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The Political and Social Economy of Care in Nicaragua:

Familiarism under an Exclusionary Social Policy Regime

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¹ This chapter was drafted by Juliana Martínez, drawing on input from Carmen Largaespada for the description of social policy, and from Karime Ulloa for the reconstruction of social practices. As study coordinator, Martínez wrote the chapter. Largaespada and Ulloa reviewed the chapter extensively and made invaluable contributions on both form and substance.

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Introduction

Nicaragua is the second poorest country in the Western Hemisphere. 70% of the population lives below the poverty line and two out of every 10 individuals is illiterate. A high percentage of households (45%) are headed by women and the gross domestic product is exceptionally low (U.S. \$958 per capita) with the main source of income as remittances sent from family members who emigrated to the United States or Costa Rica. Furthermore, it is highly sensitive to social disasters such as hurricanes and earthquakes. Within this complicated and difficult context, how do the social practices of families, State, business, and community combine and interact to provide care services, particularly those of children, in Nicaragua?

Historically, Nicaragua has been ruled by social States with inadequate public investment, social services or coverage (Filgueira, 1998). Even under import substitution and State expansion of social protection, the Nicaraguan State barely protected one quarter of its population. Currently, survival largely depends on family-oriented strategies to generate income and build social safety nets. Emigration and remittances; self-employment through the transformation of families into productive units, and social networks for coping with illness and unforeseen difficulties; demonstrate the lack of clear boundaries between labour markets, social policy and families. The result is a familialist (due to its high dependence on family deployed strategies) welfare regime with highly informal resource allocation practices (Martinez Franzoni, 2008)².

During the previous three decades, the country underwent several radical changes in its social and political organization. In the first half of the 1980s the country was benefiting from the results of the Sandinista revolution. The second half of that decade was marked by the United States' embargo, the contra revolution, the war, and the beginning of structural adjustment programmes. In the 1990s, reconstruction, a transition to democratic elections, and economic liberalization took over. These three distinct transitions have shaped the transformations and changes of the political and social care regimes in Nicaragua.

For individuals and their families, care in Nicaragua is currently at a crossroads of various social and economic changes, none of which would improve the quality of life for women, children and adolescents. Women's large assimilation into the labour market has been through self-employment, underemployment and acute conditions of informality, both within and outside of the country. While it is often essential that women generate income, the "tradition" of women heads of households and of absent or only partially present fathers, continues to worsen. Additionally, as a survival mechanism, there has been an increase in the number and type of family members that are forced to find paid work (including children, younger and older adults). As well, grandmothers are often responsible for the care and upbringing of their

² This expanded role of family relationships with respect to commercial and public-state represents a family very different from the Mediterranean countries of Europe. While in those countries the State makes demands on the families as caretaker, in Nicaragua, on the other hand, families are the "catch-all" entities that must generate self-employment both inside and outside of the country in order to offset the weakness or absence of public social services, as well as meet the demands of support and affection that is usually attributed to families. All inclusive social policy regimes are family-based. However, not all family-based regimes are necessarily exclusionary. On the contrary, they can be inclusive in their distinct way of understanding the sexual division of labour and the role of families. Generally starting from a clear division of labour whereby the care of children at early ages is the responsibility of women, which makes gender equality difficult.

grandchildren while their daughters are working outside of the country in order to send remittances.

While structural adjustment policies have had a negative impact on the lives of individual women, women's organizations and the women's movement were considerably strengthened during the 1990s. For example, the numbers and types of organizations increased, strengthening their ability to impact politics and public policy (Metoyer 2000). However, the relationships between family and work life, and care in general, have yet to be a "strong" focus for these organizations, or for any other actor in Nicaragua. For women's organizations and the women's movement, this is likely due to the priority that these organizations give to issues such as political participation and the eradication of violence rather than issues directly related to motherhood as a role traditionally assigned to women. In fact, involving a wide range of social and economic actors seems to be a major challenge for building a care system that does not leave care as a responsibility solely for women, families and the private sphere.

In order to rebuild the care diamond, we need to combine two approaches: a social-policy-oriented approach that is state-centric (as in the tradition of social policy research on welfare states and under state Socialism) with a more diversified or society-centric understanding of how social reproduction takes place (more appropriate for most developing countries) where other social institutions often work independently of, or in conjunction with, state action. The social policy regime focuses exclusively on the interventions of public policy. The care regime in contrast, goes beyond solely public policy and rests largely on practices that are not directly related to the State, although this, as much by action as omission, largely mould those same practices.

In this chapter we first present the general features of the Nicaraguan social policy regime, including changes in social spending, primarily drawing from statistical data. Second, utilizing available institutional documentation and secondary sources, we address the main components of the social policy regime that relate to care, namely, education, healthcare, social protection, and care services themselves. Third, based on focus groups, we examine the social practices involved in infant care, and relate them to the care diamond by triangulating the qualitative study with the institutional analysis and statistical data on time use presented in Chapter 2. Finally, based on these findings, we discuss the nature of the care diamond in Nicaragua.

1. Social policy regime

This section discusses the general features of the social policy regime – examining social expenditure and describing the various policy sectors involved at an institutional level in order to later analyze principal components. Four pillars of the social policy regime are considered: education, health, monetary transfers (including pensions) and care.

1.1 General features of the social policy regime

During the last two decades, implementation of the economic and social reforms in Latin America was based on the so-called "Washington Consensus". In terms of social policy, the reforms encouraged privatization, decentralisation, targeting of the social investment, and participation by the private sector. Central to this approach were the concepts of limiting the State's social responsibilities to those of compensating for "failures" in the market, promoting individual risk management and encouraging market allocation of resources to the greatest extent possible (Molyneux 2007). Since the reforms took place in very different national

contexts, the countries' current public policies are the result of combining that paradigm with the power relationships and "domestic filters" that mediated their adoption, in conjunction with the particular historical background of the particular country involved. During the 1980s, the Sandinista revolution had significantly expanded services in education, health, and care. Expansion was carried out with a vision of social services that were offered to the general population by a strong, centralized State. It was carried-out - in large measure - by organizing and mobilizing volunteers. Contrary to this Sandinista vision, the liberal governments of the 1990s promoted decentralization and the targeting of services, along with higher degrees of privatization through co-payment plans for access. Interestingly, during the 1990s when there was both the war affecting the implementation of the State's vision, as well as a liberal political regime that tended to see the State as a subsidiary to the market, there was an increase in public social spending.

In the current familialistic welfare regime, the role of the State is, in various ways, a residual one. Not only is funding extremely limited, with only basic services provided (such as primary care, as opposed to other, more complex forms of care), but the division of responsibility between the State, on one hand, and the family and community on the other, places a great deal of responsibility on the latter. This is demonstrated in data showing unpaid care work as an estimated percentage of public social expenditure (see Chapter 2).

In fact, participation by families and community organisations is mandatory for the disbursement of public funds. "Citizen participation" is, in effect, an obligation for families and communities to carry-out unpaid work. Most of the current programmes require the beneficiary populations to contribute via volunteer work, and in some instances, to make co-payments. Moreover, even those programmes that are theoretically universal in coverage (e.g., education) are a form of social policy that targets the low-income population. Overall, the relationship between the labour regime and the social policy regime is very weak: few people have access to social policy based on their access to the labour market. Finally, Nicaragua's social policy is residual in terms of the coverage it provides to the population in need of service. Consequently, the funding, the services provided, the division of responsibilities between the State and the rest of the society, the ratio of public resources to other resources, and the scope and coverage of the services constitute a welfare regime that is neither State-based nor highly defined by the social policy regime, but rather is familialistic in nature.

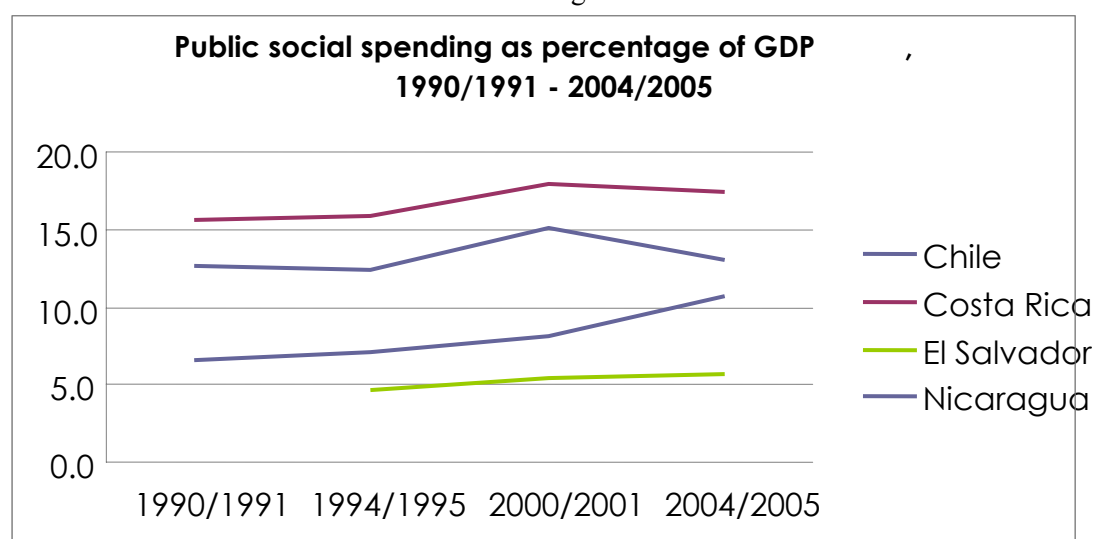
As will be demonstrated in this report, a social policy regime as mentioned above has little influence on the care system, which is heavily defined by social practices that have little to do with the State. Nevertheless, it is important to understand the role and relative importance of State institutions, including not only those with clear missions for care (such as childcare centres), but also institutions which, while designed for other purposes, nevertheless play a role in care (such as primary schools).

1.2 Changes in social expenditure³

If for Latin America the 1980s are considered the “lost decade” in social terms, the 1990s were, for Nicaragua the “lost decade” in terms of public social spending. Below, we examine changes in spending for three indicators: the fiscal priority (i.e., social spending as a percentage of GDP), the public priority (social spending as a percentage of total public spending) and the effective magnitude of the expenditure (resource allocation per inhabitant). In order to ensure that figures are comparable with those of other countries in the region, data from ECLAC, which is available until 2004 or 2005, are utilized. To assess the Nicaraguan situation, its expenditure is compared with expenditure in other Latin American countries that have State-oriented social policy regimes and the below tables therefore, show figures for Chile and Costa Rica as well as for Nicaragua. Including El Salvador, with a familialistic welfare regime similar to Nicaragua’s, this permits evaluation of Nicaragua’s performance not only in absolute terms, but also in relation to the realities and margin for action available in countries with a similar profile.

The fiscal priority placed on social spending by Nicaragua’s social policy increased through the period, from 6.6% at the beginning of the 1990s to 10.8% 15 years later (2005), with the increase becoming sharper in 2001 (see figure). As a percentage of GDP, Nicaragua’s entire investment in social policy is comparable to what Costa Rica, for example, spends in specific sectors such as education or health.

Figure 3.1



Internal comparison of the country’s fiscal effort over the period, however, shows a doubling of per capita social spending – from US\$ 45 to US\$ 90. Expenditure dropped during the first half of the 1990s (under the Barrios de Chamorro government), remained constant during the second half of the decade (the Alemán government) and then increased more sharply starting in 2001 (with the Bolaños government). Equal resources were allocated to education and health, with less devoted to housing (see figure). Note the absence of data on social security.⁴

³ Except for the last year of each government, in which social spending increased (1994; 1999).

⁴ As a general caveat, note that the effective composition of social spending in the country should be regarded with some caution. The preparatory work for the writing of the Enhanced Economic Growth and Poverty Reduction Strategy (Estrategia Reforzada de Crecimiento y Reducción de Pobreza, or ERCERP) and the National Development Plan (PND) included a review of the entire public investment portfolio, and involved a

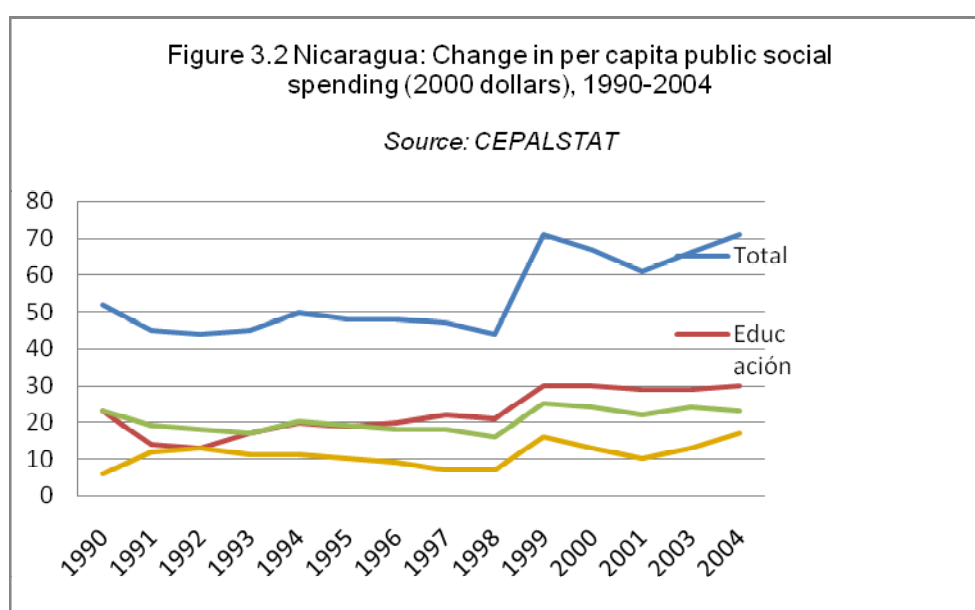


Table 3.1 Change in per capital social expenditure, 1990-2004

	Years													
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2003	2004
Total	52	45	44	45	50	48	48	47	44	71	67	61	66	71
Education	23	14	13	17	20	19	20	22	21	30	30	29	29	30
Health	23	19	18	17	20	19	18	18	16	25	24	22	24	23
Housing	6	12	13	11	11	10	9	7	7	16	13	10	13	17

Source: CEPALSTAT.

In terms of per capita social spending on health, the country spends the same today as it did in 1990. As well, the increase in per capita educational spending between 1990 and 2004 (US\$ 7) was so small that it might more appropriately be considered stagnation. The greatest change is in housing, where per capita spending rose from US\$ 6 to US\$ 17. Both overall per capita social spending and the disaggregated figures are central to assessing the effectiveness of the large number of programmes described in the following section. Nicaragua's educational spending, for example, is among the lowest in Latin America. The gap between Nicaragua and countries with State welfare regimes (such as Costa Rica, with US\$ 242) is enormous, but the difference between Nicaragua and El Salvador, which also has a familialistic welfare regime, is also vast. Indeed, El Salvador's spending in this sector (US\$ 63) in the 2004-2005 period was twice that of Nicaragua.

During the period under consideration, external funds played an important role, first decreasing and then changing in composition (with loans replacing donations as the principal component). In health, external loans were received in the second half of the 1990s. A large

classification/reclassification of public spending, principally in the area of social and anti-poverty spending. The review showed, for example, that subsidy for public transportation in the city of Managua was (and continues to be) classified as poverty spending under the more general rubric of social protection. This classification is questionable, since Managua has the lowest proportion of poor in the country. (Note by Largaespada.)

part of the additional resources were used to finance reconstruction – first of health centres, then later, of hospitals. In education there were also loans directed towards the financing of a decentralized “Chilean” model of education. The increase in housing funds in 1999 resulted from an Inter-American Development Bank (IDB) loan for the reconstruction of rural housing in the wake of Hurricane Mitch (1998).

As seen in the table, there is a lack of data on social security. This reflects the lack of protection – for risks such as old age, disability and death – that persists despite the current pay-as-you-go regime.⁵ Those who contribute to the pension plan can also opt to pay for health insurance if there are INSS healthcare services in the area where they live. Thus, there are some individuals with comprehensive coverage - disability, old age, life, and occupational risk insurance, as well as healthcare – while others have only limited coverage. During the period studied, there were no pensions available to mitigate the tenuousness of social protections associated with insertion in the labour market. Only during the first Sandinista government, when disability, old age and life insurance were combined in a single programme, were non-contributions-based pensions (e.g., for victims of war and mothers of war veterans⁶) provided from funds derived from contributions of those able to pay (Rodríguez 2005) – a system that created financial problems that persist to this day.

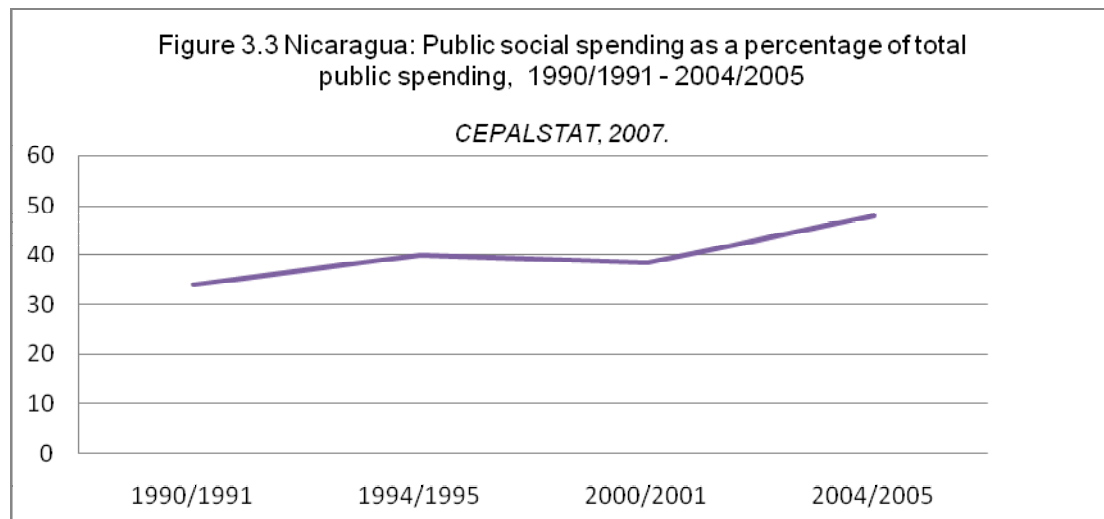
Although coverage was already low in 1993 (when data is first available) it had declined even further by 2001: from 22% to 17% for men, and from 28% to 22% for women. The gap in favour of women has persisted. More recent data – from 2003, when INSS estimates coverage at 16% – show that this trend has continued (INSS, in Rodríguez 2005). In contrast to most of the region’s countries, the majority of INSS insured are in the private sector.⁷

Returning now to an analysis of total social spending as a public priority, we see (Figure 3.3) that social spending rose considerably as a proportion of total public expenditure: from 34% in 1990 to 40% in 1994-1995 and 48% in 2004-2005, with a decline in 2000-2001, when Nicaragua joined a debt forgiveness initiative for highly indebted poor countries.

⁵ There was an attempt to replace the pay-as-you-go regime by an individual capitalisation regime, and legislation was even passed to that effect, but it was never enforced.

⁶ They were created via decrees issued between 1979 and 1992.

⁷ Within the public sector, those working in the Ministry of the Interior and the Ministry of Defence are exempt from the insurance requirement, since they receive medical care at health centres and hospitals that pertain to those ministries (Rodríguez 2005).



The country's educational system currently has a public and a private sector, financed with national and out-of-pocket resources respectively. The social security regime funds pensions and healthcare services. As will be shown, the nation's healthcare system combines social security with private sector services and public and community services, creating a highly stratified system. Although the pension system includes a private component, it is inconsequential, leaving serious gaps in protection in many cases. Education, healthcare and pensions are supplemented by social assistance and promotion programmes – both intra-sectoral and cross-sectoral – and are handled by a variety of different institutions. Of particular relevance are cash transfers and programmes in areas such as nutrition and childcare, which are designed to mitigate poverty and provide care services.

1.3 Institutional changes as a means of shaping social policy

This section presents some of the key features of social policy in Nicaragua. Social Policy which is often positioned within the context of externally imposed structural adjustment programmes. In the Northern countries, studies on social policy, welfare and care regimes can assume that adequate institutions, in which policies are based, exist. However, in the South in general and in Nicaragua in particular, there are not necessarily appropriate public institutions for implementing public policies. Nicaragua, during the period under review, was rife with insecurity, instability and change and the ability of the State to carry out various proposals was repeatedly undermined by the lack of organizational, technical and financial capabilities (Medellin 2004). In addition, the precariousness and instability was further exacerbated by the demand of external actors in shaping policies, which often went hand-in-hand with funding.

During the period under consideration, we see the emergence of "social protection" policies and of "strengthening human capital" promoted by the World Bank under the risk management approach and shared by the government of Nicaragua. This was carried out to promote minimal social investment, mainly in basic health and education services, and in the care of vulnerable children. The remainder would be the responsibility of the market and the idea was that the revenue it generates would bring about economic growth for the entire population through the "trickle down effect". Social policy would be residual and the State would intervene as little as possible.

Before focusing on policy components, the developments under each of the three presidential administrations that governed during the period will be briefly outlined below. During the 1980s, the Sandinista government created the Ministry of Social Welfare, which was responsible for implementing the revolution's social policy. The ministry, however, lacked financial sustainability and in 1983 its functions were transferred to the Social Security Institute, which at that time, became the Nicaraguan Institute of Social Security and Welfare (INSSBI) (Largaespada-Fredersdorff 2006a).

During the Barrios de Chamorro government, there was an attempt to merge social policy under a single strategy that united distinct sectors and programmes. This began with support from the Swedish International Development Cooperation Agency (SIDA), the United Nations Development Fund (UNDP) and the United Nations Children's Fund (UNICEF) in 1991, when an inter-institutional team designed the National Human, Child and Youth Development Plan 1991-2005 (Nicaraguan Government 1991). Although it was based on existing programmes, on identifying major institutional problems and, on taking advantage of institutional experience in the social sector, the plan was never formalised as law. In the words of the then Minister of the Economy, the financial resources required to implement the plan threatened to "overheat" the economy.⁸ In addition, there was the perception that any human-development-oriented discourse on social policy was a mere reflection of Sandinista rhetoric. Thus, there was an attempt to distance the discussion from Sandinista social policy and from the political significance the Sandinistas gave to the State's role in managing social risk.⁹ This ideological and domestic policy departure from Sandinista policy concurred with the prevailing public policy environment in Latin America at the time. In addition, the country was bankrupt and the proclaimed - although not necessarily actual - social policy of the Sandinistas could not be financed.

In any case, there was a change of orientation. Priority was placed on growth and employment, with social spending occupying only a supplementary and compensatory role. A study conducted from interviews with 170 Nicaraguan priests between 1993 and 1994, showed that they were "mostly sceptical of Chamorro's regime for giving too much power to unelected ministerial officials and for social policies that deepened poverty and were at odds with the church's idea of universal respect for humanity"¹⁰ (Stein in Brown 2003).

With the advent of peace, the government faced demands for land, work, food and housing, especially from demobilising groups¹¹. The social agenda emphasised responding to these demands in order to achieve demobilisation. Between 1990 and 1993, these efforts were carried out by the Vice Minister of the Presidency for Social Affairs, who coordinated programmes targeting the poor. In 1993, the Ministry of Social Action (MAS) was created to coordinate the activity of social institutions in the executive branch, which were organised under the umbrella of the so-called Social Cabinet. The government's *Social Agenda* was presented that same year, formalising the action that had been in progress for three years: universal programmes, basic education and health services, and activities targeting

⁸ Silvio De Franco, then Minister of the Economy, personal communication with Largaespada, December 1991.

⁹ A rejection of centralised power and of the politicisation of State institutions accompanied this.

¹⁰ Priests tended to be more supportive of Chamorro's educational policies, which stressed returning "Christian morality" to the curriculum.

¹¹ In contrast to the El Salvadoran and Guatemalan civil wars, Nicaragua's war did not end with a negotiated settlement but with an election that was won by the political party supported by the armed opposition. The Chamorro government therefore had no formal obligations to militants on either side to ensure demobilization. By 1992, conditions were so bad that many of the Contras rearmed themselves. However, the government was able to appease these contras primarily through land distributions and weapons repurchases (Armony, 1997).

particularly vulnerable groups, defined principally in the post-war context and in relation to the ongoing peace efforts. The social agenda was closely related to the care of children, as, in addition to poverty and vulnerability criteria, priority was given to malnourished children and children living in especially difficult circumstances.

During this period, health and education were given priority along with the recovery of the educational infrastructure which had been destroyed by war. The Nicaragua Social Investment Fund for Emergencies (FISE) was created in order to finance the reconstruction of the social infrastructure. This fund was similar to those in Latin America from several years earlier, and was used as a mechanism to offset the social effects of economic stabilization and adjustment.

As part of the Social Agenda, community involvement - inherited from the 1980s - was indispensable in health and child protection for the following three reasons. Firstly, due to the Social Agenda's vision of decentralization as the principal means of public policy. As discussed below, the education sector was among those that showed a rapid and radical institutional reform, with similar findings in the health sector. Secondly, due to the financial constraints and reduced size of the State under the framework of the structural adjustment programme of the International Monetary Fund. Thirdly, due to the appeals by the Sandinista opposition to defend "from below" the legacies of the revolution.

During the Alemán government, in 1997, the Social Agenda was replaced by what is now termed the *Social Policy*, and the formulation of policies for each institutional sector, began. As well, the existing Social Cabinet was formalized under this administration (Asamblea Nacional de la Republica de Nicaragua 1997). This *Social Policy* proposed to eradicate extreme poverty as quickly as possible, to efficiently and equitably increase the coverage and quality of public services, and to direct social investment towards the development of human capital as a central element in the nation's progress. The new priorities did not necessarily entail interrupting previous programmes, although new ones were created. The "Glass of Milk" programme, for example, continued, while the Integrated Basic Services Programme (Programa de Servicios Básicos Integrados, or PROSERBI) was eliminated and new programmes emerged, such as the Programme for Comprehensive Care of Nicaraguan Children (Programa de Atención Integral a la Niñez Nicaragüense, or PAININ) and the Social Safety Net (Red de Protección Social, or RPS).

Community participation became an official policy element under the *Social Policy*, which set forth the responsibilities of the State and those of the remainder of society, defined the government in its operational role as a facilitator, and established rights and obligations both for society in general and for specific population groups and individuals. Also during this administration, the government banned any collaboration between Sandinista organizations and State institutions, in particular in the health sector. However, this ban was rescinded with the threat of a dengue epidemic and the devastation of Hurricane Mitch, when all available help was needed.

In 2001, there was another effort to create an articulated vision of social policy under the *Enhanced Economic Growth and Poverty Reduction Strategy (Estrategia Reforzada de Crecimiento Económico y Reducción de Pobreza, or ERCERP, 2001)*, in the framework of the Highly Indebted Poor Countries Initiative that is mentioned in Chapter 1. This approach rested on four pillars: economic growth with jobs, based on increased production and on promoting the rural economy; social investment, with a focus on human development; protection of the most vulnerable population; and institutional governance and development.

Thus, regardless of whether or not one agreed with the State's vision and the relationship between growth and distribution, it is clear that the approach had at least three key virtues: first, it gave meaning to social investment; second, it started by identifying and analyzing existing policies' effects on poverty reduction; and, third, it was the result of an innovative consultation process with civil society.

The ERCERP expanded the social policy vision of previous years: priority was given to the population living in extreme poverty and was carried out through transitional measures which were mainly aimed at strengthening human capital. In order to identify beneficiaries, an “extreme poverty map” was utilized for the first time, which combined sectoral indicators related to Millennium Development Goals. As well, a critical review of existing programmes and projects was carried out in order to establish their relevance and reorient public investment accordingly.

In 2002, the Bolaños administration carried out a review of the ERCERP, in particular the strategies used to promote economic growth for poverty reduction. It was found that instead of a single macroeconomic approach; various methodologies were encouraged, based on the productive potential of distinct regions of the country. In this context, social policy should continue to promote the formation of human capital and social protection through interventions targeted at vulnerable groups¹². This review culminated in 2003 with the formulation of the National Development Plan (PND). For the first time a policy is embodied in a long-term vision (until 2050), defining the medium-term targets and estimating their costs. For example, the existing gap between the social policy sector demands, and the available budget - of the structural adjustment programmes according to the International Monetary Fund - was estimated. Findings showed that for example, by 2010, the financial gap between what is required and what is available, was estimated at 180.5 million dollars.

During the Bolaños administration the contribution of voluntary health personal was officially recognized through the payment of “stipends” (a monetary amount based on what it costs the volunteer to arrive at the worksite), mainly provided by non-governmental organizations. As well as by “recognition”, with items such as T-shirts, hats, capes, rubber boots, basic medical equipment, or labels to identify the houses as having Ministry of Health (MINSA) collaborating volunteers.

The previous sections outlined the successive efforts that were designed to orient Nicaragua’s social policy regime. In sharp contrast to the most studied countries in Europe and North America, in Nicaragua, the State’s reorganization during the period under consideration, was extremely rapid. It was not inhibited by the party system, or by civil society organizations, and it was heavily influenced by external actors such as the International Monetary Fund.

2. Principal components of the social policy regime

Below we describe the principal components of the social policy regime over the period. Among the many programmes and projects carried out – some for relatively short periods – we identify and summarize the major ones that bear on the State’s role in the care regime.

Along with these services - which we will see are markedly insufficient in quantity and quality – a key way that Nicaraguan women and families cope with care is through paid domestic work. Two out of every 10 women registered as part of the economically active population, are employed as domestic workers. Less than 1%, however, have domestic employee contracts, that are “live-in”. Terms of employment range from full-time days, to hourly work, to half-time arrangements (Tinoco et al. 2008). Clearly, the presence of paid

¹² The PND’s division entitled Human Capital Development and Social Protection, integrated themes of education, health and nutrition, training and education, and social protection as a strategy for united protection of the most vulnerable populations. This will be addressed below.

domestic work rises with increasing socio-economic levels: less than 1% of households in the lowest income quintile have paid domestic work, compared to 20% in the highest income quintile (Tinoco et al. 2008). This is indicative of the degree of socio-economic stratification for care in Nicaragua: which is predominantly private in the population as a whole. In higher-income households, care occurs with a combination of market and unpaid female work. In lower-income households, however, care is family-private, relying almost exclusively on the unpaid work of women family members and supplemented, as we shall see later, by friendly female neighbours.

In continuation, we first present the programmes related to childcare, and then address complementary services such as food and health, as well as the latest in health education, within the framework of the conditional cash transfer programme.

2.1 Educational and care services

Below, we describe two types of childcare programmes: preschools and programmes that are explicitly termed childcare services. The former cater to children between 3 and 5 years of age, while childcare services accommodate children from birth. Preschools focus on preparing children for primary school and have a more limited schedule. In some cases, childcare services also offer preschool education but differ from preschools in that children can remain in the facility for longer periods of time. Preschool services are provided by the Ministry of Education, while childcare services are run by the Child Development Centres (CDI) or the Children's Community Centres (CICOS), and are dependant on the Ministry of the Family. As shown below, both share a similar history: they were created and expanded during the revolutionary period, with a significant presence of family and community, and are relatively segmented between formal and informal forms of care.

Table 2 demonstrates the evolution of these centres' coverage between 1993 and 2005. Data from the four measurements are only relatively comparable due to changes in the sample in 1998 and 2005¹³. Despite these limitations analysis of this data is very useful, demonstrating that only 3 out of every 10 children under the age of 6 have access to some form of childcare service. Data also demonstrates a high increase in coverage between 1998 and 2001, from 19 to 31%, during the two years that the sample was exactly the same. Findings also indicate that in 2005 coverage remained at approximately 30%. Given that the sample in 2005 was increased in order to represent the entire department, we would presume that the data for coverage would be reduced, but nonetheless, it remained the same.

¹³ In 1998 the data sample was completely changed from that used in 1993. From 1998 to 2001 the sample remained the same until 2005 when it was extended to better represent the department.

**Table 3.2. Coverage of care centres among children below 6 years of age.
(Absolute numbers and percentage)**

Asistencia	1993		1998		2001		2005	
	Children	%	Children	%	Children	%	Children	%
Total	601 811	100	787 374	100	915 617	100	767 075	100
Attend	74 931	12	151 854	19	284 948	31	233 229	30
Do not attend	526 880	88	635 521	81	630 456	69	533 758	70
Ignored	-	-	-	-	213	1	89	1

Source: Own elaboration based on household surveys (ENHNV 1993, 1998, 2001 y 2005).

Table 3 shows the relative importance of each type of institution between 1998 and 2005, years for which this information is available. School attendance was included in order to register children who attend first grade but who are not yet 7 years old. The figures demonstrate that for children under 7 years old, there was no expansion in childcare coverage for preschools or CDIs, primary education however, did expand coverage. While the coverage of preschools remained between 16 and 18%; and coverage of CDIs at approximately 1%; primary school coverage increased from 2% in 1995 to 15% in 2001 and then subsequently decreased to 10% in 2005.

Table 3.3. Coverage of care centres among children below 6 years of age by income and area of residence.

(Absolute numbers and percentage)

	Household income in quintiles											
	Total		Lowest								Highest	
	Abs.	%	Abs.	%	Abs.	%	Abs.	%	Abs.	%	Abs.	%
1998												
Total	151 854	100	29 878	20	28 373	19	31 198	21	32 946	22	29 460	19
Urban	93 834	100	12 838	14	13 953	15	19 809	21	22 543	24	24 691	26
Rural	58 020	100	17 040	29	14 420	25	11 389	20	10 403	18	4 769	8
2001												
Total	167 152	100	35 154	21	34 122	20	33 034	20	32 542	19	32 299	19
Urban	102 640	100	14 601	14	18 516	18	19 715	19	25 165	25	24 643	24
Rural	64 512	100	20 553	32	15 606	24	13 319	21	7 376	11	7 657	12
2005												
Total	143 829	100	25 965	18	32 569	23	29 174	20	26 029	18	30 092	21
Urban	84 517	100	10 077	12	14 249	17	17 152	20	17 625	21	25 413	30
Rural	59 312	100	15 888	27	18 319	31	12 022	20	8 403	14	4 679	8

Source: Own elaboration based on household surveys (ENHNV 1993, 1998, 2001 y 2005).

The increase in educational coverage is consistent with other available data. We know that in the educational sector, services were expanded since 1990 despite stagnation in spending. Thus, with basically the same public resources, primary level coverage increased and secondary level coverage remained the same. School enrolment at the primary level was 73% in 1985, 72% in 1990 and had risen to 90% in 2006. As well, enrolment in secondary schools rose from 18% in 1985 to 43% in 2006 (data are lacking for 1990). In addition, the rate of

graduation from primary education had risen dramatically, from 44% in 1990 to 73% in 2006 (World Bank 2008).

Even more marked than the increase in coverage, is the notable increase in the proportion of children completing primary school: while only 51% graduated from primary school in 1989, in 2006 this number had reached 73% (World Bank 2007). Even with the challenges of rebuilding the infrastructure which had been severely damaged by war, fiscal constraints, and the lower social spending per student, the quality of education seemed to remain the same and the gap between private and public education did not increase. For example, since 1990 the ratio of students per teacher remained constant, both in primary education – between 33 and 38 students per teacher – and in secondary education with between 31 and 35 students per teacher.

In addition to external loans, the increase in educational resources was largely supplied by families' unpaid work, such as in school management and food preparation. In the area of school management, Nicaragua underwent one of the most radical decentralization reforms in Latin America during the period. "Its autonomous schools programme implements a system of school-based management with local school-site councils that have a voting majority of parents and allocate resources that are derived in part from fees charged to parents. Nowhere in Latin America have parents officially been given so much responsibility, and nowhere have they been asked to directly provide such a large proportion of school resources" (Gershberg, 1999:8).

In the context of acute budgetary constraints, in reaction to the centralization of the 1980s, and following the regional trends of reducing the size and function of the State, since 1992 the government decreased the State magnitude and promoted the educational model entitled "Self Help" (Ministry of Education 1990). Through this reform the government transferred a fixed amount of money per student to each school for administration and all other matters related to school management. After that, the central government assumed "facilitation" tasks, such as regulating the schools' operation, defining the basic programme content, establishing quality standards for material selection, and qualifying teachers and school infrastructure. The reduction in State employees in the education sector was dramatic: between 1990 and 1992, the education sector payroll was cut by more than half (Arnove Gershberg in 1999)

According to authorities at the time, the reforms were impulsive and lacked external resources during the first two years¹⁴. As a result, existing resources needed to be more efficiently utilized and community input in the maintenance and improvement of facilities was increased. The model became increasingly inspired by the Chilean experience: the then Minister of Education travelled to Chile and assessed the benefits - in particular the economic benefits – of school administrative responsibility corresponding to parents, teachers, and principals. The result was a reform that basically replicated the Chilean model of decentralized management and resource allocation from the national to the local level through vouchers per student. It is essentially an adaptation of school based management that was promoted by the World Bank throughout Latin America during the 1980s, and that financed education in Nicaragua during the 1990s. It began with the urban high schools and was extended to primary schools after 1995. It was carried out through two models, one in the urban areas through the creation of school boards, and the other, in rural areas through the creation of municipal school

¹⁴ Humberto Belli, Education Minister during the Chamorro Administration and during the first half of the Alemán administration. Interview March 28, 2008.

“headquarters”, where one school operates and maintains the bank accounts of the others and there is one board of directors at the municipal level, rather than a board for each school¹⁵.

Under this model, autonomous schools were free to solicit “voluntary” contributions from parents and to carry-out fundraising activities. The lack of resources was addressed and solutions that encouraged shared responsibility among various stakeholders linked to each school were explored. Among the positive outcomes were greater involvement and more responsibility on the part of the parents. Among the negative outcomes, was the excessive amount of time that teachers and parents had to devote to fundraising activities in order to improve economic conditions and secure staff incomes¹⁶. In addition, the voluntary contributions that were in fact a co-payment were later terminated, at least on paper, as they excluded the lower-income population. Another weakness of school autonomy was the absence of timely and adequate supervision, as well as effective mechanisms to verify the information and the reports provided by the centres. The high autonomy of the schools and their dependence on the transfers that they received from the central level, coupled with the economic and social constraints faced by the education sector led to some practices that had damaging results. For example, autonomous centres were known to alter records, reporting a higher enrolment than the factual in order to obtain more transfers¹⁷. As well, this autonomy had obvious implications for labour relations as the local level began to hire and fire teachers. Rather than being part of the national payroll, the teachers began to be hired by a commission composed of four parents and three teachers who had “full hiring and firing power¹⁸.” This new recruitment method led to tensions with the unions and the Sandinista opposition, whose support bases were precisely the union workers.

Table 4 shows the evolution of the coverage of childcare centres according to families’ income level and geographically according to the two regions (rural and urban). The distribution according to income levels has been fairly stable and uniform among the different income quintiles: in 1998, coverage was distributed to the five income groups fairly equally (ranging from 19 to 22% depending on the quintile), similar results were seen in 2005 (ranging between 18 and 23%). The coverage is distinct, however according to rural or urban regions: in urban areas coverage is better in the higher socioeconomic level: in the top quintile it rose to 24% in 1998, and 30% in 2005, while the bottom quintile was only 14% in 1998 and dropped even further to 12% in 2005. In contrast, in rural areas, the coverage reached 29% in the lowest income quintile in 1998 and stood at 27% in 2005, while in the higher income quintile it was 8%, both in 1998 and in 2005.

¹⁵ Humberto Belli, Idem.

¹⁶ Elizabeth Espinosa was General Director of Security and Evaluation of the Social Sector in the Secretary of Social Action in the Alemán Administration; in the Bolaños administration she was an expert on social protection in the Technical Secretary of the Presidency. Interview April 2008.

¹⁷ Elizabeth Espinosa, Idem.

¹⁸ Elizabeth Espinosa, Idem.

**Table 3.4. Coverage of care centres among children below 6 years of age by type of centres and year.
(Absolute numbers and percentage)**

	Relative importance of each type of centre				
	Total	Pre-school	Infant care	School	Does not attend
1998	787 374	128 205	6926	16 723	635 521
	100	16	1	2	81
2001	765 601	150 016	7 075	116 340	630 456
	100	19	1	15	82
2005	622 244	144 831	5 038	64 246	533 758
	100	18	1	10	86

Source: Own elaboration based on household surveys (ENHNV 1993, 1998, 2001 y 2005).

Between 1985 and 2005, the relative importance of private enrolment in primary education increased only slightly (from 13 to 15%), and slightly more in secondary education (from 20 to 26%) (World Bank 2008). Unfortunately, the data does not allow for distinction between public and private centres. For example, under "preschool education", the survey combines both types of services, public and private¹⁹. We do know however, that private provision, is scant, predominantly urban, and predominantly in the higher socioeconomic quintiles.

During the period under study, gaps between urban and rural educational coverage were reduced for age groups over 6 years old, particularly in Managua. The Poverty Map, which was used for resource allocation, allowed for the extension and improvement of school infrastructure in rural areas. However the results were limited overall as the expansion in coverage was not accompanied by improvements in quality. The level of knowledge of the teachers combined with the high student-teacher ratio resulted in poor quality education. These weaknesses in the educational system, combined with the prevailing poverty, the low value attributed to education by the homes, and a lack of financial resources – much of which was destined for the payment of wages -, resulted in serious limitations for effective implementation of educational policies.

Below, we will describe both preschool education and childcare centre programmes, outlining the distinct paths taken by the two different forms of services.

2.1.1 Preschool Education

During the 1980s the "National Action Plan of the Main Project for Primary Education in 1983-1986", was established by the government, whose paradigm was to promote changes in order to "form the personality of the New Man". The plan stressed that education should develop intellectual, physical, moral, and spiritual characteristics of individuals (Ministry of Education 1982)²⁰. As part of this plan, preschool education for children between 0 and 6

¹⁹ In the four surveys, public centres under the Ministry of Education, were included. In 1993, private centres, the subsidized centres, and the CDIs pertaining to the National Institute of Social Security, were included. In 1998, private centres, centres that pertain to work sites, community centres, and other types of centres were added. In 2001 and 2005, centres pertaining to the Ministry of Family, subsidized private centres (by the Ministry of Education), private non-subsidized centres, centres that pertain to work sites, community centres and other types of centres were also included.

²⁰ Characteristics of the "new man" were: *in the political*, patriotic, revolutionary, solidarity with the interests of workers and *campesinos* and the broad masses of workers, in addition to anti-imperialist, internationalist and against all forms of exploitation; *in the social and moral*, the development of responsible, disciplined, creative,

years was ardently promoted: the number of preschool children increased from 32,706 in 1980 to 81,560 in 1988. To maximize coverage, diverse, flexible methods were implemented according to the distinct educators and communities. A common trait of the methods however, was to unite parents and community actors. Although under a different ideology, this alliance between families and communities, continued during the 1990s.

Also during the 1980s, the expansion of preschools benefited from the social and community organization that remained after the National Literacy Crusade of 1980. The crusade was organized under the *Non-School Preschool Education Centers (CEPNE)* programme, using locally available educators with a low level of schooling and with minimum coordination and intersectoral participation requirements. At the onset, the Van Leer Foundation also participated, who in addition to technical advice, supported in the improvement of infrastructure, with donations of items such as furniture and food. The centres did not receive monetary transfers and the services operated with immeasurable volunteer work from parents. The Ministry of Education's sole contribution was to provide technical assistance and training to the preschool promoters²¹. The education provided was built and developed from knowledge and practices that were largely gained during the process.

Despite improvements in educational outcomes under the FSLN, at the time that Barrios was elected into office only 19% of students satisfactorily completed primary school with a 19% yearly drop-out rate, while the secondary school enrolment rate was only 25% of the eligible population with a 15% yearly drop-out rate (Government of Nicaragua 1996 in Gershberg 1999). During the 1990s, major developments took place for children, particularly in terms of legal and public policy formulation. To a large extent, these changes took place within the context of the international paradigm shift on children: which occurred in order to protect children and establish them as individuals with rights (United Nations 1990)²². The recognition of rights, however, conflicted with the macro economic stability and subsidiarity of social policy which prevailed at the time.

During the 1990s preschool education increased and diversified its coverage with the involvement of new actors: civil society organizations became involved along with parents and communities. In terms of the care model itself, the basic content and flexible implementation – with the family and community involved in providing education – were defined²³. Clearly, the force behind families and communities was, and continues to be, mainly women and mothers.

In organizational terms, in 1994 the communal movement was put in charge of the *community preschools*, while those who functioned in school centres were converted into the *formal preschools*. The fundamental difference between the two types of preschools is that the former is physically attached to a school. Their teachers usually have formal accreditation (usually teachers who graduated in primary education) and they receive a salary and benefits from the Ministry of Education. The community preschools, however, operate in classrooms

cooperative, hardworking and efficient, individuals with high moral, civic, and spiritual principles (Ministry of Education 1983).

²¹ Juan José Morales, *idem*.

²² New judicial and policy instruments were ratified at the Convention on Children's and Adolescents' Rights (1990); the adoption of the Children's and Adolescents' Code (Act 287 of 1998); the regulation of the National Committee for the Comprehensive Care and Protection for Children and Adolescents (Act 351 of 2000) and the adoption of the Policy on Integral Care for Children and Adolescents (1998).

²³ Juan José Morales, was the National Preschool Education Director from the second half of the 1990s until March 2008. Interview April 24, 2008

attached to primary schools, community halls (for example, in lunchrooms) or in private homes. In this case educators are chosen by the community and work as "volunteers". They have less training: they have a minimum of a sixth grade primary education plus eleven months of preschool training. In exchange for their work, they receive "acknowledgments" or "bonuses" that in addition to not being recognized as a salary, are usually lower than minimum wage. Both are funded by the national budget (although this can also be informally supplemented by international funding bodies) and are evaluated by the Ministry of Education – although the follow-up is infrequent and ineffective²⁴.

Additionally, there is a *roaming* form of preschool education that attends to the scattered rural population. The formal or communal educator visits homes - or groups of homes in the case of villages - to educate preschoolers and to train parents on issues of caring for their preschool-age children. In addition, a third alternative, *of civil society* care, emerged. In this case, mothers are trained to be educators in their own homes, caring for and providing basic healthcare to their children and other mothers.

Community preschools were created where there was a lack of formal preschools. Evidence that the more qualified teachers in formal preschools automatically accounts for better care, has not been found.

In 1995 the government resumed support of formal preschools through the project *Learn*. This project was financed by a loan from the World Bank, and included technical assistance, educational materials, and financial support to educators in formal and community preschools²⁵. Even though the institutional platform for preschools was established and had been defined to support children in the third level of preschool (5 to 6 years old) the World Bank loan stipulated that each educator would attend to between 15 and 25 children. It was difficult to meet this requirement in rural communities (in particular, the more dispersed ones, which are also the most impoverished) either because there was not enough children in that age range, or because parents were not accustomed to sending their children to preschool. In order to meet the minimum requirement of 15 children per teacher, the age range was amplified to between 3 and 6 years old and better use of preschool education was promoted to the adult population. In order to send their younger children to preschool, parents wanted facilities closer to home, which resulted in a decrease in the ratio of children to educators to 8 to 1. In order to encourage attendance, activities aimed at parents on childrearing, hygiene, vaccinations, disease and even prenatal and postnatal period, were offered²⁶.

In 1996, two distinct curriculums were developed: one for public schools with qualified educators and one for the non-formal programme with less qualified educators. These arrangements permitted an improved coverage and quality, always with active parental and community involvement. "In terms of curricular changes... the development of a Multilevel Guide for providing orientation and appropriate methodologies for the volunteer educators and the community, began. The process of drafting the guide was a very significant achievement, both in its theoretical methodological foundations, and in the level of commitment and involvement from civil society organizations and international organizations in the process "(Ministry of Family-Ministry of Education s/f:60).

²⁴ This same weak supervision, is seen in the private sector. Although legally, there are established Ministry of Education requirements, in practice, an effective and demanding supervision, is lacking.

²⁵ Juan José Morales, *idem*.

²⁶ Juan José Morales, *idem*.

In 1998, with the creation of the Programme of Comprehensive Care for Nicaraguan Children (PAININ) of the Nicaraguan Fund for Children and Families (FONIF, later the Ministry of Family), which is outlined in the following section, redundancies in preschool care began to emerge due to the fact that PAININ operated on the same structure of existing community preschoolers. In order to cope with these redundancies - and given that the project Learn was ending and there were no funds to hire community educators - PAININ assumed responsibility of educator recruitment for the community preschools, while the Ministry of Education was responsible for recruitment of educators for the formal preschools. As PAININ offered better wages in the community preschools than the Ministry of Education did in the formal ones - U.S. \$ 40 and \$ 15 per month, respectively - the majority of teachers wanted to work in the community preschools.²⁷ The reason for this disparity in salary is simple: PAININ received external funding (through resources from the IDB) while the formal preschools were financed with resources from the national budget. It should be noted as well, that in neither case, were educators formally recognized as State workers. In both cases, therefore, educators were subject to rash hiring and firing decisions and lacked job security.

The importance and relevance of preschool education has advanced significantly in terms of its legal and political backing, in its design and in its improvements of coverage and quality. However, since the expansion of coverage has depended on external resources, initiatives have been strongly influenced by negotiations and agreements with international cooperation, whose priorities do not always coincide with existing programmes at the Ministry of Education.

This inconsistency in implementation and initiatives could explain why, despite higher coverage for preschools, perceptions and comments regarding CDIs are more positive, which will be explained in further detail below. It could also be that the preschools are not directly associated with childcare given that in no case, do they offer services beyond the daily school schedule.

2.1.1 Childcare Services

In the early 1980s, care services, the *Children's Development Centres (Centros de Desarrollo Infantil, or CDI)* were created as part of the social security system, rather than under social assistance. Although there were financial reasons to do so, the goal was that the working (paid) population could have their children cared for (Largaespada-Fredersdorff, 2006b). In addition to caring for children, this allowed mothers to participate more widely in the labour market. The CDIs offered care, food and early childhood stimulation for children, from ages measured in days through to preschool age. The rural equivalents of the CDIs were termed Rural Children's Circles (Circuitos Infantiles Rurales, or CIRs). In the early 1980s, the system served as many as 37,000 children. The CDIs charged a nominal monthly fee, based on income as reported to the social security system.

Ten years later, along with a change in the conception of government's responsibilities for risk management, child and adolescent care was separated from social security. This change was reflected in 1993 in the division, into two separate institutions, of the institution responsible for social security (the Instituto de Bienestar y Seguridad Social, or INSSBI): the Social Security Institute (INSS) and the Nicaraguan Fund for Children and Youth (Fondo Nicaragüense de la Niñez y la Familia, or FONIF). The former focused on insured persons under the contributions scheme, the second, through targeting criteria, on the poor and

²⁷ Juan José Morales, *idem*.

vulnerable population, which also dealt with complaints concerning child support – complaints that occur in families of all economic strata.

Although there is no documentation of the evolution of the CDIs and CIRs, it is clear that although they did not disappear with the change of government in 1990, their number declined. According to data from the Ministry of the Family, there were 30 CDIs serving 3,774 children in 2005 (Largaespada-Fredersdorff, 2006b). A study conducted in 2003 showed that each school was serving only 123 students even though their capacity was for 191 children. This is a 36% underutilization of resources, resources serving a mere 1% of all children under the age of 6 even though the demand for care appears to be so much greater than the supply (Largaestada-Fredersdorff 2006b). Currently, the CDIs care for children from 45 days old to 6 years, from 6 am to 6 pm during the school year. They offer two different forms of early childhood stimulation (since 2004) and preschool education, (see above in section on preschool programmes). They also provide lunch and two snacks (morning and afternoon). Those attending are generally children whose families live in extreme poverty or are affected by unemployment, those whose parents are labourers or domestic workers, or children who have been abandoned or are at risk. Thus, the programme shifted from being a programme for the working population to targeting poverty and social vulnerability. At the same time, although it receives government funding (transfers from the national lottery), parents make a contribution in most cases.

The **Daycare Centres** were created in 1993, initially under the social security agency (INSSBI), and then under FONIF. They served children from 1 to 6 years of age, and offered early childhood stimulation, preschool education, and food prepared by women volunteers from the community.²⁸ The programme also provided for supplementary education and healthcare activities. In 1994, nearly 90,000 children were reportedly being served – over double the number served by the CDIs, and a comparable number to those that the Programme for Comprehensive Care of Nicaraguan Children (Programa de Atención Integral a la Niñez Nicaragüense or PAININ, see below) reached at its peak in 2004. The programme has three care modalities, one for nursing-age infants (45 days to 1 year of age), one for young children (1 to 3 years of age) and one for preschoolers (ages 4 to 5) (Largaespada - Fredersdorff, 2006b). Although mechanisms to select beneficiaries were not established initially, the high demand for service led to the following criterion for participation in the programme, namely that the child: have parents with monthly incomes below a specific minimum income; be an orphan (at least one parent deceased); have siblings who are dependent on other centres for their nutrition; or be suffering from serious malnutrition.

In 1998, two events shifted the State's approach to childcare issues. First, the Code of Children's Rights and Obligations was approved (National Assembly, 1997). This defined children as full rights holders, and established the obligations of the State, the family and the community towards them. Second, FONIF became the Ministry of the Family (MIFAMILIA). The latter change initially gave the unit's work a moralistic and assistance based impression, rather than one oriented to the social protection of the vulnerable population. According to Max Padilla, one of the first to hold the post of Minister in the new ministry, *"We hope that one of the things that will be done here, one of the law's mandates, is to try to promote the legalisation of unions, coincident with giving greater importance to the nucleus of the family, the husband and wife, both basic elements in the education of the children"* (Ramírez González, no date).

²⁸ The ration contained 960 calories (90 grams of rice, 70 grams of corn, 15 grams of powdered milk, 15 grams of vegetable oil, 10 grams of sugar and 50 grams of beans).

Meanwhile, based on the fact that women have historically assumed responsibility for childcare, the ministry gave priority to promoting paternal responsibility. Thus, one of the first heads of the Ministry of the Family stated, *“Here it is not the father or mother exclusively, but the family as a husband-wife pair, that we attempt to advance, with the man taking full responsibility for his fatherhood. [...] The problems of women are also part of the Ministry of the Family; one of the principal issues here is the first point in the law, which is to inculcate values in the home, to try to tell couples, tell men, that they must respect women, that they should get along together, etc., that children be taught that they mustn’t steal or do bad things”* (Ramírez González, no date)

In 2000, under the ERCERP, the ***Programme for Comprehensive Care of Nicaraguan Children (PAININ)*** was launched to look after children under 6 years of age living in poverty in rural, and marginal urban, areas. The programme has two modes of operation: one functioning in Community Children’s Centres (Centros Infantiles Comunitarios, or CICOs), where staff provide childcare, and the other in “Base Homes” (Casas Bases, or CBs), where travelling staff and volunteer mothers provide care for children and their families (PAININ 2001). Funding came from the Interamerican Development Bank²⁹, and the programme has been executed through inter-institutional coordination, by the Ministry of the Family, the Ministry of Health and the Ministry of Education. The Municipal Commissions on Children and Adolescents (Comisiones Municipales de la Niñez y la Adolescencia, or CMNAs) were the local entities that promoted and coordinated at the municipal and community level, while at the same time functioning as the society’s monitoring agent for the projects: handling allocation of programme resources in a transparent fashion and assessing the extent to which results and performance are consistent with the goals established.

The programme has gone through various stages. Although it is not reflected in an improvement of national statistics on coverage, during this period the programme served 53,144 children; between 2002 and 2005 the figure rose to nearly 100,000 children. In the priority areas of the country (67 municipalities) this represented service to approximately 30% of children living in vulnerable conditions, defined in terms of exposure to malnutrition and inadequate schooling due to lack of preschool services. PAININ’s assessments have shown positive results in terms of living conditions, childhood development (especially for those under 3 years of age), children’s growth, and childrearing practices with regard to healthcare and disease prevention and treatment.

Most importantly, evaluations document the role of families and communities: support networks have been key in terms of infrastructure,³⁰ food, and community and volunteer work. *“The importance of the support networks is that these local contributions to the projects reflect the community’s commitment, and show that the community is sharing the social responsibility which, as we have indicated, involves providing care for its children, by improving the conditions under which the CICOs deliver their services”* (PAININ, 2001). This rhetoric regarding participation is undoubtedly very positive for the CICOs and the State, given the enormous amount of unpaid work contributed (particularly by women) and the resultant decrease in monetary costs of the programme. For example, it explains the lower costs of PAININ between 1998 and 2001 than for similar programmes conducted in South America³¹. It is more questionable whether this volunteer support is appropriate for women

²⁹ 25 million dollars from an IDB loan and almost 3 million from the Nicaraguan government was collected for a total of \$27.78 million dollars.

³⁰ This includes the construction of fountains, wells, latrines, remodelling of buildings, provision of land, and contributions of construction labour and materials.

³¹ The average total cost per child was estimated at U.S. \$76.33; 60.4% of which were direct costs

and families who are already facing multiple demands, both for wage earning and for volunteer work in other State social programmes.

This demand for volunteer work of parents is ongoing and is even formalized in public policy plans. For example, the National Education Plan 2001-2015 formulated during the Alemán administration states from the onset, the "right and duty of mothers and fathers, institutions, organizations and other members of Civil Society to actively participate in the planning, management and evaluation of the educational process ... "(Ministry of Education 2001: 23). Given the scenario of low public accountability in the field of social investment in general and of care in particular, this line of public policy guiding Nicaraguan government should be seen more as an exacerbation of familialism and the feminization of the care and welfare systems in Nicaragua than as an effective realization of citizen participation.

This same cost analysis showed significant variations within the country itself, largely dependant on the non-governmental organizations that acted as "supporting service companies". At one extreme the cost per child was U.S. \$44.2 as compared to U.S. \$115.15 at the other extreme. In addition to the distance and the number of projects, these variations reflect inefficiencies among the organizations executing the programme, as well as inadequate controls and criteria in the allocation of resources by the government itself. Given the important role that non-governmental organizations play in implementing various social programmes in Nicaragua, the need to intensify the performance criteria of such organizations, is clear.

In 2006 non-governmental organizations cared for 4,437 children. If organizations classified as comprehensive care organizations are included, the number rises to 6,000 children, one third of the number covered under the governmental social programmes (excluding PAININ). This is not a very extensive coverage, particularly if we consider that these organizations mobilized approximately U.S. \$3.37 million, a figure very close to that implemented by the government for childcare programmes, again, excluding PAININ (Largaespada - Fredersdoff 2006b).

Beyond the rhetoric – at least, until 2003, when the Social Safety Net was created – efforts within this framework consisted essentially of specific actions targeting children and adolescents at risk. The interventions occurred in a highly fragmented and dispersed manner. Since the statistics and systematisation of information regarding the interventions are disaggregated and unreliable (similar to the interventions themselves), it is impossible to ascertain the scope of these activities under the different governments. However, the health and education sectors laboured under serious budgetary constraints, and in this respect the new ministry suffered even greater limitations.

2.1.2 School food programmes

As part of their survival strategy, vulnerable, low income families, often reduce food consumption resulting in risk of malnutrition. When food is provided by the school or care centre, part of the family's basic need - for at least part of each day - has been provided. Studies carried out by the World Food Program, show that in combination with the education offered, school food programmes have increased school enrolment and decreased dropouts (Chacon, 2005).

The ***Community Kitchens for Children*** were created during the 1980s in the communities with the highest indices of poverty, in order to reduce the risk of malnutrition among children, and to prevent further harm to those already affected. With the change of government in 1990, the Community Kitchens for Children were shifted to FONIF, and then to the Ministry of the Family. Since they depended entirely on food donations from the World Food Programme (WFP), and as a result of policy changes in that organisation (see section 2.1 of this chapter), the Community Kitchens for Children tailored their preschool education to incorporate components that would meet the organisation's eligibility requirements for receiving food donations. These facilities ultimately ceased operations because of a lack of sufficient food.

In 1992 the ***School Glass of Milk Programme*** began. It was initially executed by the Ministry of Education and the Ministry of the Presidency, which in the early 1990s coordinated activities and programmes targeting vulnerable groups. The goal was to improve diet, reduce school dropout rates and support academic learning in the first four grades. The programme provides one glass of reconstituted milk with 250 ml of vitamins A and D, providing 10 grams of protein and 118 calories. The target population was children attending State and community schools. Parents – in practice, mothers, who work two hours a day, 160 days a year, in coordination with school administrations – were responsible for preparation and serving. The programme was discontinued in the late 1990s, but resumed in 2003, subject to the availability of donated milk.

The ***School Biscuits Programme*** was implemented by the Ministry of Education and supported by the National Autonomous University of Nicaragua and the Pan American Health Organisation (PAHO), this programme began in 1994. Its objective was to increase attendance among 90% of the enrolled students, increase the grade progression rate to 75% of enrolled students, and improve the diet of the target population. The focus was on preschoolers and first to fourth grade students in the departments of León, Chinandega, Estelí, Madriz and Nueva Segovia, which were selected because of their high incidence of poverty and high rates of dropout and malnutrition (as reflected in subnormal height), as well as because the areas were accessible and not hindered by armed conflict or disorder. Between this programme and the Glass of Milk programme, each child received 53% of the daily protein requirement and 15% of the daily calorie requirement. Starting in 1994, some 112,500 children were beneficiaries of this programme.

After 1995, lunchroom construction was financed by loans channelled through the Social Investment Fund (FISE). However, just five years after construction, evidence of operational sustainability of the lunchrooms, was demanded. This demonstrates that problems are not only attributable to a lack of resources but also to the operational dynamics of the State, largely associated with the various sources of funding for social policy, also seen in the weakness of national planning and its inability to channel external resources in a more orderly fashion. An agreement between the Ministry of Education (responsible for food programmes) and the Ministry of the Family (responsible for the Community Kitchens for Children) made efforts to resolve the problem of disperse programming, the agreement, however, only lasted between 2002 and 2004. Through this agreement it was established that all community preschools would have food, and that all child lunchrooms would have preschool education. Unfortunately, there is a lack of data on what proportion of preschoolers benefited from this initiative. We do know however, that it had an unintended effect: parents chose to withdraw their children from formal preschoolers and enrol them in community preschools where they received food.

The *Comprehensive School Nutrition Programme (Programa Integral de Nutrición Escolar, or PINE)* began in the late 1990s in order to provide snacks to children attending the preschool education programme (ages 3 to 6) and some primary schools (ages 6 to 12), particularly in rural areas.³² Its objective was to provide supplementary food to children living in poverty and in conditions of food insecurity. Similar to the other programmes, it relies on community participation. The programme operates throughout the country in areas selected on the basis of the vulnerability of their inhabitants, as reflected by the Poverty Map. In its first year, PINE covered 137 municipalities in 16 departments in the country, serving more than 800 thousand children: 95 percent of the children enrolled in preschools, formal preschools, and primary education in the 137 municipalities (Nuevo Diario, 2005). This programme has gone through several stages, the last of which was launched in 2002, supported by donations from WFP. Since then, WFP policies have established that food deliveries would be made exclusively to schools. The agreement between the Ministry of Education (responsible for the administration of nutrition programmes) and the Ministry of the Family (in charge of the lunchrooms), gave an education component to the lunchrooms, which would allow them to continue with the support of WFP.

2.2 Health services

Health services in Nicaragua are characterised by a high degree of stratification between private sector care, public services, services provided by social security, and community services.³³ In theory, private sector care is mainly financed "out-of-pocket", public services through the national budget, social security services through contributions, and community services through a combination of external resources and volunteer work. However, in practice, these distinctions are not so clear: families pay out-of-pocket for half of what they spend each year on health care (Rodríguez 2005), and co-payments (whether as doctors' fees or for the purchase of medicines or laboratory exams), are common when accessing health services, even for public and social security services. In a country where 7 out of every 10 people live under the poverty line, 94% of all private spending comes from household budgets (and only 6% from insurance or institutional purchases) (Sanigest 2004).

Under *Social Security*, those who contribute have access to private services contracted by the Nicaraguan Social Security Institute (INSS). Social Security is only mandatory for the salaried population who reside in areas with INSS health services³⁴. For the self-employed population, insurance is optional and provides limited coverage. For domestic service workers, officially, insurance is mandatory however in reality compliance is low. Pensioned individuals have access to very limited services and only when their pension is for old-age. Economically dependent family members also have severe limitations on access to services: wives only during pregnancy, childbirth and postnatal care and, since 2004, sons and daughters have medical services up to 12 years of age (Mesa-Lago, 2008).

During the 1980s the Sandinista government had tried to unify the delivery and financing of health services in order to provide equal access to all people. Thus, contributions that were made by the insured population to INSS were transferred to the Ministry of Health, and the

³² It also supports the travelling component of the PAININ programme (for children up to age 6).

³³ There is no information on those covered by private insurers and HMOs, though these represent a small proportion of the total (Rodríguez, 2005).

³⁴ A bill has been pending approval since mid-2005, which would return mandatory coverage of independent workers, domestic workers, agricultural workers and transporters (Mesa-Lago, 2008).

same was done with the entire hospital network. The population that was insured under INSS lost their rights, and for medical attention they had to resort to a health centre or a public hospital as any uninsured person (or hire private services). This resulted in the virtual disappearance of INSS as the insurer and health provider, and it only maintained its role as a collection agency (Espinoza, 2003).

Since 1993, differentiation in services and financing, between public health and social security, was restored. Health reform returned the control of contribution resources to INSS, as well as the obligation to provide differentiated health services to its policyholders. As there was no longer a network of services or the financial ability to replenish one, the strategy was to buy health care services from private and public providers called Provisional Medical Companies (EMP)³⁵. The public providers are MINSA, the Army, and the Ministry of the Interior. 20% of the existing EMPs in the country belong to MINSA (Rodriguez, 2005). These companies are responsible for providing health services to the directly insured population, that includes attending to approximately 800 illnesses, as well as for general medical care to children less than 6 years and in obstetrics care to the wives of insured. It does not include the care of acute illnesses for which treatment is very expensive, such as cardiovascular disease. The number of people assigned to these enterprises rose from 92,000 in 1995 to almost 300,000 in 2004, representing a significant improvement in the coverage of insured by the INSS³⁶.

The Ministry of Health is the main entity providing *Public Health* services, although others, such as the Ministry of the Interior, are also involved. Formally, the Constitution (Article 58), the Sanitary Code, and others, define the right to health as a right of all people³⁷. It is estimated that approximately 70% of the population depends on these services but, at least one third of Nicaraguans, who generally have less income, are unprotected (Mesa-Lago 2005).

During the 1980s there were significant efforts in the field of primary care. For example, vaccination of children rose dramatically, from 47% in 1987 to 82% in 1990 and subsequently continued to increase gradually to 99% in 2006 (World Bank 2007). As well, the population with sustainable access to potable water and sanitation increased from 75% in 1995 to 79% in 2000. Meanwhile, the supply of curative services has not been given the same priority. For example, the proportion of hospital beds per 1,000 inhabitants declined and then remained stable, dropping from 1.2 in 1990 to 1.1 in 1995, and remaining at 1 since 2000.

In 1985, MINSA organised the Local Health Systems (SILOS), later known as the Comprehensive Healthcare System (SILAIS). These were territorial units that operated without clear regulations, in place of the previous health divisions. The SILOS were a community system composed of networks of *brigadistas*, midwives and others – all

³⁵ The EMPs receive a per capita payment that in mid-2005 was U.S. \$ 12.7 and that is allocated based on the number of policyholders who have chosen that particular EMP. The INSS pays for training, with no co-payment or limit on the number of times the insured can use the EMP. The EMP cannot target services but is obligated to provide the entire service package to the user. If an EMP does not have a particular service that is required by INSS, they must subcontract it. In the event of an employee being incapacitated, the EMP should pay a cash subsidy for illness.

³⁶ This achievement is even more important when we consider that during this period there was an increase in labour informality. Similar outcomes were seen in 13 of the 18 Latin American countries, demonstrating how management model changes affected the countries.

³⁷ Legally, states that "all citizens or residents of Nicaragua will have access to health services that are socially acceptable and compatible with the economic and social development of the country; with the aim of improving the health of the population and preventing disease and death "(MINSA 1991).

volunteers – that since 1985 operated in their communities, principally in health promotion and disease prevention in their respective communities. Thus, community health services are a legacy of the years of the revolution. Even today, they are composed of networks of *brigadistas*, midwives and other volunteers, who continue to work for the health of their communities, mainly through health promotion and disease prevention³⁸. The incentive for these groups of workers was social recognition by the community, although the volunteers gradually became “institutional *brigadistas*” with a stipend from non-governmental, generally foreign-based, organisations.

Also at this time, the Maternal Houses, which still exist today, were created. These are houses where pregnant – predominantly rural – women go to stay approximately two weeks before their due date, in order to wait for delivery of their baby. These houses help to reduce the high rates of maternal mortality. For example, there is currently one in Esteli, where we went to carry-out the qualitative work for this study (see below). It is located in Las Segovias, in the Department of Esteli, where there is a high rate of maternal mortality due to inadequate health institutions.

In 1990, at the time of the transitions from the Sandinista administration to the Violeta Barrio government, the MINSA was the main provider of health services. The MINSA served 85 out of every 100 consultations, the Ministries of Defence and the Interior served 4.5 (such as the military, police, fire-fighters, and immigration officials), social insurance served 6 and the private sector the remaining 4.5. Individuals, who did not utilize any of these institutions, used informal consultations and/or self-medication. With the exception of some remote areas, the MINSA’s coverage for health services was considered adequate, with better accessibility in urban than rural regions (MINSA 2000). Although the high coverage was accompanied by growing problems in the quality of services due to the serious financial constraints. Spending had increased from 1.6% of GDP during the 1970s, to 4.5% at the beginning of 1990; it then oscillated between 4.2% and 3.8% for the remainder of the decade.

Unlike what occurred in education and social security, changes in the government administration did not involve discontinuities in policy³⁹. Since 1991, greater decentralization of services and a shift toward preventive and primary care have been promoted. The MINSA has decentralized authority and resources, and further increased social participation for solving health problems. In its role as an intermediary between the central level establishments and health care providers, SILAIS’ function of heading health posts and centres was increased to also include the clinics and hospitals in their respective departments (Rodriguez 2005). Under SILAIS, primary care, disease prevention and health promotion, and – to a considerably lesser degree – disease attention, were emphasized. Although in principle this seemed like a good idea, in Nicaragua it posed serious problems for accessing curative care. A comprehensive view of health should not separate primary care, but on the contrary, it should strengthen the channels for moving people from one level of care to another (from primary to secondary and tertiary, which are usually handled by clinics and hospitals, respectively). In Nicaragua, this situation can easily be attributed to the sheer inadequacy of resources. However, it also reflects an ideological vision, a secondary and minimalist vision of the social policy, one that the middle-high classes would never accept for themselves, but have enthusiastically promoted for the poor. Far from the inadequacy of resources as a “given”, this ideological orientation is one factor that helps explain the situation.

³⁸ Jesús María Largaespada-Fredersdorff currently Expert on Health of the Netherlands Embassy and former National Director of Care for Children (until 1991) in the MINSA. Interview, 20 March 2008.

³⁹ For example, only staff members of confidence left the institution and people in technical positions continued.

Decentralisation was undertaken as part of a real transfer of political and decision-making power from the central to the local level, not only via legal and administrative provisions, but also in the form of funds. However, the limited budgetary resources available, and budget cuts during the 1990s – when per capita spending fell from an already low US\$ 23 in 1990 to US\$ 18 in 1996 (CEPALSTAT, 2007) – prevented this process from being successful. A decrease in public health spending was one of the requirements of the agreements with multi-lateral institutions. “Despite a nominal increase in funding for health spending, economic policy since the 1990s, under the different governments, has been oriented to reducing social spending, with 15% of social spending earmarked for health, although the trend in real terms is a declining one” (LAC HSR, 1999). Further aggravating the situation was the fact that during this period external cooperation funds decreased, external loans assumed a greater share of the total, and households took on additional burdens.

While decentralization was the main policy of the Barrios administration, during the Alemán administration, it was sector reform. This was carried out through external loans (in particular from the IDB and the World Bank), and was based on the need to adapt health services to the new social conditions, demographic changes, epidemiological problems, and the growing demand for services. It also identified the need to revise and update laws and regulations (OPS 2002)⁴⁰. In terms of services, a basic package that included reproductive women’s health and the detection and treatment of gynaecological cancers, was established. Given the precariousness of funding during the period, diversification through greater involvement of external actors was sought. In reality however, the relative weight of external participation was reduced (Ministry of Health 1997) while private, out-of-pocket spending increased.

In 2004, the 2004-2015 National Health Plan established the basic priorities that govern current policy, including increased coverage, decentralisation and the definition of target populations. Women, children and adolescents were now targeted through family planning, prenatal and post-partum medical checkups, monitoring of growth and development, immunisation, comprehensive care for childhood diseases, and sexual and reproductive health. Priority was also placed on serving various ethnic groups (indigenous peoples and communities of African descent) affected by geographical, cultural and economic barriers, as well as by marginalisation and lack of information.⁴¹

National health plans of the period included women (as mothers and as a part of the mother-child unit), children (especially under the age of 5), disabled persons, workers, and demobilised and repatriated individuals. Interventions targeting women include immunisation for pregnant women, promotion of nursing, nutritional monitoring, prenatal care for early detection of pregnancy and identification of high-risk pregnancies, and early detection of cervical-uterine and breast cancer (Ministry of Health, 1991). These programmes, which began in the 1990s, remained in place well into the new century. In addition, in 1995 MINSA implemented a domestic violence treatment model emphasising gender violence, and in 1996 a maternal mortality monitoring system (Ministry of Health, 2000). Anti-violence measures

⁴⁰ Such as, the laws of the Health General, the Unified Health System, the Organization of Social Security and of Medicines and Pharmacies; as well as regulations of food, pesticides, toxic and hazardous substances, radiation, and Professional Practice and the Law of the Sanitary Administrative Career (PAHO, 2002).

⁴¹ Providing accessible services for these communities poses serious difficulties for providers and, even more so, for users. Service is provided principally by social service personnel who have not been trained to work in these areas, and most of them are men who do not speak the languages of the Atlantic communities. This creates distrust in the user population, especially among women, who thus end up being doubly excluded.

were in place and functioning, and received ongoing support from PAHO's Gender, Health and Development Unit (Márquez, Rodríguez and Kageyama, 2005). The following year (1997) saw the first draft of the National Sexual and Reproductive Health Programme, which was published in 2002 and which led to the National Sexual and Reproductive Health Strategy, officially adopted in late 2006.

MINSa established its Comprehensive Healthcare Model, which includes the Sexual and Reproductive Health Strategy of the Nicaraguan Government. The National Health Plan incorporates gender equity as a horizontal issue. Chapter IV of that document, which is devoted to the functioning of the health sector, and to its reform, proposes a sexual and reproductive health programme with a gender focus, one that recognises the importance of countering the advance of HIV/AIDS, places high priority on reducing maternal mortality and preventing cervical-uterine cancer, emphasises prevention of gender-based violence, and stresses access to family planning services and measures aimed at preventing teenage pregnancy (Sevilla, 2005)⁴². International agencies such as the Population Fund of the United Nations and the Pan American Health Organization, took leading roles regarding sexual and reproductive health. Government cooperation agencies of the United States, Canada, the Netherlands and Norway, also provided technical cooperation and financial resources for the implementation of the programme.

In addition to the incorporation of a gender focus for the health plan itself, this approach was incorporated into a national programme for the prevention and treatment of gender violence, a result of the National Plan for the Prevention of Domestic and Sexual Violence (2001 -2006). Both were the product of the collaboration of a wide range of institutions and social actors, among them women's organizations.

However, despite significant advances in MINSa's role, its actions were hindered by the gap between planning and available resources. The work that was carried out was guided more by short-term initiatives aimed at mitigating the effects of epidemics and natural disasters than by the approved policies. As well, the absence of a single nationwide health care management model resulted in the use of a range of healthcare models that were determined by projects and programmes financed and managed by the international community, both through donations and loans, (both donations and loans have been declining in relative importance)⁴³. The result is an institution characterized by differing attention models, models that at times, conflict with each other and with the National Health Policy and Institutional Plans of MINSa.

Doctors, nurses, hospital directors, SILAIS, and even donors concur that the quality of health services in the public sector has deteriorated, largely due to serious deficiencies in infrastructure and equipment in the majority of the sector (Sanigest 2004). Evaluations carried out since 1990, and during different administration periods, show that public services have two major weaknesses: first and most importantly, is the insufficient budgetary allocation; second is poor understanding and promotion of the various advocated care measures among the healthcare personnel. Although never officially put forward, privatization of public services has been suggested and there has been some degree of commercialization of access, such as payment for private services and co-payments in public services (for example, the

⁴² Permanent Representative of Nicaragua to the United Nations.

⁴³ In 2003 donations and loans were estimated at 10% of social spending in the sector (Rodríguez).

purchase of medicines that are depleted in the MINSA). This seriously affects access to services for the most vulnerable population⁴⁴.

Results of the healthcare services are ambiguous. On the one hand, infant mortality was decreased from 45 to 31 per thousand live births in the first half of the 1990s, where it remained until 2001 - the last year for which there is information (PAHO in the State of the Nation 2008). On the other hand, mortality of children under 5 has decreased steadily, reaching 30.4 in 1996 and declining further to 24.4 which was recorded in 2006 (PAHO State of the Nation 2008). In 2005 institutional deliveries were only 67% of births, among the lowest five in Latin American, and maternal mortality was 230 per 1000 births, just below Guatemala (UNDP 2006).

2.3 Conditional Monetary Transfers

Throughout the 1990s, and in the early 2000s, the experience of programmes targeting vulnerable groups pointed to the need for coordination. Such coordination was referred to in Nicaragua as “social protection”. This rubric included childcare, the notion being that, in addition to inter-institutional coordination, complementarities must be established between the responsibilities of families, communities and government. The idea was to link the social protection programmes and projects executed by different institutions. At the time, programmes termed “comprehensive” were in fact being carried out bilaterally. One obstacle to success was sectoral compartmentalisation (the “knot” documented in many of the region’s countries), though lack of continuity in the government’s programmes, and lack of funding (or the tendency to direct funding to specific programmes) also played a role.

It was in the framework of the social policy of the 2003 National Development Plan that the country first formulated a *National Social Protection Policy* (Government of Nicaragua, 2003). This was designed to articulate and complement actions under universal coverage policies, through interventions targeting the poorest and most vulnerable, with an emphasis on children and adolescents. It was defined as a sectoral policy under the Ministry of the Family, not as an axis of overall social policy, as was the case of the Social Agenda in 1993.⁴⁵ However, there are elements of continuity with respect to ERCERP’s Social Protection for Vulnerable Groups pillar. Even if only at the level of rhetoric, this policy represents a shift from emphasising social assistance to a focus on social protection in which the poor and vulnerable population – i.e., the majority of the population – must be part of socio-economic development, rather than being simply a target for social assistance. The general objective of the policy was “to contribute to the social inclusion of persons, households and communities in conditions of vulnerability, so that they can participate sustainably in the benefits of development”. This means moving away from dependence on assistance, to training and empowering those living in conditions of vulnerability and risk to become part of the social and economic system” (Government of Nicaragua, 2003).

Consistent with the view promoted by the World Bank, the social protection policy emphasizes social risk management, and involved conditional transfers. Designed from the standpoint of care, the social protection approach officially recognized the government’s responsibility in creating minimum conditions for poor children under 6 years-old for

⁴⁴ María Jesús Largaespada-Fredersdorff, idem.

⁴⁵ Elizabeth Espinosa. Interview of March 2008. Mrs. Espinosa was Director General of Monitoring and Evaluation of the Social Sector in the Secretariat of Social Action during the Alemán government, and an expert on Social Protection in the Technical Secretariat of the Presidency in the Bolaños government.

accessing education and health. This policy served as the “umbrella” for initiatives to address the crises and emergencies that constantly afflict the country. Such initiatives include the Crisis Response Programme and efforts towards a pilot form of the Solidarity for Development System, designed and executed since 2004 by the Ministry of the Family.⁴⁶ In the present study, we focus on the programme of conditional transfers, due to the importance they have been given in educational services to children, and the visibility these programmes have gained in Latin America as the “stars” of a new social policy (Molyneux, 2007).

Hand in hand with the conditional cash transfers approach that was promoted in the region by the World Bank, in 1999 the programme *Social Protection Network (RSP)*, was created. This programme provided monetary transfers to households in extreme poverty⁴⁷. The RSP was implemented over two government administrations, Alemán (1997-2002) and Bolaños (2002-2006). Similar to other countries in the region, transfers are conditional, in this case, on school attendance of children under 12 years old, and of health control of children under 3 years of age (growth monitoring, weight and development). Although direct care of children was not incorporated, the conditional transfers did advocate that families use social services for children, including education and health services. In addition, this programme collaborated with other existing programmes that targeted vulnerable groups in extreme poverty who also had psychosocial factors, such as boys and girls in situations of extreme violence and neglect. The aim of this “micro-targeting” (Molyneux 2008) was to break the intergenerational cycle of poverty.

The RPS was initially a pilot programme launched by the FISE. Interestingly, the liberal Alemán government initially opposed the program, arguing that handing out money was a “return to the past (Sandinista way) of giving away money, which encourages paternalism, populism, and the inactivity of the extremely poor” (Largaespada-Fredersdorff 2006a:331). International cooperation agencies, also doubted the political-partisan agenda of the programme, and had concerns about the implicated costs and the lack of design materials. In general, it was agreed that the country would be unable to meet the demands of the monetary transfers. Given the financial constraints, it was originally considered that the demand would tighten the supply, forcing the respective ministries to expand their services. It was also thought, that the acceptance of the Highly Indebted Poor Countries Initiative (HIPC) would result in an increase in public spending in education and health in order to attend to that demand. In reality, these events did not take place, in part because HIPC did not become involved until after the programme had started and also because the domestic debt consumed a significant portion of the resources that should have been directed to social spending. It was only in the second phase of the programme starting in 2002, that the ministries achieved some constructive support for providing their services. Finally, the programme was designed based on the experience of Progress/Opportunities in Mexico, who also offered technical and methodological support (Largaespada Fredersdorff 2006a).

The RPS was expected to increase the demand for health services, education and food by supporting the family income, and thereby strengthen the health and education services available to the population living in extreme poverty (chronic or recent). During the first phase (2000-2002), the benefits of the RPS consisted of user vouchers, under the categories of food security (“food security vouchers”), educational and school supplies, and provider vouchers for healthcare and educational services offered by private providers. In the second

⁴⁶ Elizabeth Espinosa, *idem*.

⁴⁷ The idea of direct transfers has existed since 1997, at the time, they were meant for poor farmers in order to capitalize on their assets (Largaespada- Fredersdorff 2006).

phase (2002-2006), the programme was expanded from 6 to 9 municipalities. The benefits remained essentially the same, but the health services were extended to women of reproductive age, in the form of a complete vaccination plan. As part of the provider voucher programme, a component involving occupational training and education for adults was added, while, as part of the user voucher programme, a productive empowerment voucher was added (for beneficiaries of the initial six municipalities only). The component designed for the adult population is worth noting, in that one of the principal characteristics of conditional transfer programmes is that they generally focus exclusively on children or young adults. During the first phase, 10,000 households in 6 municipalities, and during the second, over 20,000 in 9 municipalities, were served.

Beneficiaries were selected in stages. First, municipalities were selected according to poverty criteria, and on the basis of inadequate education and healthcare coverage. Communities were selected within these municipalities based on indices of extreme poverty, and based on the magnitude of the gap in available resources. Within these communities, specific households were chosen on the basis of household poverty and the programme's ability to provide service, as well as on a formal commitment, on the part of the women who were the official beneficiaries of the transfers, to participate in the healthcare plan.

In 2003, after the approval of ERCERP - one of whose four pillars was the social protection of vulnerable groups - the RPS was transferred to the Ministry of the Family in order to strengthen collaboration and unification among various social programmes. There was also a desire to redefine the vision into one that would unify the disperse and relatively autonomous initiatives in order to promote more comprehensive actions (Largaespada Fredersdorff-2006a). Overall, the RPS cost U.S. \$ 32.2 million, money that was obtained through loans from the Inter-American Development Bank.

In 2004, RPS was placed under a broader program, the System of Attention to Crisis (SAC) which, in addition to the components of the RPS, was grouped with other existing social protection programmes and included from the onset, an occupational training component and distribution of a productive training voucher in order to improve employability.

The RPS programme is likely one of the most extensively evaluated programmes in the history of the country, including through a quasi-experimental methodology. One of the most cited studies was funded by the World Bank and conducted by IFPRI and academics from various universities. In terms of gender relations, evaluators concur that the money is transferred to women. However evaluators do not agree on the conditioning component. What is being asked of whom? Clearly, the RPS perpetuated the traditional gender roles, through which women carry out "care" activities and men do not (Fredersdorff-Largaespada, 2006a). In addition, women were part of the programme primarily as means to ensure food and hygiene of children, not as active subjects themselves (Bradshaw, 2008).

The programme basically excluded men and reinforced the notion that they do not need to be responsible for ensuring that their children attend school or go for health check-ups. "Women are presented as the 'solution' to the (male) problem. In order to circumvent the much harder task of changing men's behaviour, and society's view of this behaviour that allows it to be perpetuated, they are the ones targeted with contingent resources and responsibilities for behavioural change" (Bradshaw, 2008: 201). Therefore, as one person who participated in the design and implementation of the RPS stated, "in future interventions, it is important to operate with a gender focus that while empowering women, also addresses their partner's

responsibilities" a partner who, often in Nicaragua, abandons the home (Largaespada-Fredersdoff, 2006a:353).

A second area of controversy is how these transfers – delivered to the women – influence their lives. Clearly, due to the power relationships at home, there is no increased control over the resources. "... While the IFPRI study highlights that the RPS is not a disincentive to work, it notes that men have been able to spend more time working their own plots of land and working closer to home 'rather than having to travel long distances in search of wage labour' (IFPRI 2005: 2). This suggests that women receive the cash through the RPS is to some extent being used to compensate for men's reduced waged labour (Bradshaw, 2008). At the same time, since a high proportion of households do not have a permanent male presence, at least in these cases, women would have a greater ability to decide on how the transfers were utilized.

A third controversial aspect was whether or not the transfers increased the women's workload. RPS participants, a rather dispersed rural population, are generally responsible for the domestic and productive activities in the home. Therefore, to go out and collect the transfer and receive the bimonthly training while interacting with other women, was welcomed and could have, if not empowered them (which would be more difficult to determine) at least improved their autonomy. Thus, while the conditional transfers perpetuate the sexual division of labour in the household, at the same time they have a positive effect on the mobilization and interaction of women (which, as Molyneux explains well, is something much more specific than empowerment) (Molyneux 2006).

In addition, the RPS have an added benefit of an adult training component. Not all conditional transfer programmes included such a component. In itself, this component does not necessarily correct micro-targeting where it is believed that principally directing initiatives to children breaks the cycle of generational poverty, a notion that is inherent in the design of conditional transfer programmes (Molyneux 2007). However, it is clearly an improvement over other programmes, such as the pioneering programme Progress/Opportunities in Mexico.

Positive impacts were also seen in terms of access to health services. Even though the effects were itinerant and offered by non-governmental organizations acting as private providers, they did make a difference – albeit small – in the lives of these people. The school voucher, also delivered in cash, was used to buy school uniforms and materials (once a year) and was also offered with a food voucher, for "collaborating" with the school. In some cases mothers used these transfers to hire additional teachers necessary for the operation of the school, as the Ministry of Education did not cover such deficiencies.

Finally, the World Bank funded evaluation, did not find that these transfers increased domestic violence or that the money was appropriated by the men. It was found that these resources were used mainly for their original purposes, namely to improve the food intake children.

The main limitations of the RPS were associated with inadequate public investment for strengthening public services (both in health and education, and to a much greater degree – in care services), as well as an ineffective component for enabling women to achieve economic independence. Finally, while the programme did perpetuate a vision of female care-giving, the reality is that the vast majority of households are headed by women, and generally lack a permanent male presence.

2.4 Analytic threads

Since the 1990s liberal governments have promoted social programmes under a residual vision of social policy: economic growth being the principal aspect which would lead to greater and better distribution as a matter of course. Decentralization was the main policy mechanism, which in turn relied heavily on family participation, particularly on the participation of women (as in food preparation), and on community organizations created for this purpose (such as school boards). As well, decentralization decreased the number of State employees and weakened their capabilities, while also creating a high degree of job instability among social service workers, particularly women serving in jobs associated with care (such as nurses, teachers and cooks). Social policy was mainly organized through programmes (rather than specific policies), generally with private funding – at times, donations, but more often loans from multilateral banks - each with distinct objectives and implementation cycles. This mode of organization led to instability, dispersion and duplication of activities and initiatives. As well, the situation was exacerbated by the fact that during the period, the Nicaraguan State was composed of a set of weakly linked programmes and projects.

Throughout the entire period, community involvement was significant. However, until now, this had not been documented or explained. Tentatively, we believe that there are several contributing factors that account for the high level of community involvement. First, in some sectors, such as health, there is a very strong tradition of solidarity as a means to confront the crisis, coupled with a sound social value for community interventions in community health, in particular, among individuals with scarce economic resources. Second, the appeal of the Sandinista Government was to "govern from below" and to "continue to defend the revolutionary achievements" which strongly marked the Nicaraguan community movement. Third, empirical observations indicate even when political parties disagreed with community participation they supported it when faced with epidemics or natural crisis, both of which abounded in Nicaragua during the period.

3 Social practices: How evident is social policy?

In addition to seeking an understanding of the care diamond, or diamonds, in Nicaragua, the present study attempts to provide a methodological contribution. Pioneering studies on welfare and care regimes carried out from a gender perspective are generally based on institutional analysis. However, in countries where the welfare regime relies primarily on families and unpaid work, rather than on markets – let alone on public policy – it is vital to reconstruct the care diamond through a combination of institutional analysis and examination of social practices. Our effort in the latter area, although exploratory in nature and making no pretence to exhaustively represent the population studied, does allow us to utilize actual practice in order to assess the relative importance of public institutions, rather than simply assuming that the institutions carry-out their formally assigned roles and functions.

Below, we present our principal qualitative findings. As will be clear, they are highly consistent with statistical analysis of time use data results, and less consistent with the analysis of policies from an institutional perspective. Under a welfare regime based on a residual conception of public policy, where actual coverage and quality are low, it is to be expected that there will be a gap between what public policy aspires to achieve and what it actually accomplishes.

The fieldwork for this study included eight focus groups, seven with women and one with men, each composed of eight individuals, lasting approximately two hours. A total of 64 informants participated, including 56 women and 8 men. All participants had in common that they were responsible for children under 13 years of age. This criterion was used in order to reconstruct practices and representations at a

Box
Make-up of focus groups
<p>In Managua:</p> <ul style="list-style-type: none"> - Domestic workers, half wage-earners and half hourly workers - Professionals, half wage-earners and half independent workers - Professionals/caregivers in education and health - Own-account workers, essentially merchants <p>In Estelí:</p> <ul style="list-style-type: none"> - Housewives, urban and rural - Urban and rural women with paid wage work - Urban women who work for themselves (half outside the home, half at home) - Urban and rural men

particular stage in the life cycle where there is a high demand for care, and in where there is differing degrees of public policy, specifically in terms of educational coverage.⁴⁸ We maximised the heterogeneity of each group in terms of socio-demographic variables such as age, schooling, heads of household, type of family (nuclear or extended) and presence or absence of emigrants among the family's members.⁴⁹ Four of the focus groups were held in Managua,⁵⁰ the county's capital, and four in the municipality of Estelí.⁵¹ Estelí was selected due to existing contacts that facilitated interaction with the urban, as well as the rural, population, allowing for comparison with urban Managua. The box summarises the composition of the different groups.

In general, the participants' profiles met the established requirements. One exception was among the housewives, a number of whom had fashioned some form of income as a strategy for aligning family spending with the family's needs, under constrained economic conditions.

⁴⁸ Thus, the age bracket covered (0-13 years of age) includes children who are both younger and older than the 6-year-old point at which children begin to attend school.

⁴⁹ Ethnicity is a key factor in the Atlantic area, and could introduce significant differences in terms of practices and representations concerning care. However, it was beyond the scope of this study to do fieldwork in this area.

⁵⁰ Managua is Nicaragua's main urban centre, and accounts for 29% of the nation's population. The majority of the population there has access to electrical service (95.5% of housing units), and 49% of units have indoor plumbing, while 39% rely on outdoor plumbing (ENCOVI, 1998). Managua is the country's principal city, and draws a major portion of the country's population. There is little primary activity, and what exists is insufficient to meet the needs of the municipality's population, since most of the agriculture is for self-consumption. Currently, the main source of economic activity is commerce. For more information, see <http://www.inifom.gob.ni/municipios/documentos/MANAGUA/managua2.pdf>.

⁵¹ In the municipality of Estelí, 80% of urban housing units and 20.1% of rural units have access to electrical energy. In terms of basic services, 58.5% of urban housing units have indoor potable water, 31% outdoor, while the corresponding figures for rural housing units are 1% and 7%. Combining inactive female heads of household with unemployed female heads of household, 67% of rural female heads of household do not have paid work. In the city, the proportion is 49%, as compared with 18% among male heads of household. Meanwhile, 45% of the rural communities have no preschool education. Primary schools are present in 50% of the rural communities. However, there are secondary institutions in only four municipalities. In terms of school attendance, 73% of rural adolescents, 28% of children ages 10 to 14, and 31% of those between the ages of 5 and 9 do not attend an educational institution. Nearly one third (31%) of the rural population has no formal schooling, as compared with 12% in the urban area. The municipality's economic activity is based on agriculture (corn, beans, sorghum, potato, coffee, tobacco) and cattle; commerce and other services; and micro, small and medium-sized artisanal industries (tobacco, wood, leather). In the city, the tertiary sector (commerce, government, banking, transportation, communications, etc.) is of paramount importance. For more information, see <http://www.inifom.gob.ni/municipios/documentos/ESTELI/esteli.pdf>.

Thus, they were not, strictly speaking, housewives. We know, however, from other studies, that this is true of many housewives who, at times generate income comparable to that earned by the “head of household”.

All of the individuals were contacted by word of mouth. In Estelí, we began with one contact at the department’s “Casa Materna”. In Managua, we began with individuals who live or circulate in neighbourhoods that were within the operating scope of our researchers, in order to optimise the chances of reaching women with the necessary characteristics.

Three instruments were used to gather the information: an informant’s sheet and two guides, one for conducting the women’s focus groups and one for the men’s group.⁵² (See Methodology Appendix) The informant’s sheet focused on socio-demographic variables (e.g., age, religion, economic activity and place of residence), on the demand for care (number of children, and presence of older adults in the household) and on whether there were emigrants among the family members (a central aspect of the structure of Nicaraguan families).

The guide sought to elicit practices and representations relating to care. In regard to practices, we reconstructed the daily routines of the group members, as well as of others living in their households, with an emphasis on exploring the degree to which domestic and care work manifest a sexual division of labour between men and women. How is a normal day in the household organised? Do men perform domestic work? Second, we explored the conditions under which, and the degree of satisfaction with which, women delegate care of their children to others, either inside or outside the domestic circle, and identified their principal concerns in regard to such arrangements. Do they believe that they are the only ones that can adequately carry out this responsibility? To what degree is care “naturalised” as an individual responsibility? Third, we examined expectations – specifically, in terms of the activities that private enterprise and the State might be expected to perform in relation to care. To what extent is care considered a private matter, and to what extent an area for intervention by other spheres? To what extent is having, or having had, more children contingent on the circumstances under which care occurs? And, beyond questions of State and market, what would the informants wish to change in their lives?

Once the information was collected, the analysis consisted of identifying and commenting on tendencies, exceptions, consistencies and contradictions. On the basis of our findings from all eight groups, we present below, first, a reconstruction of the care diamond in Nicaragua, based on practices – i.e., on how people “resolve” the care demands imposed on them by children, older adults, the infirm, etc. This implies being able to make distinctions between the roles of women themselves, their families (other women and men), the market, the community, and public services. Second, we deal with representations, i.e., notions of who is expected to do what, in terms of both the sexual division of labour and the role of family (vs. that of public services and other collective services). Third, we describe the tensions between practices and representations.

3.1 Profile of people interviewed

In total, 54 interviews were carried out, 26 in the municipality of Estelí and 28 in the municipality of Managua. Overwhelmingly, housewives were from rural areas and the professionals from urban areas; the rest were distributed evenly among rural and urban areas. The breakdown by age was relatively evenly dispersed among age ranges with the exception

⁵² See Annex 2 for these three instruments.

of the range of 55 years and older (table 3.5). The level of education was varied, with a predominance of incomplete primary school at one end, and complete university at the other. The level of education varied considerably by occupation of those interviewed: between domestic workers, half had incomplete primary education (and one had no schooling), while among educators incomplete university education was prevalent.

Range of age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-60
Level of education	8 None	7 Primary school Incom.	7 Comp.	10 Secondary school Incom.	7 Comp.	8 University Incom.	6 Comp.	2 No data
	1	14	4	7	5	7	14	1

Source: Own elaboration based on interviewee's record.

Just under half (25) were married or common-law, the rest (29), were single, (including those widowed). Equal numbers of housewives and professionals, had partners in the home. Almost 3 out of every 5 had at least one relative who had emigrated (generally siblings). The average number of children was 3.13 (compared to 2.95 which is the national average recorded in the population census of 2005)⁵³. The group with the highest average number of children was the group of self-employed women in Esteli, however, it should be noted that this group included one rural woman with 18 children and an urban woman with 8 children. The average age at first birth was 21.18 years. Younger maternity was found among domestic workers and housewives (17 and 18 years respectively), and older maternity between the salaried women and professionals (23 years). It is striking that the age of first birth is so low among the professionals. This could be explained because they are educators, a profession that can be carried-out part-time and is considered socially compatible with motherhood. In religious matters, the ratio is 3 to 1 between Catholic and Evangelical (34 and 13 respectively). Seven did not specify religion on the informant's sheet and one was identified as Jehovah's Witness.

3.2 Care practices

How is the daily life of the individuals interviewed characterized? To what extent are the market, the State and unpaid work intertwined in addressing care needs? Below, we describe the daily lives of these people, placing particular emphasis on domestic and care work.

Regardless of whether or not they engage in paid work, women's daily routines begin similarly. The great majority are involved in care almost immediately upon waking: principally, preparing children for school or early education facilities. This means waking, bathing and dressing the children (if not directly, then monitoring their dressing) and serving them (and the spouse or partner) breakfast. Even where grandmothers provide care, it is generally the mothers, or sometimes fathers, who prepare the children for school before leaving for work.

Housewives also typically make tortillas⁵⁴ and in the case of those with partners at home, see their husbands off to work. The husbands therefore leave for work having already had their breakfasts and, (particularly in rural areas where work is far from home) take along their

⁵³ In: <http://www.inec.gob.ni/censos2005/ResumenCensal/Resumen2.pdf>

⁵⁴ This may consist of preparing them from ready-made dough, or it may be the entire process beginning with removing the kernels of corn, cooking the grain in water with lime, grinding it fine to make the dough, and forming and cooking the tortillas.

lunches – prepared and packed by their wives. Housewives differ from the other female informants in that they devote the rest of the morning to domestic work (cleaning, sweeping, washing clothes and dishes, and preparing lunch). Only after lunch and dishwashing do their activities diversify, turning to further domestic and care work (e.g., helping with or monitoring homework), paid activity (e.g., taking in washing) or work in the field (e.g., helping spouse to plant, weed or harvest.⁵⁵). In the evening the routine of most women becomes similar again, as they prepare the food, serve it to children and their spouse or partner, wash the dishes and clean up the kitchen.

Within this relative homogeneity, the routine of those women who do not consider themselves housewives fall into two patterns, according to whether their paid work involves leaving the house on a schedule – whether set by themselves, as in the case of hourly or piecework domestic workers, or by their employer, as with full-time domestic workers, salaried workers and teachers. These women do their domestic chores before and after their paid work, and have variable daily work schedules depending on their socioeconomic level. The most extensive work days are carried out by domestic workers (who rise at 3 a.m. and go to bed at 12 p.m.) The least intense work days are carried out by women who have shorter paid hours and who have some form of family support. A different pattern was observed among the self-employed, independent of their socioeconomic level (such as street vendors or consultants), who alternates care, domestic work and paid work throughout the day.

Two things stood out when the women described their daily routines to us. One is that a number of women included attending church as a part of their daily routine (rather than as a weekly event). The second is that in reconstructing the daily routine, few mentioned any recreational activity, and the most frequently mentioned was television. Only in one case did a woman mention conversing with neighbours.

National statistics indicate that a large portion of Nicaraguan women are raising their children on their own. Although not considered a criterion for involvement in the study, the majority of the informants were single mothers or grandmothers. Men and women agree that whether events are routine or out of the ordinary, it is the women who provide care, followed by their mothers and, to a lesser extent, older daughters, when they live in the same house. Sisters, mothers-in-law and sisters-in-law who do live in the same house participate in care in exceptional situations such as illness and birth. Domestic workers are mentioned, but to a much lesser extent and they are predominantly involved in domestic work rather than caretaking. Mothers living alone with no support are in the most precarious situation, since if they themselves do not provide care, and they have no adolescent son or daughter, there is no one else to provide it. Only one woman in this situation mentioned the support of a female neighbour. Among all the people interviewed, teachers are the only ones who take their children to work – apparently an exceptional situation.

Men were found to only participate in domestic activities when there was no alternative. In only one case was there an even distribution of domestic and care work between the woman and the man in the household. In general, however, women believed that men's monetary contributions were enough; being income providers is their primary mandate. Given the shortage of jobs in Nicaragua, some are able to accomplish this mandate and some are not. In either case, domestic work and care are far from being part of the male mandate. Thus, men make comments regarding domestic work and care, such as; "I have to", "when I am

⁵⁵ Caring for chickens or other animals is part of the domestic work performed by rural women, and does not involve leaving home.

unemployed”, or “I want to”, reflecting their views of the role that domestic and care work play in their lives.

In exceptional situations, some of the wives mentioned having their husbands’ support for domestic and care tasks, although it was impossible to identify regular trends. There were discrepancies between women and men in the reconstruction of their daily practices. While rural men mentioned doing some domestic work – principally water hauling – only one of the rural women stated that she had received help from her spouse in this type of activity, and only in exceptional cases – when she was in fragile health following a birth.

Contrary to our expectations, neighbours were mentioned only as a last resort in situations of great need, when it was impossible for the woman of the house to provide care – for example, when care needs coincide with working or study hours.

When asked to describe significant events that changed routines, the primary one mentioned was the birth of children or grandchildren: those who did not have paid work had to find a job, and those who did were forced to reduce their paid workload. Other important changes were marriage (which meant beginning to take on household work that the mother had done before), separation (which implied returning to the mother’s house, ceasing to be a housewife, and going to work), and children’s growing up (which left time for paid work). In all of these cases, the change is related to the demand for care (as opposed to having finished studies, changed jobs, etc.).

Among men the opposite was seen: significant events described were related to job changes which directly affected the availability of time to devote to the family. For example, switching from self-employment to a wage-earning job; or to a higher paying job which permitted a decrease in the amount of time worked. Two of the eight men also mentioned giving up alcohol as significant, a matter brought up without being asked, which points to the existence of social practices that are generally ignored in designing and implementing social policy, but that do seem to be addressed by other institutions, particularly religious ones.

3.3 Representations of care

What roles *should* men and women have? Independent of whether they are housewives or perform paid work, women generally believe that they should carry-out domestic and care work. The main reason is simple: if they do not do it, no one will. Most women, in fact, feel obligated to carry out this role. In the case of domestic workers, this obligation is directly linked to their status as mothers, or as women.

Teachers stressed that there are gender-related activities that *should* be performed by women, such as giving advice to their children on sex-related issues, bathing them, getting the child support from the bank and getting the children’s clothes ready. Few women mentioned activities that only they *know* how to do (such as cooking, preparing tortillas, saving). This was preceded by the discussion regarding men being capable of carrying out domestic and care activities, but not learning how to because they don’t want to do them. In addition, a few women mentioned activities they actually *enjoy* – such as cooking and cleaning house – because they enjoy the outcomes, such as having the house clean.

Only one informant said that her partner takes responsibility for caring for her daughter. This is the case despite the fact that generally, women believe that their partners are capable of

carrying-out domestic and care work. The principal problem they encounter is that the men either do not know how to properly carry-out the activities – or act as though they are incapable of performing them well, so as to not be asked to do them. It is apparent that there are some efforts to change the sexual division of labour, but with little practical results.

Men admit that housework is not exclusively a woman's responsibility. Even so, men only carry-out these activities when they do not have other things to do – and when they want to. In addition, they generally refer to their role in domestic work as “helping”, rather than as their responsibility.

3.4 Delegation of care: concerns and requirements

Who can assume the responsibilities of care when mothers are unable to? Grandmothers are clearly the best choice for care when a woman needs to find paid work but does not have enough money to hire help. As well as insufficient income, women also site a feeling of unease when leaving their children with hired care as a significant reason for not doing so. They site a number of fears, including fears about physical safety, hygiene (illness), accidents and mistreatment. However, the circumstances with which they feel most secure vary. Some feel comfortable when the children are in school, while others feel quite the opposite, since they have had experience with accidents or carelessness, such as situations where the adults are unaware that the children have gone out. School is also associated with the threat of mistreatment by other children, and a case of rape was even mentioned. For other women, and for men, the concern centres on the time between leaving school and arriving home. What concerns them is what can happen on the way, as in the case of one girl who was run over by a car, and one boy who was a victim of a street crime.

Inside the house, there is less concern, and what concern there is, centers around the caregiver, and how she may put a child at risk. Where elderly persons provide care, their health and age are a concern to mothers. In the case of hired help (family members or others), concerns include hygiene and whether children will be fed. Cases of children staying at home generally occur when they are under school age (i.e., under three, which is the minimum age for entering preschool, which the State provides without charge), when there is no money available to pay for daycare, or when the idea that “there's nothing like family!” prevails. There are three basic requirements for entrusting children to someone: that the person be responsible, that he/she attend to the child's needs, and that the adult care about the child and provide love and affection and, to less extent patience. They also mentioned trust-related attributes – e.g., that the person be someone who is known and is reliable.

In addition to school, childcare centres also have the advantage of allowing parents to work. Interestingly, there is recurring talk of “CDIs” as a generic name for these centres, even though the ones today, are not those that were created in the 1980s during the Sandinista revolution. However, care within the family is preferred over this alternative. A small number of the women used a childcare centre but only because they had no other alternative. In addition to the familialistic vision, reasons for lack of use of childcare centres included limited coverage - for example, these centres do not exist in rural areas – and the payments. Some private childcare centres even charge in dollars; even in the public CDIs, monthly payments - however minimal (U.S. \$11 per month was mentioned) need to be made. Two other drawbacks are the transmission of infectious diseases and the schedules: the hours of operation might not meet the needs of the mother.

However, in general those who did not utilize the centres, did not need them because they had someone they trusted (a close family member, such as their mother) to care for their children, generally in the same house. The idea that care is better done in the house, is widespread, and becomes even stronger as the socioeconomic level decreases.

Women – including professionals - yearn for the free-of-charge CDIs from the 1980s, especially now, they say, because it is private and not public centres that offer the better quality care while in the past, public centres were superior. CDIs are the most frequently mentioned types of centres, not only because they allowed single mothers to work, but because regardless of whether they were used or not, they were highly valued by the population in general. When asked to compare private and public centres, the principal difference identified was the costs (lower in the case of public centres) and also to a large extent, the conditions of the centres (better in the private centres).

When asked to comment on the advantages of sending their children to these centres, whether public or private, as opposed to leaving them at home, several interviewees mentioned the socialization with peers, the support they receive from skilled people, the learning and self-esteem attributes that the children attain, as well as language development, and psychomotor skills. Interestingly, given the large number of households with domestic helpers, some interviewees commented that, unlike when children are left in the home with strangers, such as domestic workers, in childcare centres the children are well cared for and not maltreated, in addition to receiving medical attention and food. There were also some cases where resources were sufficient to have domestic helpers, and the women commented that they prefer that the helper carry-out domestic, rather than care giving, chores.

As for the ideal conditions for childcare centres, the emphasis was on attitude and training of personnel. In several groups training was associated with diverse professions such as doctors, nutritionists and psychologists. It is noteworthy that on the one hand, the expectations of expertise are placed in these terms and on the other, the first option is for care in the home, where this level knowledge and expertise is usually not present. In the home, affection is given - which is associated with proper care - as care is usually given by a close relative, mainly the grandmother. This outlook is generally believed to be true because children like their grandmothers, and they are responsible and trustworthy. Care givers should also care for the children "as if they were their own children." Strikingly, this emphasis was put forward by the teachers themselves.

Besides personnel issues, informants stated that the facilities should be "in good condition" and – the most frequently mentioned factor – that the conditions should provide safety and food and involve low cost. In addition, cleanliness, supervision, availability of toys, games and appropriate furniture were mentioned. Generally, it was teachers, and those who have previously used childcare centres, who placed the most emphasis on these non-personnel issues.

3.5 What States and business should do regarding care

When the subject shifted from the current situation to expectations, views on the delegation of care changed, and many, if not all, of the women expressed increased expectations of the State. Moreover some, consider it is the State's obligation to help with care, especially in the case of single mothers who need to work away from home, as they have no one to help with care and lack resources to pay for private care services. They believe that this support, besides

being good for them, generates jobs and improves their job performance. Even though they refer exclusively to mothers (rather than fathers also) they have a very broad vision of who should be eligible. They concur that a larger and better State participation through the creation and maintenance of more CDIs, both for public and private workers, both for mothers who need to work and for those who want to work, is needed. However, some interviewees emphasized that services should be for everyone (including professionals), and others only for those with limited resources (domestic workers and informal self-employed). The men agreed on the need for more public services destined for care.

In addition, particularly the self-employed, spoke of the State's responsibility to ensure that care-related institutions such as the Ministry of Education and Ministry of the Family are performing their functions well. For example, follow-up on situations of abuse or inappropriate care in schools and health centres. Much of the demand to the State focuses on a simple idea: the need for compliance with laws, among these, the Paternity Act. In addition, educators cited the need to increase the resources available in schools, for example to ensure the food programmes, as well as improved wages and working conditions. Beyond care, it was also noted that the State should monitor working conditions, and help women to improve their job performance and their productive capacity.

Domestic workers differed from the other groups, in that they mentioned more specific forms of support: a scholarship for their daughters; rebuilding the wall of a house; having a space of their own. In general, when the question focused on care, the expectations expressed a shift to more general conditions regarding the State's role in providing access to resources and to minimum living conditions that would permit mothers to meet the needs of their children.

Regarding the responsibility of business for providing childcare, several women stated that business should create childcare centres in or near their company facilities, or provide funding for CDIs outside the business. This support would not only benefit women but improve work performance. Beyond childcare, the interviewees perceived an ideal role for business similar to the ideal role of State. For example, medical care was mentioned in two of the groups. In addition, the need for businesses to actually hire women, insure their female workers, create schools, provide money for medications at health centres, offer products to CDIs at favourable prices, contribute economically to schools, give scholarships, and provide low-interest loans, was stated.

3.6 Self Expectations

Most women do not want to have any more children, mainly due to their difficult economic situation. Even those who have only one child, and would like to have another, think that they will not. Those who did express the desire for another child expect secure futures – quite consistent with a family-based welfare and care regime.

It was difficult for them to answer the question regarding what they would like to change in their lives. Once the silence was over, the great majority – including the men – said that they would like to improve their economic situation. The housewives wanted to earn their own money, the self-employed wanted to own a business and have better income or a fixed salary, and the wage-earners wanted better incomes. In other words, the principal expectations are much more associated with socioeconomic conditions than with maternity, care or gender relations. Nevertheless, if we examine the individual statements, we find desires related to life goals (some of the housewives would have liked to continue studying, in order “to be

someone”), to working conditions (some of the professionals would like better enforcement of laws), to gender equity and shared responsibility for care, to having a house of one’s own, and in the case of one of the men, to having a job that would take less time, so that he could spend more time with his family.

Only some of the self-employed urban and professional women mentioned having more time for themselves as their principal desire. They stated that care giving, even more than paid work, does not leave time for diverse activities such as recreation or doctor’s visits.

Men were asked to indicate what they thought their wives desires were. Fewer than half answered this question. The tendency was to refer to equitable distribution of domestic and care work, as well as having children involved in these tasks.

3.7 How should care be defined?

Both chores and care giving are considered work, and while there is some difference between the two, they are closely interrelated. In the focus groups we separated one from the other, after a brief discussion, the women arrived at the following conclusion. In this initial differentiation, “chores” were considered to apply principally to domestic tasks, as opposed to care giving, education and security for the children. The former was defined as a mechanical activity, in contrast to the education and physical and emotional health of others. However, this initial distinction was abandoned as the informants agreed that, like domestic work, care involves an investment of time and effort, not only physical, but mental. In addition, the two must often be carried out simultaneously

In both care and domestic work, the sense of obligation predominates; there is a sense of “If I don’t do it, no one will” – which, in turn, is significantly related to “knowledge” and “power”. However, what the women would like to change does not focus on equitable distribution of domestic and care work, or on having a partner (the majority of these women are single), but rather on earning better incomes. It is for economic reasons that they do not want to have more children, and economic factors are also what they would most like to change in their present situation. Greater income improves their life conditions in general and allows them to pay for help with the domestic work in particular.

Meeting care needs is more complicated for mothers living alone with their children than it is for the other women interviewed. Single mothers have had to leave their children at home alone while they go out to earn wages, and have even had to take them out of the hospital while they are still sick as they were unable to provide the required care because they had to work. Unless they have children close to adolescence, these women are also without help for domestic and care work. Those who live with their mothers or fathers – mothers being the most common case – confront an additional complexity, since the parent can need care, as well as providing it. This is especially true in cases of illness, when extended-family strategies must be deployed – although these are not always feasible. Thus, even though childcare is a more important factor, the need to provide care for older adults is just as real, and the issue needs to be addressed by the State and/or through other collective forms of organised care.

Housewives generally have partners who provide income while they are in charge of domestic chores and care taking. Most of these women live in rural areas, are relatively isolated, have low educational levels and have very limited earning opportunities. As a survival strategy, in addition to domestic work, they raise domestic animals and help their spouses or partners with

farming. Additionally, and out of necessity, many of these women work to earn wages on their own, in whatever ways possible – such as washing and ironing clothes. They are housewives in that their principal activity is unpaid work; however, they do carry-out paid work, even if they do this only as a complement to other activities.

Male involvement increases with higher levels of education and in urban rather than rural areas. Still, such participation is seen as mere support. This view is stronger among the rest of the men, who participate in domestic work only when there is no alternative (e.g., having no partner present); they have time (e.g., being unemployed); and want to help (rather than feeling obliged). Accordingly, we did not see evidence that responsibility was viewed as a shared one, either in practice or in representations, but only in the rhetoric.

When women do have support from others, it is usually other women, principally immediate family members (mother, sister, daughter) or, less frequently, in-laws (mothers-in-law). The community – specifically neighbours – was hardly mentioned, though it participates in care in cases of extreme need. School does play a role, inasmuch as it provides relief from care duties for much of the day, making a difference for those who care for their children at home – mothers, in the case of housewives, self-employed workers, and grandmothers in cases where the mother works outside the home.

There is a recurring reference to the free childcare centres established in the 1980s - both because they were free-of-charge and because they were very highly valued. However, it is not clear why the State should be involved with care. The strongest and clearest consensus is that it is obligated to provide conditions so that working mothers can be more productive. Other proposals are that the State needs to comply with the laws and with State institutions whose profile is caring. As well, private businesses are believed to have responsibility in creating care services for working mothers. In fact, there is little distinction between how State and Business are perceived as responsible for care. It is even mentioned that both should finance, or co-finance, care centres, health centres, and social projects outside of their installations. It is also noteworthy that the people interviewed stressed the need for services for single mothers who lack support, thus giving a residual (rather than universal) focus to the role of the State and other entities beyond the family.

3.8 Care practices and the care diamond

We now formalise the findings of the qualitative study – i.e., in terms of the practices involved – in order to provide an overall assessment of how the care regime combines unpaid work, the market and privately purchased services, State or public services, and community relationships, especially neighbourhood relations. We then triangulate these results with those of the statistical data on time use, which also focus on practices. In comparison with the qualitative study, these data have the advantage of being representative of the population; however the disadvantage is that the unit of analysis – the household – restricts the information to those living within the actual household, thus omitting the “family care chains” or “female care chains” that, as we shall show, emerge from the qualitative study.

Based on the comments of the women interviewed, the following table formalises the operative care diamonds that were identified. First, it presents the occupations of the informants. In addition to housewives, it cites three occupational categories that make it

possible to approximate the women's socioeconomic level:⁵⁶ vulnerable workers (a category that includes self-employed workers and domestic workers who work on a piecework or per-day basis, performing tasks such as washing or ironing), non-precarious workers (salaried workers and full-time domestic workers) and professionals (salaried and self-employed workers).

Second, the table identifies the informants as urban or rural – an important distinction in light of the fact that the services available (private as well as public) vary considerably with this parameter. Third, the table indicates how the family is organised in order to generate income. It is termed “traditional” when there is a male provider and female caregiver, “modified” when the women (although not freed from domestic and care work) also generate income, and “unified” when the women who provide income and care have no income-generating partner.⁵⁷ Although this method of characterising the organisation of the families omits other important characteristics (such as whether it is nuclear or extended), it facilitates an examination of the sexual division of labour, which needs to be reflected in the care diamond. Third, the table indicates the age of the child in the family, since this sets the framework for the family's current care needs. In the rows of the following table, we deal with the features of the care diamond itself, referencing the participation of spouses or partners, participation by women family members, by the State, and by private service providers (including domestic workers). Finally, we characterise the care diamond as “solely familialistic”, or as “familialistic with involvement of other components”, either public or private. The column marked “cases” refers to the number of informants in each category.⁵⁸

⁵⁶ This is an adaptation of the categories of Pérez Sáinz et al. (2004), previously used in Martínez Franzoni (2008).

⁵⁷ This is an adaptation of the categories of Barbara Haas, previously used in Martínez Franzoni (2008).

⁵⁸ For a total of 54. We omit one whom it was not possible to fit into any of the categories.

Occupation	Rural or urban area	How family is organised in order to generate income	Age of (minor) child	Spouse or partner	Women family members	Public services	Private services	Person/s to whom care is delegated (in order of importance)	Care diamond	Cases
Housewives	Urban	Traditional	11 years	No	No	No	No	Children's grandmother and/or aunt (only in case of recent birth)	Familialistic, feminised	1
		Traditional	8 years	No	No	No	No			1
	Rural	Traditional	3-11 years	No	No	No	No			6
		Traditional	1 year and 11 years	No	No	No	No			2
Vulnerable workers (own-account and domestic workers who work on piecework or daily basis)	Urban	Modified	8 months to 11 years	No	Yes	No	Yes	Immediate family and domestic worker	Familialistic, feminised, with private services	8
		Unified	2-10 years	--	Yes	Yes	No	Older son/daughter and, to lesser extent, the CDI	Familialistic, with some public services	11
	Rural	Unified	10 years	--	Yes	No	No	Older son/daughter	Familialistic	1
Non-precious workers (salaried, and full-time domestic workers)	Urban	Modified	1-8 years	Yes	Yes	No	No	Close relatives and husband	Familialistic	5
		Unified	1-5 years	--	Yes	Yes	No	Grandmothers, aunt, child's mother, and CDI. Neighbour in case of emergency.	Familialistic, feminised, with public and community service	6
	Rural	Unified	8 months and two 7-year-olds	--	Yes	No	No	Grandmothers, aunt, and child's mother. Neighbour in case of emergency.	Familialistic, feminised, and community	3

Occupation	Rural or urban area	How family is organised in order to generate income	Age of (minor) child	Spouse or partner	Women family members	Public services	Private services	Person/s to whom care is delegated (in order of importance)	Care diamond	Cases
Professionals (salaried and own-account)	Urban	Modified	9 months to 5 years	Yes	Yes	No	Yes	Grandmother, private service and, to lesser extent, husband	Familialistic, feminised, with private service	6
		Unified	1-5 years	--	Yes	No	No	Grandmother	Familialistic, feminised	3

As the table 3.4 shows, Nicaragua's care diamond is clearly familialistic. Within this framework, it should be noted that women's insertion in the labour market introduces a clear difference: the diamond is *both* familialistic and feminised – and devoid of other support – only when the women do not have paid work and devote full time to unpaid work. On the other hand, when they have paid work of any type, the familialisation is not exclusively feminine, with public or private arrangements often prevailing, even if only in a secondary role.

Notably, there is no clear difference in the care diamonds of vulnerable workers, non-precarious workers, and professionals. The explanation for this lies in the diverse income levels of vulnerable workers. Those who have businesses (a small eatery, store or clinic) have incomes greater than those who sell newspapers, tortillas or cosmetics. The non-precarious, on the other hand, may receive salaries and have insurance, but their incomes are not necessarily sufficient, and in many cases they may even have to perform supplementary work. In terms of the professional women, in Nicaragua many of these work as taxi drivers or street vendors (e.g., booksellers). Thus, when what is at issue is income, actual occupation may not suffice as an indicator of a worker's true situation: variations in the care diamond are a function of income and the availability of family members to care for children. At the same time, although the care diamonds may be the same in terms of the share of the weight borne by the different "vertices", differences can be expected in the type of private services used, and in the amount of care time that draws on family support.

The community is a source of care-giving through women neighbours. However, belying the working hypothesis posed in Chapter 1, this presence is relatively marginal, since it is associated with emergency situations. It nevertheless provides an alternative in both rural and urban settings (within Estelí, but not in Managua). The absence of more formal community arrangements such as associations, or even women who provide care for other children along with their own, should also be noted. As emerges from the analysis of the social policy regime, it is the non-governmental organisations (sometimes referred to as the "third sector") that play an important role, though more in organising services provided under the State's social policy than as autonomous expressions of civil society.

3.9 Triangulation with time-use statistics

Given that our qualitative study makes no pretence of being representative of the population, it is worth exploring the extent to which its findings coincide with, and complement, those that emerge from the statistics presented in Chapter 2. Here, we shall draw on the principal results summarised in the conclusions to the chapter.

In regard to commodification of the labour force, the qualitative study suggests that women are more likely to have paid work if they have no spouse or stable partner. In different occupational categories, and despite the fact that this was not a criterion for selection, there are households that we classify as "unified", in which women provide both care and income. The statistical data show the opposite among men: it is the absence of a partner, or the fact that the men do not have (or do not spend time on) other activities, that accounts for their devoting some time to domestic tasks and caregiving. Consistent with the conclusions of the statistical study, it would seem that, with certain exceptions that prove the rule, deviation from typical female and male roles occurs principally as a function of economic need, and thus does not necessarily reflect changes in the sexual division of labour.

Moving to the care regime itself, the qualitative study confirms the statistical data on one issue, namely, that having paid work does not free women from their responsibility for unpaid care work. The analysis showed that although women with paid work devote the least time to care work, they still devote approximately 4 hours per day to these activities, in addition to the time they spend performing paid work.

The qualitative study also confirms that as socioeconomic level rises, less time is devoted to unpaid work. Nevertheless, the qualitative study indicates that the lightening of the burden of these mothers leads to delegating care – not to market or publicly provided services, but rather to other women in the family such as grandmothers, sisters and daughters. It also confirms that urban women devote more time to paid work than do rural women, although this is due partly to the fact that rural activities centre around production for self-consumption and are less commodified, thus tending to result in an underestimation of the time devoted to activities that, ultimately, are not unlike the commodified activities that they make possible. For example, the work involved in raising an animal that may eventually be sold for cash, which in turn will be used to purchase agrochemicals, is not generally considered equivalent to the work (e.g., cutting cane or harvesting coffee) performed by the spouse or partner.

Whether care is provided by mothers themselves or by other female family members, the study shows a high degree of feminised familialisation of care. The statistical data show that the greatest number of hours are devoted to care among women over 17 who are married or have a partner, and who have responsibility for children under the age of 6. Since the unit of measurement is the household, what the statistics do not show is women's "care chains", especially within the family – chains that the qualitative study clearly demonstrates.

One finding from the time-use statistics is the relatively small amount of time devoted to care of persons, and in particular children, as opposed to other types of unpaid work, such as domestic work. Unlike other studies, which show that women "adjust" their time by reducing domestic work,⁵⁹ the statistical data show that in the population at large, women devote an average of 4.2 hours per day to domestic work, while care consumes only 1.1 hour. These data, if reliable, suggest that self-care plays a major role, even among young children. Although the gap is reduced when the average number of hours is calculated per person participating in the survey, it nevertheless is present. In this case, the gap may also be reflecting the fact that when family members – whose contribution, as we have seen, is so central in Nicaragua – are present, it is easier to delegate care than to delegate domestic work. In both cases, the data could reflect problems of measurement, especially given the practical, as well as theoretical, difficulty of clearly distinguishing between domestic work and care. This difficulty was discussed in the groups, and is associated with the social construction of care. For example, in watching television with one's daughter, is one engaged in recreation or care? Does cooking constitute domestic work or care? The informants found it difficult to draw the line between the two types of activity. Just as the social construction of childhood or maternity may vary under different regimes, or from North to South, the variances here may be attributable to differences in the social construction of "specialised" activities involved in providing children with necessary care.

With respect to the feminisation of care, our qualitative findings confirm the statistical conclusions. The latter show that women increase the time they devote to care when there are

⁵⁹ For the case of Costa Rica, see a qualitative, exploratory study (Martínez Franzoni and Ramírez, 2008).

children under 6 in the home – a time when children not only require more attention, but when public services are also less present than they are for children of school age. The time that men devote to care, on the other hand, does not vary in this way – a circumstance consistent with the fact that, even in the case of women who perform paid work, the familialisation of care is predominantly feminised.

3.10 Analytical threads

The 54 interviewees are responsible for the care of their children with some support, usually from a female family member. In general, they believe that a man's primary responsibility is to provide household income. They also have a high familialist vision of care: girls and boys are better off at home, however, when that is not possible, childcare centres are a good option. In these cases, the co-payments create difficulties and free-of-charge services are an important necessity. Despite the familialistic and maternalistic vision of care, the majority have high expectations regarding the State's – rather than civil society's - role in care, in particular for support to women working outside of the home. These expectations of State's role seem to be a legacy of the Sandinista revolution of the 1980s. In particular CDIs, even though in reality, these centres only support 1% of children under 6 years old. However, in the minds of the women, these centres are an important and successful part of care in Nicaragua and they would like to have more of these centres.

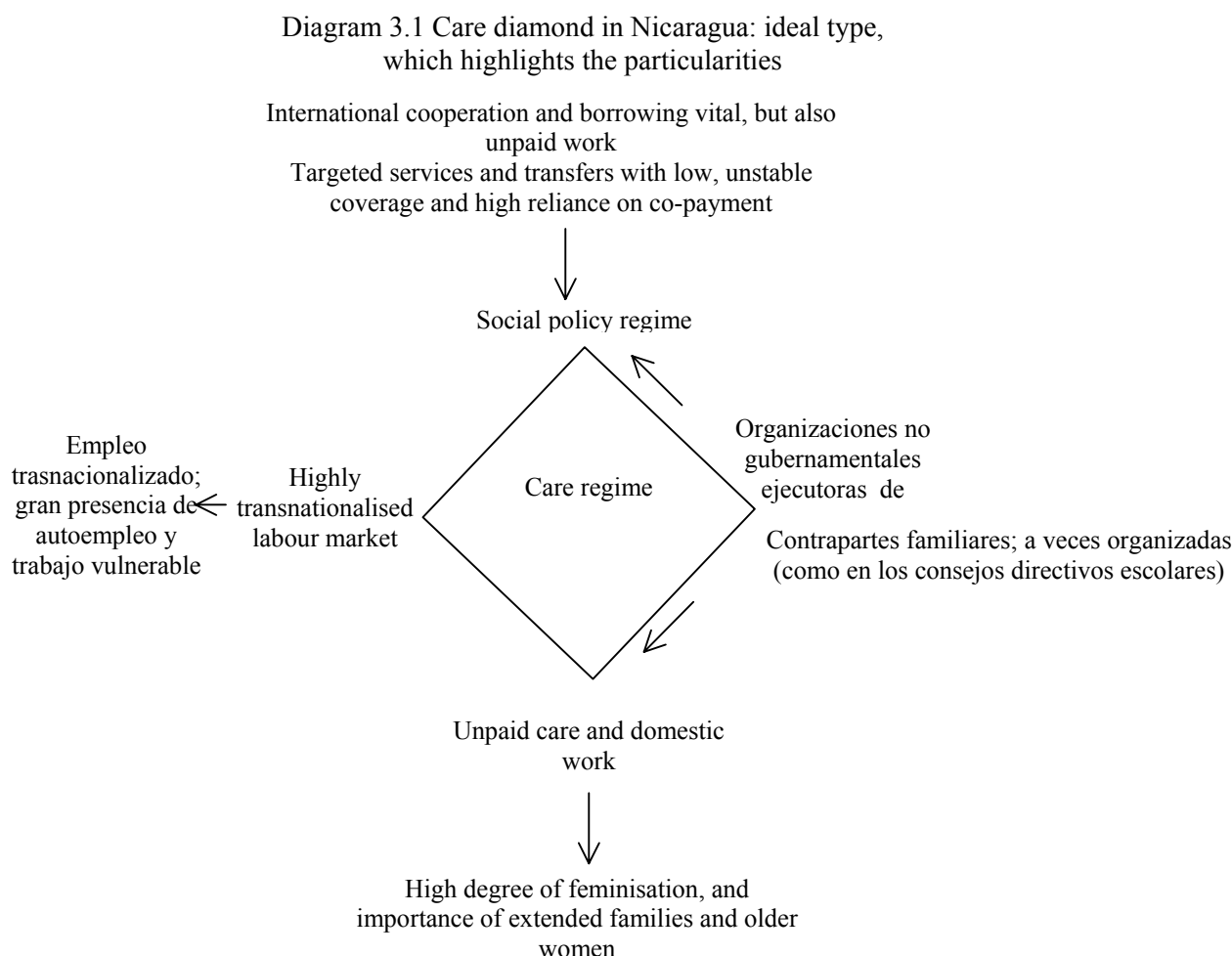
Conclusions: The Care Diamond

We conclude this chapter by discussing the care diamond that prevails in Nicaragua. With respect to the *labour market*, we confirmed that the majority of the population in Nicaragua, as discussed in Chapter 1, finds it difficult to commodify its labour within Nicaragua's borders. Hence, a large portion of the labour force commodifies its labour elsewhere, principally in Costa Rica and the United States. Generally, families survive through self-employment, under-employment and at the high cost of intensifying the work of all family members (including children and adolescents). This struggle for survival changes the family structure, for example, grandmothers become heads of households, extending their life cycle for responsibility of caring for and raising children. (Largaespada-Fredersdoff, 2006a).

Interestingly, we found that the main factor for care and for household organizational structure is the presence of paid work, both for men or women. Whether work is temporary or permanent, or within or outside of the country, grandmothers are caring for their grandchildren. As well, we did not find evidence that remittances translate into purchasing private care services. In fact, private purchases of this type of service appear to play a relatively marginal role, even among higher-income families. Remittances facilitate the subsistence of caregivers, and shift unpaid work from certain women to others. This finding confirms previous studies indicating that families function as "accordions", expanding and contracting according to the availability of resources (Agurto and Guido, 2001), making it possible, when necessary, to reduce costs and solve the problem of caring for children or young people by shifting this burden to adults other than the biological parents – often grandmothers (Fernández Pacheco, 2003).

Thus, in Nicaragua family and family strategies are the predominant, if not the only available, approach to escaping poverty and ensuring subsistence for the majority of the population. The family relationships, which do not necessarily depend on marriage, often involve mother-

daughter relationships, thus clearly reproducing relationships of dependency and excess work – paid, for some and unpaid for others. Strategies for commodifying work mean, that families in general, and women in particular, assume the high cost of “compensating for” the inability of labour markets to provide paid (let alone well-paid) work within the country (Martínez Franzoni, 2008). In short, the Nicaraguan scenario is characterised by the fact that, within the family, women do not necessarily depend predominantly on their spouses or partners, but rather on other female family members.



Regarding *social policy*, we have confirmed that levels of social spending are low, and are completely inadequate to address the extensive social needs. Nicaragua is among the four countries in Latin American with the lowest per capita social investment. Currently, there are extensive social needs; however, even if a much larger portion of the population were to be well educated, with access to potable drinking water, and electricity, with enough income to pay for services, and with a largely decreased need for social services, the per capita social investment would still be insufficient.

The country has tried to formalize and organize public policy, both within the specific sectors and amongst them. This is reflected, for example, in a considerable increase in both the coverage of primary education and the proportion of children completing primary school. In addition to being important in terms of the human capital represented by boys and girls, this

expansion of the State's capacity to provide educational services carries implications for the care regime.

Nonetheless, Nicaraguan social policy remains very limited, both in terms of inadequate available resources and the poor institutional structure that makes use of those resources. The social policy regime is further weakened by the ineffectual State bureaucracy and the high dependence on non-governmental organizations and parent associations, who assume strategic functions of the State. In addition, in order to mitigate the lack of resources, social policy is supported by external resources (increasingly loans and decreasingly grants), which in turn define – often inconsistent – priorities that do not support public institutional strengthening. Consequently, the resultant State - organized around programmes and lacking in resources - is insecure, unstable, offers poor services and has serious difficulties in improving its capacity.

In addition, the high dependence on unpaid - predominantly female – work intensifies these weaknesses: mothers, who have not finished primary school, are managing educational institutions. These same mothers are also expected to generate income, care for their children, and be volunteer cooks or *brigadistas*. This high dependence on unpaid work traverses all social policy sectors, from health and nutrition, to social protection and education. The dividing line between public participation and unpaid work is obviously blurred. Unpaid work does not always lead to good community programming and strategic planning.

Parents' associations, non-governmental organizations, and other forms of local associations and organizations play an important role in compensating for the absence of State and for implementing public policies. There are distinct modes of operation: from volunteers implementing social policy (such as school boards or health brigades) to families as partners in social policy through unpaid work (as in food preparation). These family partners are more-or-less formalized as associations depending on the area of social policy and the close interrelationship between what is truly part of the public realm or State and what is not; at times making it difficult to distinguish between actors. For example, in terms of care, we find State programmes funded by cooperation resources and executed in some measure by volunteer staff (such as food programmes), and others financed by the national budget, and managed by civil society organizations (such as in schools and high schools).

When a country is rebuilt, as in Nicaragua, some of the population – specifically families with power - manages to generate income and access to public social services while others do not. It is clear that there are no defined logics for resource allocation and that although there is a “dividing line” between the resource allocation that mediates social policy and family arrangements; it is not always clear. Even in social policy sectors where there has been progress, it has been minimal. Social policy is still residual, minimalist, and highly dependant on the participation of families and women. Ironically, in Nicaragua, both the limited existing decommodification as well as the commodification of the work force are highly familialistic and feminized. Unlike welfare regimes with strong markets, in Nicaragua, an acceptable standard of living, as well as the very survival of many people, depends heavily on the family networks that are mentioned above and with which we began the description of the care regime.

Our analysis raises several important questions. How does this feminized familialist regime affect women's lives, both while they are carrying-out paid work and during their old age? What changes in the social construction of care and shared responsibility – in addition to the obvious increase in public spending - should be promoted for changes in the care diamond?

How can changes in the care system generate positive and continuous results for the services provided?

Before exploring the answers to these questions, the following chapter will focus specifically on women whose paid work is part of the current "social infrastructure" of care (Camacho and Martinez Franzoni 2007), such as educators and domestic workers. Based on these women's roles in the current care regime, we can derive implications for a future care regime, one that would create conditions for some degree of defamilialization and defeminization of care and/or value the time dedicated to care (for example, with monetary transfers). As will be discussed below, this agenda could be important not just for women and gender equity, but also for the "mainstream" of the policy agenda and for its implications on employment generation and overcoming poverty.

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