The rights-based approach to care policies: Latin American experience

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Abstract Care policies are high on the public policy agenda in Latin America. This is partly explained by the region's structural conditions, typical of middle-income countries, such as increasing life expectancy and women's relatively high participation in the labour market, but also by the politicization of care, derived from the recognition that the unequal distribution of care provision is a powerful driver of gender and income inequalities. Women's movements have positioned care policies high on their own agendas and, with varying degrees, States have progressed in the implementation of care policies, supported by a strong gender-equality agenda which is framed within a rights-based approach to social protection. This article presents the Uruguayan and Costa Rican "care systems" as examples of Latin America's rights-based approach to care policies. It succinctly explains their political and institutional evolution, and presents the main features of their legal frameworks. It pays particular attention to the actors that have mobilized to support and, eventually, shape them. It also identifies the dimensions that are singled out by other countries in the process of replicating and adapting these examples to build their own "care systems" following a rights-based approach to care policies. The article closes with a focus on implementation challenges.

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Introduction

Care policies, ranging from early education and development services, to maternal and parental leaves, long-stay facilities for older persons, or personal assistance for persons with disabilities, are high on the public policy agenda in Latin America. This is partly explained by the region's structural conditions, typical of middle-income countries, such as increasing life expectancy and women's relatively high participation in the labour market – in other words, by the fact that care needs are growing and it cannot be expected that families, and particularly women, will continue to provide for these.

Relatedly, the expansion of care policies is also explained by the politicization of care, derived from the recognition that the unequal distribution of care provision is a powerful driver of gender and income inequalities. Given care policies can contribute to gender equality and mitigate other dimensions of inequality – or exacerbate them – women's movements have positioned care policies high on their own agendas, articulating claims to the State. In turn, a well-developed gender equality agenda at the regional level has provided the frameworks and tools for States to respond to these claims (Esquivel and Kaufmann, 2017). And finally, a strong rights-based approach to social protection has provided fertile soil for the growth of a rights-based approach to care policies. This has been explicitly built into legal frameworks and policy documents, orienting policy design and implementation. There has been a move from rhetoric and judicial enforcement to actual practice that is a salient feature of care policies in Latin America (Sepúlveda Carmona, 2014). Still, it should be noted that care policies are contested terrain, and competing care agendas – i.e. the normative principles, frameworks and institutions that indicate who should provide care, for whom, and at what cost – are behind variations in the forms of provision, coverage and financing of care policies in the region (Filgueira, 2015; UNRISD, 2016).

This article presents the Uruguayan and Costa Rican "care systems" as examples of Latin America's rights-based approach to care policies. It succinctly explains their political and institutional evolution, and the main features of their legal frameworks. It pays particular attention to the actors that have mobilized to support, and eventually, shape them. It also identifies the dimensions that are singled out by other countries in the process of replicating and adapting these examples to build their own care systems following a rights-based approach to care policies. This article closes with a focus on implementation challenges.

Care policies

Care policies are public policies that assign resources to the provision of care in the form of money, services and time. They range from payments and subsidies allocated to caregivers or to people who need care, and from the direct provision of care services to complementary service provision, such as access to clean water and sanitation. They also include labour regulations, such as maternity protection and paternity leave and the regulation of paid working times, which assign time to care. Care policies therefore encompass policies developed by various sectors, including health and education, labour and social protection policies. They are designed to serve different purposes, including poverty reduction, enhanced labour force participation, employment creation and the expansion of future generations' human capabilities (UNRISD, 2016).

Whether some care policies are favoured over others – the particular "care policy mix" – varies across contexts, depending on demographic, economic, social and cultural factors (Daly and Lewis, 2000; Razavi and Staab, 2012; Sainsbury, 2013). Amongst these, the coverage of the social protection system and the strength of public-sector delivery are obviously relevant, but other factors, notably whether a strong gender-equality policy is in place and the degree of mobilization around care, also play a role (Esquivel and Kaufmann, 2017).

The above definition of care policies builds on the United Nations Sustainable Development Goal 5 "Achieve gender equality and empower all women and girls", which in target 5.4 makes a call to "recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies"; and on Sustainable Development Goal 8 "Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all", as maternal and parental leave periods and paid leave for caregivers are arguably part of what the International Labour Organization (ILO) calls "decent work" (UN, 2015). This definition is broader than care service provision, and implies applying a "care lens" to the design and implementation of social protection policies and to care-related infrastructure policies (UNRISD, 2016; Esquivel and Kaufmann, 2017).

Target 5.4 is the culmination of a large mainstreaming effort to make unpaid care and domestic work a public policy issue, and it marks an unprecedented advance in the care agenda in terms of the visibility of care as a central dimension of sustainable development. Yet, this progress at the international level is not yet reflected at national and regional levels. For the latter levels, few social protection and childcare policies explicitly acknowledge the role these policies play in redistributing unpaid care and domestic work between women and men as well as between households and society at large. This is especially so where gender-egalitarian agendas are weak and/or confer care policies a relatively low priority (Esquivel and Kaufmann, 2017). As we now discuss, Latin America is the exception.

In Latin America, the redistribution of unpaid care and domestic work figures prominently as a central dimension of gender equality at the regional level (ECLAC, 2015a), and there has been enormous progress in the development of "care systems for children, older persons, and people with an illness or disability" (UNDP, 2016).

A rights-based approach to care policies in Latin America

A rights-based approach to care policies has been progressively enshrined in the regional agreements that have emerged from the Regional Conferences on Women in Latin America and the Caribbean: namely, Santiago (1997), Lima (2000), Mexico City (2004), Quito (2007), Brasilia (2010), Santo Domingo (2013) and Montevideo (2016). These regional agreements, or "Consensuses", alongside the Montevideo Consensus on Population and Development, adopted at the Regional Conference on Population and Development in Latin America and the Caribbean (2013), have succeeded in making care a public policy issue. The Economic Commission for Latin America and the Caribbean (ECLAC, 2016a, p. 21) evokes this political evolution through the themes the consensuses have tackled: "the social and economic contribution of unpaid work and the need for the women who do this work to have social security (Lima Consensus); [the] recognition of work in care services, reconciliation between the family and working life of men and women (Mexico City Consensus); the role of care and domestic work in economic reproduction, the importance of redefining the sexual division of labour and care as a public issue that pertains to States, firms and families (Quito Consensus); the adoption of policies to recognize the economic value of care services in the national accounts, and to promote universal care policies and social protection for domestic workers and caregivers (Brasilia Consensus); and [the] consideration of care as a public good and as a right that involves the redistribution of care tasks between the government, market, society and men and women (Santo Domingo Consensus)".

These consensuses show the evolution in the regional language from that of the Beijing Platform for Action (UN, 1995) – with its emphasis on the recognition and measurement of "unremunerated work" coupled with the absence of a political agenda that would follow suit –[1] to the need for care policies, firmly established in Quito and elaborated upon in Brasilia. A novelty of the Brasilia Consensus, further emphasized in Santo Domingo, was the adoption of the "Triple R" framework (see Box 1). Care policies, in particular universal care services and labour market policies (parental leaves and other provisions for workers with family responsibilities) are, in these texts, the means through which care is redistributed. This regional language has supported, and indeed pre-dates, the international agreements reflected in target 5.4.

1. There are historical and political reasons why this was the case; for further elaboration, see Esquivel (2011).

Box 1. *The Triple R framework*

The Triple R framework, which calls for recognizing, reducing and redistributing unpaid care and domestic work, expands the Beijing Platform for Action's call for recognition and valuation, typically interpreted as measurement, by adding a concrete economic justice dimension.

- Recognizing unpaid care and domestic work means avoiding taking it for granted, challenging social norms and gender stereotypes that undervalue it and make it invisible in policy design and implementation. It therefore involves more than facilitating women's unpaid care and domestic work with measures that recast women as the main care providers.
- Reducing unpaid care and domestic work means shortening the time devoted to it when it involves drudgery, primarily by improving infrastructure.
- Redistributing unpaid care and domestic work means changing its distribution between women and men, but also between households and the society as a whole.

Note: The "Triple R" framework is a reinterpretation of Nancy Fraser's (1997; 2000) "Triple R" framework for identity politics: recognition, redistribution, representation, proposed by Elson (2008). See Esquivel (2011) for an elaboration and Esquivel (2013) for practical applications to policy.

Source: UNRISD (2016, p. 100).

The Brasilia and Santo Domingo Consensuses frame "care as a universal right, which requires strong policy measures to effectively achieve it, and the co-responsibility of the society as a whole, the State, and the private sector" (ECLAC, 2010, p. 2). This formulation builds on the co-responsibility framework, which expands the more limited work-family reconciliation discourse and gained traction in the region following the publication of a 2009 International Labour Organization and United Nations Development Programme report (ILO and UNDP, 2009). Similar in intent to redistribution, enacting social co-responsibility in care requires a strong public sector to guarantee that not all care responsibilities fall onto families, and women in particular. Somewhat differently from the Triple R framework (see Box 1), though, it places stronger emphasis on the private sector, making it co-responsible for care provision. While the Triple R framework centres on the idea of care as a dimension of well-being, and finds applicability in social policy design, the co-responsibility framework positions interaction in the labour market at the centre of the debate and is more geared towards labour market policies and regulations (Martínez Franzoni, 2015).

Care systems: The cases of Uruguay and Costa Rica

Exemplified by Uruguay and Costa Rica, Latin American "care systems" entail an integrated approach to care policies. They have been established by law,

are universal in ambition, aim to overcome fragmentation and entail the institutionalization of inter-sectoral coordination mechanisms. Further, they are firmly rooted in social protection systems (Cecchini et al., 2015; ECLAC, 2015b).

The Uruguayan Integrated National Care System (*Sistema Nacional Integrado de Cuidados* – SNIC) includes existing policies on health, education and social security and new policies for priority populations, in particular older persons, persons with disabilities, and pre-school age children. For the latter, the SNIC aims to provide universal care service coverage for children aged 3, and increased coverage for children aged 0–2, including the extension of parental paid leave and the possibility of part-time work for mothers and fathers during a newborn child's first 6 months (Sistema de Cuidados, 2017). The SNIC comprises an array of care alternatives, strengthening the supply of public services, regulating private supply, guaranteeing quality standards and providing training to caregivers (Junta Nacional de Cuidados, 2015). Explicitly excluded from these alternatives are direct payments to family care providers, which would boost household (and women's) care provision, particularly in poor households, and limit state responsibility to the provision of cash for care (Scagliola, 2014).

The SNIC is based on the principle of co-responsibility of the State, the community, the market and families, as well as of women and men, in the provision of care. The aim is for it to be the "fourth pillar" of Uruguay's social protection system, "along with health, education and social security" (EUROsociAL, 2015). Among SNIC's explicit objectives are changing the sexual division of labour within households and the social (re)valuation of paid care work in the market sphere. Other principles are solidarity in the distribution of care work and its financing, the autonomy of care recipients and universality both in coverage and in the level of quality, irrespective of whether the provider is public or private (Piñeiro, 2015).

The law that created the Uruguayan SNIC, passed in November 2015 (*Ley de Cuidados,* No. 19.353/2015), specifies care as a right of persons in dependent situations; this is a more specific framework than "care as a universal right". In the wording of the law: "*Care* comprises of the services that dependent persons must receive to guarantee their right to perform their daily activities and fulfil their basic needs as they lack the autonomy to do these by themselves. [Care] is a right and also a social function…" (author's translation).[2] The law defines as right holders under its purview "A) Persons in a dependent situation …: 1) Girls

2. In the original Spanish: Art. 3, "A) Cuidados: las acciones que las personas dependientes deben recibir para garantizar su derecho a la atención de las actividades y necesidades básicas de la vida diaria por carecer de autonomía para realizarlas por sí mismas. Es tanto un derecho como una función social que implica la promoción del desarrollo de la autonomía personal, atención y asistencia a las personas dependientes". See <www.bps.gub.uy/bps/file/10433/1/ley19353-sistema-nacional-integrado-de-cuidados.pdf>.

and boys up to 12 years of age. 2) Persons with disabilities who lack the autonomy to perform their daily activities and fulfil their basic needs. 3) Persons older than 65 years of age who lack the autonomy to perform their daily activities and fulfil their basic needs. B) Persons who provide care services" (author's translation).[3]

From a rights-based perspective, two features are salient in this legal text. First, it goes beyond the reference to established human rights frameworks for particular groups (children, persons with disabilities, older persons, etc.) to actually define new rights for persons who are in dependent situations broadly, with the duty "to fulfil the rights of persons in dependent situations, sufficiently and according to needs" falling on the Sate – i.e. the State is positioned as a duty bearer (Sepúlveda Carmona and Donald, 2014).[4] Second, the identification of *all caregivers*, both paid and unpaid, as rights holders. In including caregivers, who are mostly women, this legal framework is true to its "gender and generational perspective … [aimed at] overcoming the cultural sexual division of labour and distributing care provision amongst all social actors",[5] as explicitly mentioned in the opening remarks of the National Care Plan 2016–2020 (Junta Nacional de Cuidados, 2015, p. 5). It also brings the situation of paid care workers to the fore, who are usually low waged but whose working conditions and levels of pay determine to an important extent the quality of care provided (UNRISD, 2016; Razavi and Staab, 2017; Esquivel, 2017a). This is particularly noteworthy as it is an innovation unique to the Uruguayan legal framework, which came into being, as it will be elaborated below, only as a result of the persistence and involvement of Uruguayan feminist movements in the run up to SNIC's creation.

The National Care Secretariat within the Ministry of Social Development is the inter-ministerial coordination body in charge of the SNIC. Incumbent ministries and secretaries form the SNIC "board", which establishes broad policies and

3. In the original Spanish: Art. 8, "Son titulares de los derechos establecidos en la presente ley: A) Quienes se encuentren en situación de dependencia, considerando como tales las personas que requieran apoyos específicos para el desarrollo de sus actividades y la satisfacción de las necesidades básicas de la vida diaria. Por ello, se consideran personas en situación de dependencia: 1) Niñas y niños de hasta doce años. 2) Personas con discapacidad que carecen de autonomía para desarrollar actividades y atender por si mismas sus necesidades básicas de la vida diaria. 3) Personas mayores de sesenta y cinco años que carecen de autonomía para desarrollar las actividades y atender por si mismas sus necesidades básicas de la vida diaria. B) Quienes prestan servicios de cuidados". See footnote 2.

4. In the original Spanish: Art. 5, "El Estado, considerando sus disponibilidades presupuestales, prestará a las personas en situación de dependencia, el amparo a sus derechos en la medida necesaria y suficiente, procurando el mayor grado posible de desarrollo de su autonomía personal". See footnote 2.

5. In the original Spanish: Art. 4, "Son principios y directrices del SNIC: … G) La inclusión de las perspectivas de género y generacional, teniendo en cuenta las distintas necesidades de mujeres, hombres y grupos etarios, promoviendo la superación cultural de la división sexual del trabajo y la distribución de las tareas de cuidados entre todos los actores de la sociedad". See footnote 2.

priorities.[6] An advisory board with members of civil society, academia, private providers and care workers also interacts with the board and the secretariat (Sistema de Cuidados, 2017).[7]

The National Care Secretariat was originally envisioned as a coordinating body, but it has since been allocated a budget to expand childcare services, in a move to give it political traction. Over time, the care services provided by other ministries and state agencies should fall under the SNIC budget allocation, a move that might generate resistance.[8] Indeed, under the SNIC, different conceptual frameworks co-exist — including the competing "targeting the poor" and rights-based approaches — as do institutional traditions involving entrenched sectoral views on education and health taking pre-eminence over systemic views. Also in tension are the universalistic ambition of the system and the necessarily phased nature of policy implementation, which may jeopardize scalability given that different policies may be accorded different levels of priority. In addition, although it is a great achievement that the gender perspective is endorsed by the law, the National Women's Institute must nonetheless strengthen its position on the SNIC board to guarantee that gender mainstreaming takes place also in the policy design and implementation phases (Espino and Salvador, 2014).

In comparison, Costa Rica's Early-childhood Development and Care Network (*Red de Cuido y Desarollo Infantil* – RedCUDI) is narrower in scope, as it is an early childhood care policy for girls and boys younger than age 7. Successive executive decrees from 2010 onwards laid the foundations of the Network, which was finally established by law in March 2014. RedCUDI incorporated existing initiatives, policies, and private and public care services with the aim of universalizing integral early childhood care and development services. Central to the proposal was the expansion of the coverage of one of the pre-existing early childhood care services: Education and Nutrition Centres/Integral Childcare Centres (*Centros de Educación y Nutrición/Centros Infantiles de Atención Integral* – CEN-CINAI) and the creation of municipal Child Care and Development Centres (*Centros de Cuido y Desarrollo Integral* – CECUDI) – the latter more comprehensive than CEN-CINAIs in terms of care services provision, as these include development and educational objectives on top of those of nutrition and health (Guzmán León, 2014, pp. 16, 26–27, 29).

6. These include the Ministries of Social Development, Education, Labour, Health, Finance, and the Budget Office, the public education administration, and the Social Insurance Bank (*Banco de Previsión Social)* – the pension system's state administrator.

7. See also Fassler (2009, p. 110) on the need of participatory mechanisms and technical expertise to steer the SNIC.

8. For the SNIC budget, see <www.mef.gub.uy>.

The RedCUDI is rights-based, framing early childhood care services as every child's right. It is aimed at promoting social justice, equality and equity. Among the Network's stated objectives is that of ensuring that the provision of childcare services allows fathers and mothers to work for pay or engage in education (IMAS, 2016).[9] RedCUDI is decentralized in its organization, and the resources to establish, administer and run CECUDIs are channelled to municipalities but are provided by the national government. A variety of financing sources, administered by the central government, should support the universalization of childcare services while guaranteeing uniform and high-quality standards (Guzmán León, 2014, p. 28, p. 39). Yet, as in the case of Uruguay, universalization will be a challenge given existing budget constraints (Guzmán León, 2014, p. 55).

RedCUDI is overseen by a Technical Secretariat and coordinated by the Inter-institutional Technical Commission (CTI), in which all incumbent public actors take part, including the Ministries of Social Development and Education, the National Institute of Women (INAMU) and several agencies charged with developing carers' skills, childcare centres' infrastructure, and supporting community-based childcare centres (Guzmán León, 2014, pp. 33–35).

Mobilizing for care policies in Uruguay and Costa Rica

That care policies are high on the public agenda in Latin America is certainly an achievement of the feminist movement. It reflects the evolution of the movement, which has become professionalized, has forged alliances with other social movements and actors, and has increasingly engaged with the State to influence public policies (Montaño and Sanz Ardaya, 2009). It also reflects the contribution of feminist academics, who have succeeded in framing care as a public policy issue and have politicized it (Esquivel, 2015; Rodríguez Gustá and Madera, 2015). As the case of Uruguay illustrates, women's movements' engagement in the political processes that supported the emergence of "care systems" has been crucial to the establishment of a rights-based approach to care policies. Their relative weakness, in turn, appears to explain the absence of a stronger reference to women's rights alongside the rights of care recipients.

Mobilization in Uruguay

Uruguay's Integrated National Care System (SNIC) was the result of extensive and stepwise negotiations and a weaving of broad alliances to bring care policy to the

9. See: Law No. 9220/2014 <www.sipi.siteal.iipe.unesco.org/normativas/1331/ley-no-92202014-red-nacional-de-cuido-y-desarrollo-infantil>.

public debate. Its conception spanned more than seven years and three progressive presidencies (Aguirre and Ferrari, 2014).[10] A strong human-rights approach to social protection, which progressed on expanding coverage beyond minimum floors in health, education, housing and social security, provided the backdrop for the development of the Care System (Olesker, 2014). Time-use data showing women's and men's unequal unpaid domestic and care work, which revealed important variations depending on the presence of dependents, provided the evidence to make the case for care policies (Salvador, 2014).[11]

The SNIC began from an alliance of women's movements, social movements, female politicians, and feminist academics, organized as the Gender and Family Network, a non-governmental organization (NGO) that set in motion an incidence strategy to make care prominent on the public agenda (Fassler, 2009). Important actions were the "Dialogues on Care" carried out amongst political parties with parliamentary representation, which succeeded in positioning care as a political issue and not simply a public policy matter. The alliance's engagement with the ruling political party and government actors proved crucial in advancing the care agenda: by 2008 the National Care System figured in the electoral campaign programme of *Frente Amplio,* the ruling party for the period 2010–2015.

The first institutional step was taken in 2010, with the establishment of a governmental working group within the Social Policy Cabinet (whose members are now part of the SNIC board). The working group defined the broad guidelines of the SNIC, the target populations and the care policies comprised by the system and drafted a formal proposal for the SNIC in 2012 (Aguirre and Ferrari, 2014). In other words, the working group made possible the institutional development of the SNIC, providing a platform for state institutional actors to develop ownership. Meanwhile, a phase of national debate took place, with the aim of raising awareness about care, sharing information and incorporating local realities into the design of SNIC. The national debates, with their broad-based participation and high visibility, gave all actors involved the political credibility and public support to continue to push for the SNIC.

The national debates also revealed a variety of interpretations of what care is (or is not). "Care" appeared to be contested by teachers specialized in early childhood education, who understood care as being different from education

10. Aguirre and Ferrari (2014, p. 6) examine the process of consensus building around the SNIC in Uruguay focusing on conceptual frameworks, including knowledge and data generation, actors, enabling/disabling factors, and policy results.

11. The time-use evidence was produced by Universidad de la República and then taken on board by the National Statistical Office (Aguirre and Ferrari, 2014).

and therefore defined it as non-professional work. The debates also saw a departure from the strong feminist foundation that had originally sparked the SNIC's development and saw a stronger presence of associations of persons in dependent situations promoting their claims (Aguirre and Ferrari, 2014, p. 37). The care workers' perspective was also absent from the debates. This led feminist actors to fear that the rights of caregivers would be diluted in the final SNIC proposal and the gender perspective overlooked. The situation was partly due to a relatively weak women's machinery but also to the difficulty in more strongly articulating the care agenda as also being a feminist agenda (Espino and Salvador, 2014). At this point, the Gender and Family Network came together in a "pro-SNIC" network in 2013 to mobilize support, while the government working group continued to draft the more detailed aspects of the SNIC design (such as financing or required regulations and care workers' training).[12] As was the case at the onset of the process, network involvement proved key in guaranteeing that strong gender language remained in the law and that caregivers were still considered one of the four SNIC target population groups, with professionalization being one of the stated objectives for the System.[13]

Mobilization in Costa Rica

Costa Rica's experience with the Early-childhood Development and Care Network (RedCUDI) has several points in common with Uruguay's SNIC:

- open dialogue channels with NGOs and academic experts, including from the National University, who helped conceptualize and provided technical support for the care network format;
- the support of social movements, which as early as 2009 listed care service provision and social infrastructure as one of their ten proposed measures for the new government;
- the creation of formal inter-institutional coordination spaces, in particular the Action Plan pro-RedCUDI, 2012–2014, whose members would become part of both the Technical Secretariat and the Inter-institutional Technical Commission;

12. United Nations agencies actively supported the government and civil society organizations in the process (Aguirre and Ferrari, 2014).

13. In the original Spanish: Art. 9, "El SNIC perseguirá los siguientes objetivos: … E) Profesionalizar las tareas de cuidados a través de la promoción de la formación y capacitación de las personas que presten servicios de cuidados, incentivando su desarrollo profesional continuo, el trabajo en equipos interdisciplinarios, la investigación científica, fomentando la participación activa de trabajadores y personas en situación de dependencia". See <www.bps.gub.uy/bps/file/10433/1/ley19353-sistema-nacional-integrado-de-cuidados.pdf>.

• the inclusion of childcare policies in the *Partido de Liberación Nacional* electoral campaign programme that politicized childcare provision.[14]

The political process behind the building of RedCUDI, and the involvement of civil society actors, differs from that of Uruguay's SNIC. The social movements that put early childhood education high on the agenda framed public childcare service provision as a means to generate employment *and* increase women's labour force participation in the labour market (ANEP, 2012, cited in Guzmán León, 2014, p. 47). Yet, the inclusion of care in the electoral programme seemed to have been based on expert suggestions (Guzmán León, 2014, p. 47, based on an interview with the elected President, Laura Chinchilla) and driven more by an attempt to connect with the female electorate (Flórez-Estrada, 2010) rather than by the involvement of civil society.

Moreover, once the decrees started the process of setting up the Network, NGOs specialized in children's rights became increasingly involved, as did the United Nations Children's Fund (UNICEF), which provided strong support in the form of technical assistance. As a result, children became RedCUDI's main (and sole) rights bearers and their "integral development", even beyond "care", became the focus of the Network (Guzmán León, 2014, p. 46, based on interviews with UNICEF officials). In comparison, women's organizations were less involved, and the run-up to RedCUDI's establishment by law was more technical and top-down and less political than was the case in Uruguay (Guzmán León, 2014, p. 64; Blofield and Martínez-Franzoni, 2015, p. 26). This is reflected in RedCUDI's legal framework, which lists among the Network's four objectives the possibility for fathers and mothers to engage in employment and/or education,[15] but excludes both women's rights and an adherence to a gender perspective. It should be noted, however, that the Costa Rican Beijing +20 report states that RedCUDI is a strategic component of the National Gender Equality and Equity Plan (INAMU, 2014).

Care policies in Latin America: The way ahead

Uruguay and Costa Rica are not the only countries in Latin America to have established care policies. Indeed, care policies exist in the region for different population groups and with different levels of coverage and quality (Rico and

14. *Partido de Liberación Nacional* won the elections, and its electoral campaign programme became the National Development Programme when President Laura Chinchilla (2010–2014) took office.

15. In the original Spanish: Art. 2, "Objetivos: … d) Procurar que los servicios de cuido y desarrollo infantil permitan la inserción laboral y educativa de los padres y las madres". See: Law No. 9220/2014 <www.sipi.siteal.iipe.unesco.org/normativas/1331/ley-no-92202014-red-nacional-de-cuido-y-desarrollo-infantil>.

Robles, 2016; Esquivel and Kaufmann, 2017). Prior to the developments in these two countries, Chile, for example, had expanded early childhood care services with its "Chile Grows with You" programme (*Chile Crece Contigo*), focusing on children's rights but without a universal ambition made explicit in the law (Staab, 2016). Ecuador, El Salvador and Mexico, in turn, have also implemented care policy coordination mechanisms within national governments. These mechanisms include roles for officials from social development ministries, who specifically focus on the needs of children, women and persons with disabilities, as well as for representatives from the education, health and social security sectors (ECLAC, 2016b, p. 99).

Yet, the "care system" experiences, in particular that of Uruguay, are laying the path for replication and adaptation in other countries. Colombia, for example, has included in its 2014–2018 Development Plan the creation of a National Care System along with "a national agenda on the Care Economy" (DNP, 2015, p. 505). In the run-up to the National Care System (the so-called SINACU or *Sistema Nacional de Cuidado*), the government has established an inter-sectoral working group and is in the process of officializing its planning coordination mechanism.[16] Chile is progressing along the same lines (Ministerio de Desarrollo Social, 2017), as is Mexico City (Mancera, 2016).

Although with national specificities, these experiences are building on several aspects of the Uruguayan care system. First, they combine from their inception broad political alliances, including the involvement of women's movements. This results in a two-pronged strategy to develop care systems: pressure and engagement from civil society groups combines with a process of institutional development within the State, itself following from a political commitment at the highest level and including cross-sectoral planning coordination mechanisms.[17] The latter elements guarantee state officials' buy-in, and helps generate the mutual trust needed to work together as members of the advisory boards/policy coordination mechanisms which are created in the subsequent implementation phase.

Second, they take a strong and explicit rights-based approach to care policies, including women's rights, following the Uruguayan legal formulation. The SNIC definition of care as a right of persons in dependent situations is particularly amenable to frame social policies – although care-receivers' rights are usually explicitly included in the formulation of care policies in the region. The novelty to imitate is the inclusion of caregivers, both paid and unpaid, as care systems' rights bearers, which brings with it a strong gender perspective without the maternalist undertones (i.e. care policies are subsidiaries of the care that should be provided by

16. Personal communication with members of the "Technical Intersectoral Committee".
17. Being a governmental process, this also makes it possible for UN agencies to provide technical assistance, as was the case in Uruguay and Costa Rica.

families/mothers) or instrumentalist undertones (i.e. care policies help women enter the labour market and thus contribute to growth) typical of existing social policy frameworks (Blofield and Martínez Franzoni, 2015; Esquivel, 2017b). Indeed, in aiming to simultaneously fulfil the rights of care receivers and those of caregivers, the new care systems have the potential to be *transformative* – to contribute to the reversal of social inequalities, including gender inequalities (UNRISD, 2016).

And third, they are institutionalizing care systems as part of (rights-based) social protection systems, a fact that lends support for both their universal ambition and their gender equality dimensions.

Concluding remarks

As both the Uruguayan SNIC and Costa Rican RedCUDI are in their initial phases and other initiatives are only being drafted, the key challenge lies in the implementation of a rights-based approach to care policies. For the vision of a rights-based approach to care policies to be realized, and to surmount the many obstacles ahead, including the necessary financing, the institutionalization of accountability mechanisms will prove key. There are some promising developments that bode well in this regard. The Uruguayan SNIC Advisory Board, established by law, channels the participation of civil society actors, providing them with a platform to interact with state actors. Further, the implementation progress reports contribute to transparency and access to information for meaningful civil society participation.

In sum, the rights-based approach to care policies in Latin America is work in progress, but several promising avenues have been formulated, including placing a responsibility on States as the duty bearers to meet care needs and focusing on care receivers and caregivers, both paid and unpaid. Focusing also on caregivers situates gender equality as central to the advancement of care policies, as meeting the care needs of persons in dependent situations is equal in importance to how these needs are actually met.

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