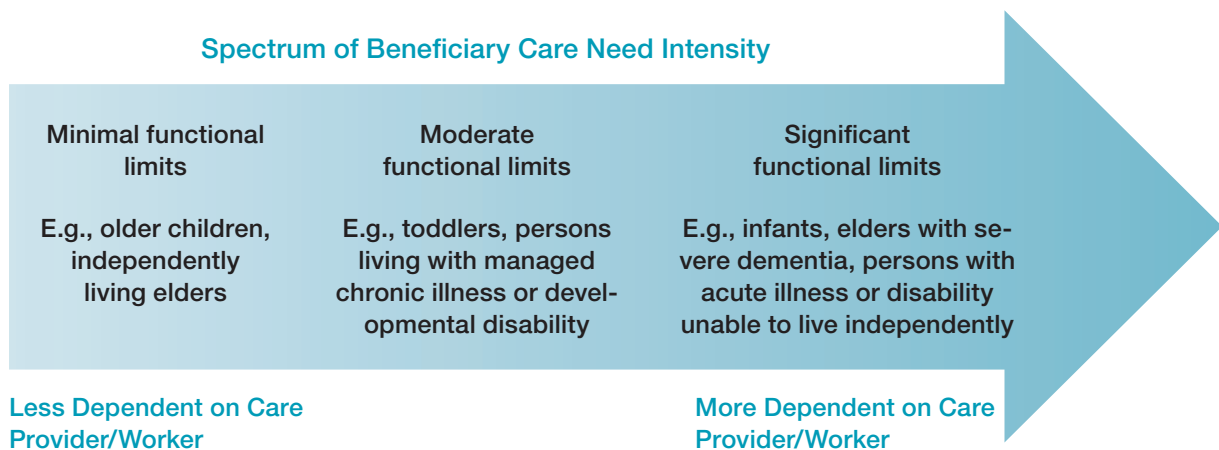
To a large degree, the varying nature of care provided is a reflection of the cooperative response to beneficiaries' needs, as well as the diversity of care needs across communities and populations.

1.5 Intensity of Care Needs and Implications for Care Workers

The intensity of care needs varies by population and the type of care required (see Figure 1). For instance, infant children and adults living with severe illness require more assistance than elders living independently.

Variations in beneficiaries' care needs shape the nature of care work that employees take on in at least two ways. First, the greater a care recipient's dependency on a care worker is, the more labour intensive the work is likely to be (Paraprofessional Healthcare Institute, 2014; Munn-Giddings & Winter, 2013). Second, the more persons for whom a worker provides care, the greater the work load is (Ehrenreich & Hochschild, 2002; Paraprofessional Healthcare Institute, 2014). For example, a domestic worker who is required to take care of two children versus one has a heavier work load. This has significant implications for the tasks and the time which a care worker is expected to work, and the compensation to be expected in return.

Figure 1. Spectrum of care need intensity



Source: Author

1.6 The Cooperative Advantage

Various contributions that cooperatives make, both as care providers and employers, emerged from the literature review. It is important to note that the advantages concerning workers and users vary according to cooperative type. The mode of ownership is an important factor in evaluating different types of advantages for both workers and users.

Provision of Improved Wages and Benefits

Across the literature, the advantages of the cooperative model with respect to employees' wages and benefits repeatedly emerged as a salient theme (Contay, 2014; ILO, 2014; Sacchetto & Semenzin, 2015). As the research suggested, cooperatives consistently and almost unanimously reinvest profits into worker wages and benefits. Further, care workers employed by cooperatives often earn higher wages than care workers in other types of service providers (Flanders, 2014). Benefits cooperatives may provide include health insurance, guaranteed hours and retirement plans—benefits that are rare in the greater care sector, which tends to be characterised by underpayment and a lack of benefits (Ehrenreich & Hochschild, 2002; UN Women, 2015). Despite these reports, recent ILO (2016) work suggests that some cooperatives face financial constraints, which may limit the enterprise's ability to provide higher wages and benefits (ILO, 2016).

Improved Worker Retention Rates

Staff turnover is common in care work, a function of the low wages paid, long hours worked, and labour-intensive, high-stress tasks often demanded (Colton & Roberts, 2007). Women workers—and particularly minority women—are most affected by such turnover. Cooperatives appear to have a positive effect on worker retention, which is most likely due to the higher wages and benefits provided, as well as workers' loyalty to and ownership of the enterprise, which the cooperative model facilitates (Flanders, 2014).

Cooperatives also tend to cultivate close beneficiary-care provider relations, fostered by their democratic and inclusive nature of governance. Such a process is especially relevant for the cooperatives in which the beneficiaries are members of the cooperative (e.g. user and multistakeholder cooperatives). While this may foster retention, recent interviews conducted by the ILO (2016) caution that such close provider-beneficiary relationships may facilitate worker burnout if the care worker is too deeply involved in individual client cases.

Regulation and Formalisation of Informal Home-Based Care

Historically, caregiver jobs have been informal, low-wage, unregulated arrangements characterised by the lack of social and legal protection and coverage (Colton & Roberts, 2007; Paraprofessional Health-care Institute, 2014). Cooperatives can help to mitigate worker rights' abuses common in informal care work by introducing practices and instruments that help formalize informal conditions. Such practices include provision of worker contracts, regularizing the flow of work and providing vocational training certificates.

Care Worker Professionalization and Training

One of the most recurrent themes discussed in the literature is the way in which cooperatives invest in their workers' professional development and training (Borzaga & Santuari, 2004; Borzaga & Tortia, 2006; Carpita & Golia, 2012). Across most of the case studies examined, skills-training was provided. Such training ranged from technical caregiving skills and vocational training to life skills. Cooperatives also engage their members in implementing training through methods such as group facilitation and peer mentoring.

By participating in professional development and training programmes, care workers have been able to leverage newly incurred skills to secure better work conditions and wages in and beyond cooperatives. Furthermore, the provision of such training has enhanced the quality of care provided to beneficiaries, thus improving well-being across the care chain.

Facilitation of Safer Working Conditions and Environments

When care workers are worker-members of a cooperative, they have the power and the support of the cooperative behind them in negotiating better terms and conditions of work. The member-needs driven nature of cooperatives has helped secure safer working conditions for worker-members in the care sector, primarily in domestic work and home-based care (ILO, 2014). To ensure safer conditions, cooperatives perform site visits to determine whether a home is adequate for work. Across the care chain, home-based care carries the highest risk for abuses, given the lack of regulation and oversight of households as workplaces (ILO, 2014; North-South Centre for Dialogue, 2010). Cooperatives may also require that clients fully disclose conditions which may affect the health of cooperative members in providing care, such as present illnesses or diseases.

Preference over Public, Private and Other Non-Profit Alternatives

Research suggests that service users pursue a cooperative model when the quality of cooperative services are perceived to be better than public, conventional private and non-profit alternatives (Cooperatives UK Limited, 2016; Murray, 2014; Vamsted, 2012). Contrary to such other care provider models, cooperatives do not simply administer services—they co-produce them (Conaty, 2014). Particularly in the multistakeholder model, users of care services become *partners* in care as voting members, rather than simply being recipients, working directly with care providers and staff to better target care plans.

Various studies point to service users' preference for the cooperative model over others, including a study of childcare cooperatives in Sweden for children with special needs (Vamsted, 2012). As this study evidenced, due to lack of public resources, municipal childcare providers could not provide adequate care for the children, which led to unintended discrimination. Private providers were not an option, as parents believed that for-profit private childcare providers 'cut corners' to save costs, such as not hiring enough staff. In this community, parents opted to adopt a cooperative childcare model to meet the needs of their children—which neither private nor public options were fulfilling.

A Focus on Inclusion and Autonomy—Not Illness and Dependency

One of the most salient themes across the literature is the ways in which cooperatives encourage active caregiving across beneficiaries (Chappelle, 2016; Grove Seniors Cooperative, n.d.). Whether instilling values of collaboration and democratic inclusion through a cooperative day care curriculum or facilitating elders' active participation in caregiving plans, cooperatives move away from simply treating ailments to giving voice to all across the care chain (Chappelle, 2016). With this approach to care, cooperatives address the physical, mental, social and emotional needs of beneficiaries, which stems from democratic inclusion and respect for all stakeholders' contributions.

Spill-Over Effects on Community and Economic Development

Among the most distinctive contributions of cooperatives to the care sector is how they provide care as extension of other types of cooperative services (Chang-bok, 2012). Various cooperatives providing care emerged as either an outgrowth or added-on service put into practice by cooperative members to meet a specific care need (e.g., UPAVIM of Guatemala). Less common but still reported was the emergence of other types of cooperatives from a cooperative providing care services—for instance, a consumer cooperative which emerged from a cooperative day care. This trend suggests that once manifested, the cooperative model is potentially self-reinforcing, emerging to meet social as well as economic needs.

Chapter 2: The Diversity of Cooperatives in the Care Sector: Selected Case Studies

This chapter sets forth 16 examples from six groups of cooperatives that provide care according to their target groups or membership base. These six groups of cooperatives are: cooperatives providing childcare, cooperatives providing eldercare, cooperatives for persons living with disabilities, cooperatives for persons living with illness or disease, home-based auxiliary cooperatives, and domestic worker cooperatives. The cases included in this section were selected in an effort to present an array of services provided, populations served, cooperative models used and geographic areas represented. As such, these 16 snapshots set forth a broad variety of the types and nature of cooperatives that provide care services.

2.1 Childcare Cooperatives: Day-care, Foster Care and Beyond

Beyond Care Childcare Cooperative

Country:	United States
Year founded:	2008
Services provided:	Childcare
Number of members:	38
Types of members:	Care workers, Board members
Website:	http://beyondcare.coop/

Beyond Care Childcare Cooperative was established in 2008 by 17 immigrant women in the neighbourhood of Sunset Park in Brooklyn, New York. The worker-owned cooperative was built using models designed by other immigrant-owned cooperatives in metropolitan areas of the United States, which have helped immigrant women and men secure decent work and higher wages. Current care services which the cooperative offers include full-time and part-time childcare, nanny share for multiple families, “rapid childcare” for on-call and emergency services for short periods of time, and group childcare for organizations.

During its early incubation and formation stages, Beyond Care was supported by the Centre for Family Life, a local non-profit community-based organization providing social services and support to community members for over 35 years. Acting as a business incubator and serving as a legal advisor, the Centre for Family Life has played a role in guiding the establishment of other immigrant-owned cooperatives in the neighbourhood, such as *Si Se Puede!* (Yes We Can!), a domestic workers’ cooperative.

Supported by the infrastructure of the Centre for Family Life, Beyond Care has recently begun introducing technology to provide services in novel ways. Alongside *Si Se Puede!*, Beyond Care worker-members are experimenting with Coopify, an emerging application and online platform that lets the users select the service they need through worker cooperatives, in this enhancing members’ competitive advantage (Quart, 2016). Now in the final development stages, the app will soon allow workers to

manage their schedules and communicate with other workers and members in real-time. The app will also enable workers to connect with clients and allow clients to book jobs online.

Beyond Care members pride themselves on providing quality jobs that pay a living wage and guarantee a safe and healthy working environment for employees. The cooperative ensures that services provided are high-quality and accountable through additional practices, such as requiring a probationary period of all childcare staff. As of 2016, 38 cooperative members had completed specialised training courses, including business development and nanny training.

The Foster Care Cooperative

Country:	United Kingdom
Year founded:	1999
Services provided:	Foster care placement and services
Number of members:	175
Types of members:	Foster care families, staff, Board members
Website:	http://fostercarecooperative.co.uk/

Founded in 1999 by a social worker specialising in child welfare, the Foster Care Cooperative is currently the only foster care cooperative in the United Kingdom and one of the few in the world. The Foster Care Cooperative was established as an alternative to conventional private foster care companies, as well as a solution to the limited number of foster care providers across the country. The enterprise is registered under the 2002 Fostering Services Regulations in England and Wales, and currently offers four main types of care services:

- **Long-term foster placement** for children and youth up to 18 years who cannot return to their birth families,
- **Short-term foster placement** of a few weeks to a year-plus for children in between birth family reunification and foster care, or whose reunification has not yet been determined by local authorities,
- **Sibling placement**, or group placement which allows siblings to remain together,
- **Respite care**, or short-term relief for families in crisis or otherwise in need of immediate, short-term relief.

The cooperative generates revenue through service fees, which are determined by child age and length of stay. All profits are reinvested by the cooperative into employee training and benefits (e.g., insurance) as well as expanded services.

In 2016, the Foster Care Cooperative merged with Jigsaw Independent Fostering, a non-profit foster care organization. Given that the cooperative's management is shared, the merger is a prime example of cooperation in the childcare sector and a testament to how the cooperative model can grow to serve even more families in need.²

2 Sullivan, J. 2016. "Foster care co-op saves independent agency with takeover." *Cooperative News*.

Sungmisan Village

Country:	South Korea
Year founded:	1994
Services provided:	Day care, afterschool program, complementary non-care cooperative services
Number of members:	170+ families
Types of members:	Care workers, teachers, community families
Website:	http://www.sungmisan.net

Sungmisan Village is a unique cooperative community that was established in 1994 by a group of parents to serve the day care needs of 20 local families (Chang-bok, 2012). An afterschool programme was later established to complement the day care programme. In 2001, the scope of community cooperation further expanded with the formation of a consumer cooperative, which sells eco-friendly products to members.

Later, in 2004, the Sungmisan Village School was established. With a curricula focused on subjects such as ecology, the school provides an alternative learning environment in which community engagement is stressed. Currently, the school serves about 170 families with primary and secondary school-age children. Central to the various childcare and education programmes is an emphasis on cooperation among children, rather than competition between them.

Taken together, the Village comprises an entire community system which practices and reaffirms cooperative values and principles, and transmits values of cooperation in children for the future. In recent years, Sungmisan Village has drastically expanded, now hosting over 20 cooperative enterprises that employ over 150 community residents. In addition to the day care centres, afterschool programme and school, various other care services are being provided through a cooperative forum, including eldercare.

UPAVIM (Unidas para Vivir Mejor)

Country:	Guatemala
Year founded:	1994
Services provided:	Social, health and educational programmes for children
Number of members:	80
Types of members:	Care workers, other staff, administrators
Website:	http://www.upavim.org/

What started as a handicraft cooperative aiming to economically empower women and communities in Guatemala, UPAVIM (*Unidas para Vivir Mejor*, or United for a Better Life) has grown significantly over the years to offer a roster of social, health and educational programmes for children across the community.

In 1994, the Children's Centre Programme was founded by UPAVIM cooperative members to provide community childcare. Medical services, including a clinic and a pharmacy were also added early on. The programme has since expanded to house a school, the Alternative Learning Centre. Established in 2002, the school offers a place to learn for community children ranging in age from kindergarten to grade-six. The school operates on principles of democratic inclusion, incorporating these values into the curriculum to transmit ideals of cooperation to future generations. Over 150 students attend the school, which is staffed by eight teachers and a director.

There are reduced monthly fees of USD16 for children of worker-members to attend the Alternative Learning Centre and USD3 for a medical consultation at the clinic. Medical and health services are provided at no cost for the highest need families when funds are available. Expenses for maintaining the day care, clinic and school are covered in part by sales of handicrafts made by the cooperative workers. To generate further revenue, some services are provided on fee-basis. For instance, Additional private contributions, donor funds (e.g. Kellogg Foundation) and partnerships keep the cooperative financially viable. In addition, the cooperative has secured supportive funding from international sources, such as the partners in the United States, to support operations.

Today, the cooperative boasts over 80 members, some of whom are worker-members. UPAVIM employs over 40 salaried workers in total, including a full-time doctor, nurses, a teacher, administrators, cooks and cleaning staff, among others.

2.2 Cooperatives for Persons Living with Disabilities

Y Owl's Maclure Cooperative Centre

Country:	Canada
Year founded:	1999
Services provided:	Personal care and support services to persons living with developmental disabilities
Number of members:	240
Types of members:	Workers, families of workers, other staff, Board members
Website:	http://www.ysowлмаclure.org/

For nearly 35 years, Y Owl's Maclure has worked with the community of Ottawa, Ontario, Canada to provide services and support to persons living with developmental and intellectual disabilities. Y Owl's Maclure was formed through a merger of Y's Owl Co-op and the K.C. Maclure Habilitation Centre. These two separate agencies unified in response to the Ontario Ministry of Community and Social Services "Making Services Work for People" initiative, a framework which aimed to improve services for children and adults with developmental disabilities.

Today, the cooperative's central mission is to promote a person's right to become a fully participating member of his or her community. Under this mission, the cooperative provides services to over 300 clients, offering a broad range of services which fall into five key programmes:

- *Foundations*, which help young adults with developmental disabilities transition from school to a wide range of community participation activities, including the labour market.
- *Linking Individuals through Naturally Existing Settings (L.I.N.E.S.)*, a social, recreation and leisure programme for adults with developmental disabilities.
- *Outreach*, a community-based programme for adults with a developmental disability or a dual diagnosis, which focuses on raising clients' and their support networks' awareness of existing services in their community.
- *Owl Employment*, a comprehensive employment programme that supports and assists people with disabilities in finding and maintaining paid employment, internships and/or other work experience in their community.

- *The Life Skills Training Centre*, which helps young adults identify their interests and gain the relevant skills—including life skills—necessary for their careers.

Through its various programmes and practices, Y Owl's Maclure supports decent employment in the care sector in two distinct but mutually reinforcing ways: (1) by providing care workers with excellent work opportunities, benefits and training, and (2) by providing skills and equitable access to labour markets for those who receive care.

Spazio Aperto Servizi

Country: Italy
 Year founded: 1993
 Services provided: Mental health and developmental health services for various populations
 Number of members: 351
 Types of members: Care workers, beneficiaries, Board members, other supporting members
 Website: <http://www.spazioapertoservizi.org>

Registered as a social cooperative, Spazio Aperto Servizi provides various mental health services to persons with mental and developmental health needs in the city of Milan and surrounding areas. Each year, the cooperative provides services to approximately 600 children and youth, 1,300 families and 500 people living with disabilities or autism.

One specialised service is immediate short-term psychological care in an overnight shelter facility for children ages 2-12 diagnosed with acute trauma. Paid care workers and a programme coordinator work closely with psychologists, providing intensive short-term services. The cooperative also recruits unpaid volunteers to assist in the facilities.

Spazio Aperto Servizi is a member of the Social Enterprise System Consortium (SIS), a consortium of Type A and Type B social cooperatives operating across Italy (see Box 2).³ The consortium serves as an information source, network hub, incubator and advocate for social cooperatives across the country.

2.3 Cooperatives for Persons Living with Physical Illness or Disease

Tubusezere Twihangire Imiromo Cooperative

Country: Rwanda
 Year founded: 2012
 Services provided: HIV and AIDS care and prevention
 Number of members: 41
 Types of members: Care workers
 Website: <http://www.sfhrwanda.org/?p=58>

³ In Italy, social cooperatives are categorised into two groups: Type A and Type B. Type A Social Cooperatives provide social services to vulnerable groups, including the elderly, children, persons living with disabilities and homeless persons. Services offered by Type A cooperatives often fall into the areas of social, health and educational services. Type B Social Cooperatives aim to provide employment opportunities within a given cooperative to vulnerable groups (e.g., persons living with mental illness or physical disability). For more information, see Thomas (2004).

Established in 2012, Tubusezere Cooperative provides care and treatment for women living with HIV and AIDS in Rwanda. What makes this cooperative unique is that services are provided for former sex workers, by former sex workers.

The women's cooperative emerged from a group of former sex workers seeking information on group support for social and health treatment for HIV and AIDS, and reaching out to CBOs and NGOs for resources, support and organizational know-how. One NGO in particular, the Society for Family Health, provided the women with skills and knowledge on HIV and AIDS treatment and prevention, and encouraged them to establish a cooperative. The partner NGO provided care and cooperative management training throughout the process of cooperative incubation and start-up.

One year after its 2012 inception, the cooperative reached a membership of over 40 women. The women of Tubusezere are of all ages; many are migrants from the interior and post-conflict zones. Some of the members were pushed into prostitution following the 1994 genocide in order to survive. To join the cooperative, a potential member must be a former sex worker and pay a membership fee of RWF 5,000 (approximately USD 0.65).

The cooperative sells discounted condoms in both urban and rural areas, sexually transmitted infection (STI) and tuberculosis screenings, advocacy and awareness training sessions, and social support for persons living with HIV and AIDS. Services are provided for free or at a subsidised rate to members and non-members of the cooperative. Non-members tend to be populations vulnerable to HIV and AIDS transmission, including former and current sex workers. In addition, the cooperative provides monthly HIV and AIDS training as well as family planning services.

Zimbabwe National Association of Housing Cooperatives (ZINAHCO)

Country:	Zimbabwe
Year founded:	1993
Services provided:	HIV and AIDS support within housing cooperatives
Number of members:	10,000
Types of members:	Housing residents, administrators
Website:	http://www.zinahco.co.zw/

Zimbabwe National Association of Housing Cooperatives (ZINAHCO) is establishing cooperative housing for persons living with HIV and AIDS with the support of NGOs and CBOs including international organizations such as We Effect Swedish Cooperative Centre and Rooftops (a Canadian CBO).

Founded in 1993, ZINAHCO was registered in 2001 under the Cooperative Societies Act of Zimbabwe. Today, ZINAHCO membership reaches nearly 200 primary housing cooperatives across five districts, representing approximately 10,000 individual members.

According to We Effect (2015), housing cooperatives for persons living with HIV and AIDS aim to:

- Enhance HIV mainstreaming and enhance partners' capacity,
- Provide focused care and support to cooperative members,
- Strengthen social-economic capacity for members,
- Provide better quality housing in an effort to reduce HIV and AIDS risk,
- Advocate for the housing needs of this population.

The services provided include safe shelter to persons living with HIV and AIDS, as well as support groups, knowledge and information training and capacity building programmes. Furthermore, these cooperatives aim to enhance members' socioeconomic capacity and food security through cooperative activities, such as savings groups. Complementary programmes include tuberculosis screening and awareness—a critical programme, given that people living with HIV are from 26-31 times more likely to develop TB than persons without HIV (WHO, 2016).

2.4 Home-Based Auxiliary Care: Providing Care in the Home

Care and Share Associates (CASA)

Country:	United Kingdom
Year founded:	2004
Services provided:	Home care services for elders, children and persons living with disabilities
Number of members:	850
Types of members:	Care workers, Board members
Website:	http://www.casaltd.com/

With operations in six branches across the U.K., Care and Share Associates (CASA) has emerged as one of the country's leading worker-owned home care providers. Targeting elders and persons living with disabilities, CASA offers a range of services from general domiciliary care, personal care to end of life and comprehensive palliative care. CASA also offers specialised programmes, such as LIFE, a tailored support service for persons living with mental health and learning difficulties.

CASA employs over 850 employees, including both care workers and staff holding full and part-time positions (Cooperatives UK Limited, 2016). All employees are provided with a secure guaranteed-hours contract. Structured, nurse-led training is provided to all care workers, with topics including health and safety training, infection control, equipment and electrical safety, control of substances to hazardous health and fire safety. In addition to completing various training courses, care workers are provided the opportunity to continue and achieve the National Vocational Qualifications certification.

CASA's Board blends expertise from both the cooperatives movement and other types of private enterprises. Board members include individuals with over 40 years of cooperative experience, as well as executives with experience in marketing, enterprise development and stakeholder management.

CASA is not only an advocate of worker-owned enterprises, it is also a leader in advancing the model with other organizations that wish to follow suit. The CASA franchise offers numerous services to other groups interested in forming a worker-owned care service cooperative. Their support services include preparation of a business plan, registering with requisite regulating bodies (e.g. the Care Quality Commission), securing start-up funding, product innovation and other product development efforts.

Cooperative Homecare Associates (CHCA)

Country:	United States
Year founded:	1985
Services provided:	Home care services for elders, persons living with disabilities and chronic illness
Number of members:	2,000
Types of members:	Care workers, Board members
Website:	http://www.chcany.org/

Based in the Bronx, New York, United States and guided by the motto, “committed to delivering quality care by creating quality jobs”, Cooperative Homecare Associates (CHCA) is a worker-owned care provider specializing in home-based domiciliary care to adults living with disabilities, persons living with chronic illness and elders. CHCA was founded in 1985 by 12 home health care providers. It has since expanded into an organization of more than 2,000 staff emerging as one of the key employers in the Bronx, a low-income neighbourhood of New York City.

Staff training and support are pillars of CHCA operations. Nearly all CHCA staff are Latina and African-American women from low-income neighbourhoods. The cooperative strives to create professionalised employment opportunities, and provide high-quality care services, through employee training and education. Such training includes one month of free health aide training available in English and Spanish—in which over 600 of women partake each year. Upon completion of the training programme, graduates earn a dual certification as a Certified Home Health Aide and a Personal Care Assistant.

Training graduates are also secured employment through the cooperative. Guaranteed positions provide full-time hours and competitive wages, time-and-a-half overtime when applicable and worker ownership of the cooperative. In addition to building caregivers' technical skills and facilitating transition to the labour market, CHCA's workforce development programme also provides supervision and coaching, peer mentoring and financial literacy training.

Like its staff, CHCA's Board is comprised of home care workers who are cooperative worker-members. In 2012, CHCA became a certified B Corporation ('B Corp'), which guarantees that issues of social justice and equity are embedded into its employer practices and services. CHCA was the first homecare company in the United States to earn 'B Corp' certification.

Cooperativa Caminos

Country:	Uruguay
Year founded:	2002
Services provided:	Nursing, physical therapy, therapeutic care, with a focus on elders
Number of members:	Not available
Types of members:	Care workers, Board Members, Health Professionals

Cooperativa Caminos (Pathways Cooperative) is the largest auxiliary care and therapeutic assistance cooperative in Uruguay. Specialising in eldercare and operating 365 days a year, 24 hours a day, Caminos provides personal assistance in the home, clinics and hospitals. A registered worker cooperative, Cooperativa Caminos employs a multidisciplinary team of health professionals, including licensed nurses, medical practitioners and psychologists. With every individual client case, Caminos service users and their families, as well as care providers, work together to create a care plan for each user, stressing self-reliance and family collaboration whenever possible.

Cooperativa Caminos is a founding member of the Caregiver Cooperative Consortium of Uruguay, an alliance of four cooperatives serving older adults. Formed in 2015, this consortium fosters resource sharing, provides training and conducts research to optimise the efforts of the cooperative response to care across Uruguay.

Box 1. How to develop a user care plan? Insights from Caminos Cooperative

Through home and clinic-based personal assistance with elders, Caminos Cooperative of Uruguay determines service user care plans by an evaluation of three main criteria:

- Level of care dependency required
- Life cycle stage of the beneficiary (i.e. chronological and emotional age of the service user)
- Characteristics of the health and disease process (i.e. moderate, acute or chronic disease)

2.5 Eldercare and Ageing Cooperatives: Housing and Beyond

Chamarel Association

Country: France

Year founded: 2010

Services provided: Cooperative housing for seniors

Number of members: Not available

Types of members: Housing residents, Board members

Website: <https://cooperativechamarel.wordpress.com/>

The Chamarel Association, also known as the Residents' Cooperative Housing Residence of East Lyonnais, is the first cooperative for elders in France. Located outside Lyon and established in 2010, this housing cooperative is operated for and by retirees. Facilities for the Chamarel Association were completed in 2017 with 16 accommodations and complementary public spaces. These facilities accommodate retirees without the personal financial means or familial assistance to provide housing as they age.

The cooperative was founded by two retirees who wanted to provide a safe, community-oriented space for themselves and their peers. Disenfranchised with for-profit senior housing alternatives—many of which are too costly for middle and low-income retirees—the founders pursued the cooperative model to fill the affordable housing gap. With this housing model, it is seniors who are taking their environment in hand, and doing so with a high level of engagement. Such motivation, as well as financial benefits in avoiding high-cost housing alternatives, contribute to overall wellbeing.

The cooperative values of democratic inclusion and participatory decision-making have guided the organization since its establishment. For example, members collectively opted to serve as their own general contractors, and chose to employ eco-friendly practices and materials in facility construction. Start-up funds to support the programme were secured through a 50-year bank loan paid to the cooperative founders.

Chamarel has sought advice from the Fédération Française des Coopératives D'Habitants (French Federation of Residents' Cooperatives). Founding members have recounted that Federation's guidance on the legal steps for establishing the cooperative has been critical, particularly during the early stages of formation.

Change AGEnts

Country: United Kingdom
Year founded: 2010
Services provided: Social and mental well-being and care, employment opportunities for seniors
Number of members: Not available
Types of members: Workers benefitting from services, Board members
Website: <http://changeagents.coop>

Change AGEnts is a unique worker cooperative that focuses on active ageing and employment of senior citizens through democratic collaboration on community building projects. The cooperative focuses on promoting the social, physical and mental well-being of seniors through active engagement in the community. The motto guiding the Change AGEnts' approach is that seniors are an asset—not a liability—to communities. As such, seniors are a wealth of knowledge and experience and by partnering with them, other community enterprises have much to gain. Promoting intergenerational knowledge sharing and collaboration is also key to the cooperative's operations.

ChangeAGEnts employs a structure of collaboration which enables their members, colleagues and associates to earn an income by forming self-managed community development project teams. The Change AGEnts teams respond to requests for collaboration and invitations for collaboration from other cooperatives, government agencies and other community organizations. The projects which Change AGEnts members take on are focused on building responsible, just and sustainable communities.

Japan Older Person's Co-operative Union (Koreikyo Union)

Country: Japan
Year founded: 2001
Services provided: Home and centre-based senior care
Number of members: 100,000
Types of members: Care workers benefitting from services, other care beneficiaries, Board members
Website: <http://koreikyo.jp/>

Since 2000, Koreikyo has emerged as an innovative model in cooperative care provision in Japan, a country with one of the most pressing ageing crises in the world on account of low fertility rates and high life expectancies.

Koreikyo has developed a truly innovative eldercare model: all services are operated for elders and by elders. The active elderly, aged 55 to 75 years old, provide care for the more dependent elderly persons of 75 years-plus. With this model, Koreikyo's guiding mission is to help seniors and elders remain active, independent and engaged well into their later years. This is achieved by providing services needed to maintain a healthy, social life, as well as providing a platform to allow seniors to continue working as they move into older adulthood.

Operating as a worker-producer hybrid, Koreikyo has reached over 100,000 members across numerous chapters over the past decade. The cooperative's core services include a home helper service and nursing home assistance. Other services provided include transportation, clothing re-tailoring and home renovation. Some chapters provide hot meals in service centres, as well as adult day care centres and three assisted living centres. Since 2000, expenses incurred for care and health services provided by the cooperative may be reimbursed by *kaigo hoken*, the national long-term nursing care insurance.

Cooperative members pay a joining fee of USD 10 to USD 50, which is reimbursed if they leave the cooperative. Members also pay an annual membership fee of approximately USD 30. Like other cooperatives, Koreikyo operates on one-member, one-vote policy. Furthermore, the board of directors and cooperative officers are member-elected, with each local chapter having representation on the board.

Grove Seniors' Village

Country:	Canada
Year founded:	1992
Services provided:	Senior housing
Number of members:	90
Types of members:	Housing residents, Board members
Website:	http://www.grovetillage.ca

In Canada, one of the most common types of cooperative eldercare service is through housing. Cooperative senior housing services across the country include establishments such as apartments, townhouses, shared living arrangements and units equipped to support persons living with physical disabilities.

Located in Alberta, Canada, Grove Seniors' Village is one such senior housing cooperative. The cooperative provides nearly 90 affordable housing units for seniors. Of these units, 18 are one-bedroom duplexes and 71 are two-bedroom single-family dwellings. Residents of Grove Seniors Village are independent elders and seniors of 55 years of age or older with low to moderate levels of income. All Grove Village residents are members of the cooperative. These member-residents share responsibilities of maintaining and operating the community services, including the community library and garden. As with other Canadian housing cooperatives that serve seniors, one of the largest sources of funding stems from member shares and rentals.

2.6 Domestic Workers Cooperatives: Cross-Over into Care

Service Workers Centre Cooperative Society Limited (SWCCS)

Country:	Trinidad and Tobago
Year founded:	2009
Services provided:	Domestic services, childcare, other in-home care
Number of members:	50
Types of members:	Care workers, domestic workers, Board members
Website:	Not available.

With expanding care needs worldwide and few public resources to meet those needs, domestic workers are increasingly providing in-home care to meet client family needs. Previous research suggests that domestic worker cooperatives are pushing to ensure that their cooperative members receive fair pay and formal contracts, are guaranteed safe working conditions, and are compensated in full for their work. In Trinidad and Tobago, SWCCS is working to do exactly that.

Founded by leaders of the National Union of Domestic Employees (N.U.D.E.) of Trinidad and Tobago, Service Workers Centre Cooperative aims to provide safe and decent work opportunities for its worker-members. The cooperative provides contracts to all employees. These contracts stipulate the domestic services and care tasks that a worker is expected to undertake for a given job, and state the pay that is to be received for those services. This is a significant contribution, given that home-based domestic work is among the least likely of all care work to be compensated in full.

Service Workers Centre Cooperative also provides ongoing training and wellness programmes for their worker-members. Such training includes vocational skills education and life skills courses. The training enhances professionalization of domestic and home-based care work, which worker-members may leverage to secure better paying, high quality jobs.

While these practices are valuable for all cooperative members, they have a particular impact on migrant domestic workers. Migrant workers are among the most vulnerable across the care chain, due to barriers such as uncertain visa status and language barriers. Migrant workers are also the most likely to accept live-in work arrangements, which impose exploitations such as time inflictions, and even physical and sexual abuse. Because the worker-members are employed by the cooperative, not individual households, such exploitations can be mitigated and controlled. In other words, domestic workers have the power and the voice of the cooperative behind them as an institution.

Chapter 3:

Institutional Factors

At least four broad groups of stakeholders play a role in fostering conditions in which cooperatives providing care may thrive: the cooperative movement, the care sector, governments and international organizations. In this chapter, these groups are identified and the ways in which they may enable the provision of care through cooperatives are discussed.

3.1 The Cooperative Movement

Collaboration and Support Institutions

Literature stresses that collaboration across the cooperative movement is needed in order to enable and sustain of cooperatives in the care sector (Conaty, 2014; Dopico & Rogers, 2015; Ifateyo & Nangwaya, 2016). Such collaboration takes the form of knowledge and resource sharing across cooperatives, peer mentoring between cooperatives and inclusion in consortia and other cooperative-supportive entities at the local, provincial, national and international levels. Secondary-level organizations (i.e. consortia and federations) were cited as being particularly impactful in enabling new cooperatives, particularly in the beginning stages.

Collaboration across the cooperative sector is also critical. Cross-cooperative collaboration allows for the leveraging of costs and alleviates financial burdens. Ways through which cooperatives may collaborate include facility and space sharing, and cross-sector financial support. For the latter, financial cooperatives that serve cooperatives (e.g. credit unions) play a particularly important role in providing care cooperatives' access to loans and other financial services (Dopico & Rogers, 2015).

A Space for Care

Further enabling the provision of care through cooperatives is the securing of a space for these enterprises within the care sector—something which is developing, but is still in its early stages.

In terms of the share of cooperatives in a given sector, the scope of care services is small in both size and recognition in comparison to more wide-spread cooperative areas such as agriculture, finance and housing (ILO, 2016). Part of this is due to the relative newness of cooperatives in care; there are not as many cooperatives that provide care in existence and their experiences are not yet widely documented and researched. This may also be due to a relatively new understanding of the care sector within the cooperatives movement, particularly in terms of size, scope and potential impact; the cooperative model's recognition by the other care sector providers; and the availability of capital, among other issues.

Box 2. Support at the National Level: Social Enterprises System (SIS) Consortium of Italy

Sistema Imprese Sociali (SIS) of Milan, Italy is a consortium of 29 social cooperatives in Italy. Established in 1995, SIS aims to promote social innovation and inclusion through a cooperative model across social sectors and among vulnerable populations in need. Of the 29 members, 15 are Type A social cooperatives, which aim to provide some sort of social service.

Among the main objectives of SIS consortium are:

- To serve as an incubator and network hub for social cooperatives,
- To provide consulting services in areas such as quality systems management and hybrid organization modelling,
- To connect members and others stakeholders for large-scale social innovation projects,
- To provide vocational education and training programs for social entrepreneurs.

3.2 Care Sector Providers

Stakeholders involved in care provision also create an enabling environment for cooperatives in care in ways described below. These stakeholders include care practitioners, such as nurses, social workers, and medical providers; medical facilities; and professional training programmes, such as medical colleges and schools of nursing and public health.

Awareness of the Cooperative Advantage among Care Workers and Professionals

As a handful of authors noted, the cooperative approach to care provision is gaining traction, but awareness of cooperatives as care providers remains low among care professionals. Previous research from the ILO (2016) found that despite the synergy between the provision of care and cooperatives, few care professionals are trained in universities or other types of professional development institutions on cooperative models. This speaks to the silos in which care (and business) professionals are trained and ultimately practice – without fuller or more comprehensive access to different business governance models.

Studies on cooperatives note that across business sectors, including care and health, there is a persistent belief that cooperatives are less efficient and less productive than investor-owned enterprises. Thus there is a pressing need to not only begin educating practitioners on the cooperative enterprise model, but to also set forth evidence debunking the myth of cooperatives' un-competitiveness (e.g. Ifateyo & Nangwaya, 2016). Evidence and data which illustrate the added-value and contributions of cooperatives, in the care sector and beyond, would aid this effort.

Understanding of Cooperative Options in and among Care Beneficiaries

Public awareness of the cooperative model in the provision of care is largely absent in many countries (ILO, 2016). Much like practitioners in the broader care sector, most care service users remain unfamiliar with the cooperative model and its relative benefits. As one study of perceptions of cooperatives of various types in France and Sweden found, users tend to have a positive perception of cooperatives—namely as a positive characteristic of the brand of 'doing good' and socially-minded business practices (Nilsson, Ruffio & Gouin, 2007). However, the average potential user lacks knowledge of the coopera-

tive model which is perhaps due to the broad lack of marketing of the cooperative advantage. Overall, users tend to have good attitudes but poor knowledge of the cooperative option, a trend which holds across different types of cooperatives.

On the other hand, in countries with long-established histories of cooperatives providing care (e.g., Italy and some regions in Canada such as Quebec), the cooperative model is quite familiar among care beneficiaries (Conaty, 2014). Nevertheless, by spreading the word on existing cooperatives and enhancing the general public awareness of the cooperative model, more potential users and worker-members will be made aware of the contributions of cooperative enterprises as care providers.

3.3 Government

While literature is inconclusive on the role of government in the provision of care through cooperatives, most authors agree that the government is at least a stakeholder. As such, government at all levels—from municipal to national—plays a role in facilitating an enabling environment of the cooperative provision of care.

Development of Supportive Legislation

Given the diversity of care needs, legislation across care is varied and subject to specific requirements, depending on the population, country and service type. Regardless, literature contends that legislation must position cooperatives on a level playing field with other types of enterprises—while also preserving the cooperative model and privileging local identity and context in business practices (International Co-operative Alliance, 2013). Researchers across cooperative sectors note the importance of government in facilitating supportive legislation that (1) allows cooperatives to provide care and (2) allows care practitioners to form cooperatives.

An example of supportive legislation is the childcare cooperative legislation in California, which permits groups of parents to form not-for-profit childcare cooperatives for up to twelve children without having to obtain a family childcare home license (Co-Op Law.org, 2016).

Box 3. Supportive childcare legislation: License exemption for family-run childcare cooperatives in California, United States

State legislation from California, United States aids small groups of families and guardians to provide childcare in a cooperative way. As the local legislation sets forth, families provide care through a cooperative arrangement for up to 12 children and be exempt from obtaining a family child care home license and the requisite fees, as long as:

1. Parents/guardians combine their efforts and rotate care,
2. No profit is gained to retained for cooperative childcare services,
3. No more than 12 children are served,
4. Care is provided by at least one parent or guardian of child(ren) present.

Source: Co-opLaw.Org. 2016. Childcare cooperatives and childcare licensing laws.
Available from <http://www.co-oplaw.org/types/childcare-cooperatives/>

Access to Funding and Resources

Literature states that cooperatives' access to funding, capital and other resources is a significant challenge, particularly in the start-up and incubation phases of their development (Birchall, 2014; Hazen-burg, Seddon & Denny, 2013). There are various ways in which governments may enable cooperatives' access to funding and resources. One sustainable and systemic form of financing is to include cooperatives as recognised care service providers in national social protection schemes.

Direct Promotion of Cooperatives' Provision of Care

While cooperatives should be autonomous of government influence, research suggests that government support and collaboration play an important role in cooperatives' provision of care. One vein of literature contends that governments have an innate responsibility to ensure the health and well-being of their citizens; hence, if cooperatives are viable care providers, government should help facilitate cooperatives' activity in the care sector. Such government support may be facilitated through resource and facility sharing, reserving service contracts specifically for cooperative providers, tax breaks, benefit from public procurement social clauses, and facilitating emerging cooperatives' access to start-up credit (Conaty, 2014).

Another action that is critical with respect to the cooperative model that governments do – or can do – is assigning cooperatives a priority option on account of the social and community development roles they play.

3.4 International Organizations and Other Partners

International organizations, including the International Co-operative Alliance and the ILO, social partners, community based organizations and complementary social movements such as the women's movement, play a role in creating an enabling environment in various ways.

Access to Funding and Resources

As the selected cases suggest, international organizations are critical players in enabling cooperatives in the care sector. For example, international NGOs have assisted with access to knowledge, resources and funding to cooperatives providing care in the Global South. Leveraging these international ties allows emerging cooperatives to secure start-up capital as well as gain access to cooperative know-how.

Platforms for Collaboration, Information Sharing and Knowledge Creation

International organizations and other supportive partners play a critical role in knowledge sharing and collaboration efforts. These organizations serve as a central hub of information and connect players through outreach and collaboration. Among the enabling tasks in which these actors engage are information sharing on issues such as contract facilitation and bylaws, and dissemination of lessons learned from the field.

Chapter 4:

Outlooks and Recommendations

To conclude, this chapter sets forth critical challenges, opportunities and ways forward in the provision of care through cooperatives.

4.1 Challenges

A Fragmented Knowledge Base and Understanding of Care through Cooperatives

Among the most pressing issues cited in the literature and the case studies was where to go for knowledge and information on the cooperative model in care (e.g. Conaty, 2014). As the cases set forth, information gaps were centred around a lack cooperative know-how (e.g. where to access start-up funds) and a lack of information on care service provision (e.g. knowledge on treatment and care options) (Social Family Health Rwanda, 2015).

The limited understanding of the role of cooperatives in the provision of care extends to the public and the overall care sector (Nilsson et al., 2007). Hence the cooperative model and its value-added are often unclear to stakeholders not involved in the cooperative movement. In many ways, cooperatives' challenges in accessing knowledge is reflected in the nature of the literature—knowledge is fragmented and spread across various fields of inquiry.

Nevertheless, the cases cited and the literature both identify key resources and actors which serve to fill these information gaps. Such sources include national and local consortia and federations, cooperatives in other sectors and other actors in the care and non-profit sectors. As research further suggests, knowledge-sharing platforms and key partnerships are critical to addressing knowledge gaps.

Issues of Strategic Planning

Stemming from the above issue is the challenge of devising and implementing informed and focused strategic planning (Conaty, 2014; Ifateyo & Nangwaya, 2016). As discussed in the literature, cooperatives are often established by a relatively homogenous group with the purpose of serving the needs within an immediate community or population. However, as conditions and needs of members evolve, the cooperatives are also required to change. Doing so in a strategic way is particularly onerous for leaders with minimal experience beyond the care sector, or for those with little experience with cooperatives.

Case studies set forth examples of successful practices used to overcome challenges of strategic planning. One strategy is to recruit interdisciplinary staff and board members with varying and complementary areas of expertise—for example, some members with non-profit management and others with direct practice experience in care.

Scalability and Competitiveness

Literature suggests that the time for cooperatives to make an impact has never been greater, given a growing global sentiment for new forms of business and growth, alongside a general disenchantment with public and other private models—including in care (Borzaga & Galera, 2014; Borzaga & Santuari,

2004; Conaty, 2014). However, scaling up of cooperative activities to meet this potential remains a challenge for a variety of reasons, including funding, know-how and legislation barriers (Davis, Hanna, Krimmerman, & McLeod, 2014).

One particular challenge is that the provision of care can be costly, particularly when serving highly-dependent persons or individuals requiring extensive health-related services. Overhead costs may be high, as may be the cost of infrastructure and technology required to provide certain types of care. While cooperatives may have been creative in leveraging costs (e.g. providing care in the facility of an existing cooperative or health clinic) and finding unique funding sources (e.g. strategic partnerships with international NGOs with consistent donor streams), scaling-up care services when needed remains a real challenge. As a result, cooperatives may not have access to the same types of resources and opportunities as other types of care providers. Foregone opportunities include knowledge about and invitations to respond to proposals for public grants, access to health care technology and input in systemic care sector policy and design.

All of this said, issues of scalability are not ubiquitous. Large groups of cooperatives that provide care, particularly in Italy, have been established precisely to address scalability issues (e.g. SIS consortium). Such efforts are supported and reinforced by supportive policies and an environment of institutions, where care provision through cooperatives can thrive (e.g. supportive legislative environments of Italy and Quebec, among others) (Salvatori, 2012).

4.2 Opportunities

Adoption of Supportive Policies

It is increasingly argued that care must become a component of social policy, and that the provision of care must be integrated into countries' social protection schemes (UN Women, 2015). When such schemes fail to exist, finding ways to tap into community resources becomes ever-more critical. As cases from Quebec, Canada; Italy; France and other countries suggest, with the right policy, legislation, financing and institutional support systems in place, it is possible for cooperatives to be viable, community-centred providers of care services.

As an example, the legal recognition of social cooperatives in Italy through the adoption of Law 381 dramatically increased the ability of cooperatives to assist elders and persons living with disabilities (Gosling, 2002). Going forward, there is much to be learned from the Italian case, as well as other countries with supportive policy contexts (e.g., France, Portugal, Canada) in forming and advocating for cooperative supportive policies.

Provision of Care in Niche Markets and Populations

Although the emergence of cooperatives in the care sector is a ground-up, organic process, there are population segments that, given current demographic shifts, may be particularly viable and necessary targets for cooperatives in care (Active and Assisted Living Programme, 2015). One such population segment is elders. While the cooperative model is suitable to meet the needs of myriad populations, the sheer number of ageing adults worldwide suggests a growing space for alternative, innovative solutions that meet this group's care needs in a participatory manner.

In this context it is also worth noting that young people, people living with disabilities and the elderly should not only be seen merely as service recipients. With orientation and training they can also be better integrated into the care sector as workers, and into cooperatives providing care as workers and members.

Through local ownership, cooperatives are closer and more responsive to the needs of care service beneficiaries than private and public solutions. Proximity to beneficiaries is difficult to facilitate through public provisions, which are allocated to a large public and may be void of the personal connection to the community, or through private providers, which often lack the social motivations central to the cooperative model (Conaty, 2014; Vamsted, 2012). For example, Niche elder markets are often in need of home-based services, housing solutions, and community and social engagement centres, and may be reached through innovative uses of social media and health technology.

Collaborations across the Care Sector, Cooperative Movement

Cases set forth in the previous chapter illustrate ways in which cooperatives in care may collaborate with a variety of actors to enhance their service delivery and reach, as well as leverage costs and resources (Conaty, 2014; Ifateyo & Nangwaya, 2016; Borzaga & Santuari, 2004). As mentioned, cooperative collaborations range from teaming with other cooperatives for service provision, to partnerships with public care providers, to mergers and acquisitions with other non-profit care providers.

What appears to be key in pursuing such collaborations is the fit of services, as well as a mutual understanding across collaborating partners of the cooperative model and its relative advantages. In this sense, clarification of the ways in which cooperatives address care needs—as well as a transparent discussion of the limitations of a cooperative provision of care—are required for successful collaborations and partnerships.

Redefinition of the Concepts of Productivity and Costs in Care Enterprise

As scholars have argued, the classic neoliberal business model and its emphasis on humans as productive inputs is at a breaking point (Conaty, 2014; Salvatori, 2012). As new models for business and growth are being considered in public policy and practice, there is a clear space for cooperatives to help reshape how business is done. Ways through which cooperatives may help redefine this discourse include a focus on collaboration and cooperation in business practices, as well as the importance of empathy and ethical behaviour—areas of particular importance in helping industries such as care.

Discussion of negative externalities and non-financial costs (i.e. social costs) are also of critical importance for cooperatives, particularly those in the care sector. There is also a space for cooperatives to set forth evidence of how community inclusion through care and health practices, and a shift from individual to shared values, positively impact society overall, with respect to social and economic returns (Girard, 2014; Conaty, 2014).

Contributions to economic debates, however, hinge on data and numbers which illustrate the cooperative advantage in a way that governments, partners and stakeholders in the care sector understand. With this lies yet another opportunity for the cooperative movement and cooperative support institutions: to collect and analyse the information on the cooperative provision of care, and conduct and disseminate findings of focused research on the cooperative advantage in care, particularly in regards to broader social and economic gains.

The generation of transparent, complete data is not only the responsibility of cooperatives, but also of governments. However, across existing data on care, there is often no differentiation of types of providers, due to questions not being asked on whether providers are registered as cooperatives or whether they operate or are governed as one. As a result, cooperatives—and the cooperative contribution to care—are lost in the data.

Harnessing New Technologies and Social Media to Broaden Reach

To promote the cooperative model in care to the general public, cooperatives that provide care services should consider engaging with new technologies and social media outlets to facilitate a broader reach. Such technology and social media outlets could, for example, be online platforms that match potential users needing care with a cooperative that provides the desired service. Using state-of-the-art communications and social media—and doing so in innovative ways—may help position cooperatives as a new and fresh model in the care sector. Other possible modes include introducing mobile and web-based applications such as Coopify to reach new clientele, and engaging with real-time social media platforms such as Facebook Live to promote the cooperative in action.

4.3 Recommendations for Ways Forward

Technical, Vocational and Managerial Training

Training at various levels is needed, both at the practitioner and cooperative management levels (Galera, 2010; Health Coops Canada, n.d.). For care workers, training on direct care provision as well as complementary care services (e.g. information dissemination) is necessary. At the managerial level, training on cooperative know-how is needed, particularly during start-up phases. The latter training should include information on strategic planning, financing and day-to-day operations, as well as employee support and professional development. There is a need to provide information on the cooperative option to potential members and users as well.

Creating and Fostering Alliances

Among the most salient areas of need and opportunity discussed in the literature is creating and fostering strategic alliances across stakeholders, including but not limited to cooperatives, care providers, governments, supportive national and international actors and other stakeholders (Conaty, 2014; Mancino & Thomas, 2005; Ifateyo & Nangwaya, 2016). Alliances set forth in the case studies include national and local consortia and federations, other non-profits, and existing public and private care providers, such as clinics. Literature points to other potential alliances for cooperatives that provide care services, including trade unions and global social movements, like the women's empowerment movement.

Expanded and Refined Data Collection and Further Research

Researchers and practitioners alike stress the need for further research on cooperatives in care, including in-depth case studies (Borzaga & Galera, 2014; ILO, 2016; Roy, Donaldson, Baker & Kerr, 2014). The case studies discussed in the present report are at most snapshots of cooperative services and practices in the realm of care. What is needed going forward are thorough case studies assessing cooperative enterprises' true capacities, needs and challenges, among other themes, with respect to care.

Looking ahead, additional research on the use of technology is needed. Such technology includes, for instance, communication and clinical information systems that enable voice interaction and monitoring

of home-based care recipients; mobile applications that provide care coordination, education, and medication adherence tools; day-to-day support technologies in home-based care such as durable medical equipment; and task management applications, among others. These technologies have the potential to reduce operational costs of care provision as well as care spending, and enhance individuals' quality of life. Additional practices and information from cooperatives in these areas will facilitate the exploration of new employment and forms of work in the care sector.

Quantitative figures illustrating the added-value of cooperatives in care are also needed. Of particular importance are hard data showcasing the economic and social contributions delivered by the cooperative model in comparison to other models of care provision. Without such critical comparisons, promotion of the model runs the risk of being seen as advocacy. Evidence of socioeconomic performance at the individual, community and even national level are particularly warranted. To generate such figures, however, disaggregated data on cooperatives' provision of care must be made available. This begins with differentiating the types of providers within government data systems, and by asking whether providers they are registered as, operate as, or are governed as a cooperative.

Additional areas warranting further study include analysis of the content and development of existing social cooperative legislation. Countries with established cooperative legislation that deserve closer examination include Italy (Cooperative Sociale), Spain (Cooperativa de Iniciativa Social), France (Société Coopérative d'Intérêt Collectif), Portugal (Cooperativa de Solidaridade Social) and Quebec (Coopérative de Solidarité).

An additional area which begs further research is economically sustainable horizontal entrepreneurial combinations, such as large social cooperative consortia (e.g. SIS consortia in Italy).

Finally, there is a need for greater collaboration and partnerships between practitioners and researchers (ILO, 2016; Roy et al., 2014). Although growing, research on cooperatives, particularly in the areas of innovation and evaluation, remains sparse. Going forward, there is ample space for collaborative research on innovation and performance of cooperative approaches to the provision of care.

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Annex 1: List of Case Studies by Region

Africa

Tubusezere Cooperative

HIV and AIDS care and prevention for and by former sex workers, Rwanda
Website: <http://www.sfhrwanda.org/?p=58>

Zimbabwe National Association of Housing Cooperatives (ZINAHCO)

Cooperative housing and care for persons living with HIV and AIDS, Zimbabwe
Website: <http://www.zinahco.co.zw/>

Asia and the Pacific

Koreikyo Cooperative

Senior housing and eldercare services, Japan
Website: <http://koreikyo.jp/>

Sungmisan Village

Cooperative day care and school, South Korea
Website: <http://www.sungmisan.net/index.php>

North America

Beyond Care Childcare Cooperative

Childcare cooperative, United States
Website: <http://beyondcare.coop/>

Cooperative Homecare Associates (CHCA)

Home-based auxiliary care, United States
Website: <http://www.chcany.org/>

Grove Seniors' Village

Senior housing, Canada
Website: <http://www.grovetillage.ca>

Y Owl's Maclure Cooperative Centre

Services for persons with developmental disabilities, Canada
Website: <http://www.ysowлмаclure.org/>

Latin America and the Caribbean

Cooperativa Caminos

Home and hospital-based auxiliary care and therapeutic assistance, Uruguay

Website: <http://caminos.coop.uy/>

Service Workers Centre Cooperative Society Limited

Domestic workers cooperative, Trinidad

Website: Not available.

UPAVIM (Unidas para Vivir Mejor)

Artisanal worker cooperative with add-on cooperative child services, Guatemala

Website: <http://www.upavim.org/>

Western Europe

Care and Share Associates (CASA)

Home-based auxiliary care, United Kingdom

Website: <http://www.casaltd.com/>

Chamarel Association

Retirement and housing cooperative, France

Website: <https://cooperativechamarel.wordpress.com/>

Change AGENTS

Eldercare and social inclusion programmes, United Kingdom

Website: <http://changeagents.coop>

The Foster Care Cooperative

Cooperative foster care, United Kingdom

Website: <http://fostercarecooperative.co.uk/>

Spazio Aperto Servizi

Care for children and adults with developmental needs, Italy

Website: <http://www.spazioapertoservizi.org>

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