

The Political and Social Economy of Care in Nicaragua

Familialism of Care under an Exclusionary Social Policy Regime

*Juliana Martínez Franzoni, with Carmen Largaespada-Fredersdorff,
Karim Ulloa and Koen Voorend*

This United Nations Research Institute for Social Development (UNRISD) Programme Paper has been produced with the support of the International Development Research Centre (IDRC, Canada), the Swiss Agency for Development and Cooperation (SDC), and the United Nations Development Programme/UNDP (Japan/Women in Development [WID] Fund). UNRISD also thanks the governments of Finland, Mexico, Norway, Sweden, Switzerland and the United Kingdom for their core funding.

Copyright © UNRISD. Short extracts from this publication may be reproduced unaltered without authorization on condition that the source is indicated. For rights of reproduction or translation, application should be made to UNRISD, Palais des Nations, 1211 Geneva 10, Switzerland. UNRISD welcomes such applications.

The designations employed in UNRISD publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of UNRISD concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The responsibility for opinions expressed rests solely with the author(s), and publication does not constitute endorsement by UNRISD.

Contents

Acronyms	iii
Acknowledgements	iii
Summary/Résumé/Resumen	iv
Summary	iv
Résumé	v
Resumen	vi
Introduction	1
The Nicaraguan Social Policy Regime	2
General features	2
Changes in social spending	3
Institutional change and social policy	6
Principal Components of the Care Regime	10
Care services for children under six years of age	10
Preschool education	13
Childcare services	15
A note on primary school services	18
School feeding programmes	20
Health services	22
Conditional cash transfers	26
Analytic threads	29
Social Practices: How Evident is Social Policy?	29
Methodology of the focus groups	30
Profile of people interviewed	31
Care practices	32
Representations of care	34
Delegation of care: Concerns and requirements	34
What should states and business do regarding care?	35
Expectations	36
Care practices and the care diamond	36
Triangulation with time use statistics	39
Analytical threads	40
Conclusions: The Care Diamond and Gender in Nicaragua	40
Bibliography	44
Boxes	
Box 1: Make-up of focus groups	30
Figures	
Figure 1: Public social spending as a percentage of GDP, 1990–2006	4
Figure 2: Nicaragua: Evolution of per capita social spending, 1990–2006	4
Figure 3: Nicaragua: Public social spending as a percentage of total public spending, 1990–2006	6
Figure 4: The care diamond in Nicaragua	41
Tables	
Table 1: An overview of the main changes in the Nicaraguan social policy regime	7
Table 2: Coverage of care centres among children below 6 years of age	11

Table 3: Coverage of care centres among children below 6 years of age, by type of centres and year	11
Table 4: Coverage of care centres among children below six years of age, by income and area of residence	12
Table 5: Overview of the preschool programmes implemented in Nicaragua	13
Table 6: Overview of the school food programmes implemented in Nicaragua	21
Table 7: Interviewees by age range and level of education	31
Table 8: Nicaragua's care diamond on the basis of data from focus groups	37

Acronyms

AIDS	acquired immunodeficiency syndrome
CB	Casa Base (<i>Base Home</i>)
CCT	conditional cash transfer
CDI	Centros de Desarrollo Infantil (<i>Child Development Centres</i>)
CEPNE	Centros de Extensión Preescolar No Escolarizada (<i>Non-School Preschool Education Centres</i>)
CICO	Centro Infantil Comunitario (<i>Community Children's Centre</i>)
CIR	Centro Infantil Rural (<i>Rural Children's Circle</i>)
CMNA	Comisión Municipal de la Niñez y la Adolescencia (<i>Municipal Commission on Children and Adolescents</i>)
ECLAC	Economic Commission for Latin America and the Caribbean
EMP	Empresas Médicas Provisionales (<i>Provisional Medical Companies</i>)
ERCERP	Estrategia Reforzada de Crecimiento y Reducción de Pobreza (<i>Enhanced Economic Growth and Poverty Reduction Strategy</i>)
FISE	Fondo de Inversión Social de Emergencia (<i>Social Investment Fund for Emergencies</i>)
FONIF	Fondo Nicaragüense de la Niñez y la Familia (<i>Nicaraguan Fund for Children and Families</i>)
FSLN	Frente Sandinista de Liberación Nacional (<i>Sandinista National Liberation Front</i>)
GDP	gross domestic product
GNP	gross national product
HIPC	highly indebted poor countries
HIV	human immunodeficiency virus
HMO	health maintenance organization
IDB	Inter-American Development Bank
IFPRI	International Food Research Policy Institute
IMF	International Monetary Fund
INSS	Instituto Nicaragüense de Seguridad Social (<i>Nicaraguan Social Security Institute</i>)
INSSBI	Instituto de Bienestar y Seguridad Social (<i>Nicaraguan Institute of Social Security and Welfare</i>)
MINSA	Ministerio de Salud (<i>Ministry of Health</i>)
NGO	non-governmental organization
ODA	oversees development assistance
PAHO	Pan American Health Organization
PAININ	Programa de Atención Integral a la Niñez Nicaragüense (<i>Programme for Comprehensive Care of Nicaraguan Children</i>)
PINE	Programa Integral de Nutrición Escolar (<i>Comprehensive School Nutrition Programme</i>)
PND	Plan de Desarrollo Nacional (<i>National Development Plan</i>)
PROSERBI	Programa de Servicios Básicos Integrados (<i>Integrated Basic Services Programme</i>)
RPS	Red de Protección Social (<i>Social Safety Network</i>)
SAC	Sistema de Atención en Crisis (<i>System of Attention to Crisis</i>)
SAPs	Structural Adjustment Programmes
Sida	Swedish International Development Cooperation Agency
SILAIS	Sistemas Locales de Atención Integral de Salud (<i>Comprehensive Healthcare System</i>)
SILOS	Sistemas Locales de Salud (<i>Local Health Systems</i>)
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WFP	World Food Programme

Acknowledgements

This paper was written by Juliana Martínez Franzoni, drawing on inputs from Carmen Largaespada-Fredersdorff (for the analysis of social policy), and from Karime Ulloa (on social practices). Koen Voorend was of a great help in revising the last version of the document.

Summary/Résumé/Resumen

Summary

Nicaragua is the second poorest country in the Western Hemisphere. Its gross domestic product (GDP) is extraordinarily low (\$958 per capita), and its main source of income is the inflow of remittances from emigrant families working in the United States and Costa Rica. Seventy per cent of the population lives below the poverty line, and two out of 10 people are illiterate. Many households are headed by women, who are responsible for both care and paid work. Furthermore, Nicaragua is highly susceptible to natural (and social) disasters such as hurricanes and earthquakes. Within this complex reality, how do social practices in the household, state, community and markets combine and interact to provide care services and, in particular, care for children?

Historically, the country has been a socialist state. Inadequate public investment in social protection and services resulted in limited coverage. Even under the import substitution model, and during the period when the state increased social protection, only a quarter of the population was covered. Currently, the welfare of the population depends to a large extent on family strategies designed to generate income and build social protection networks. Heavy dependence on emigration and remittances, self-employment through the transformation of families into productive units, and reliance on social networks to deal with illness and other unforeseen circumstances demonstrate the absence of clear boundaries between labour markets, social policy and the family.

Over the last three decades, Nicaragua has undergone radical changes in its political and economic system. The early 1980s represented a honeymoon, following the Sandinista revolution. The second half of the decade was characterized by the embargo by the United States, counter-revolution, war and the introduction of structural adjustment programmes. The 1990s were marked by reconstruction, a transition to electoral democracy and economic liberalization. Through these three transitions, unpaid work by women, as well as volunteer work and community participation, played a central role in providing care services.

During the 1980s, the Sandinista revolution significantly expanded education, health and care services, underpinned by a vision that social services should be provided by a strong centralized state serving the population as a whole. This expansion depended mostly on organizing and mobilizing volunteer workers. Moving away from this vision, the liberal governments of the 1990s promoted a subsidiary role for the state, with respect to both the market and households. Specifically, this meant the decentralization and targeting of services, as well as increased marketization of access through co-payment arrangements. These neoliberal changes also relied on large-scale efforts to mobilize unpaid women workers, recruit volunteers and encourage community participation.

During the period studied in this paper—from the 1980s to the 2000s—the role of the state was, in various ways, subsidiary to that of unpaid, volunteer and community work, providing only rudimentary support. First, only the most basic social services were provided by the state (in the area of health services, for example, only primary care was offered), and coverage was far from adequate. Second, households and communities played a more dominant role than did public institutions. Third, most public programmes were dependent on strong family and community participation.

Drawing on statistical sources, official documents and secondary sources, this paper explores the general features of the Nicaraguan social policy regime, in terms of both social spending and the principal components of education, health, social protection and actual care services. On the basis of 54 interviews with women and men from two very different municipalities—Managua and Estelí—the paper describes the prevailing care practices, interpreting them in the

light of available time use statistics. Finally, it discusses the mix of public, market and family care practices in the context of the findings.

Juliana Martínez Franzoni is Professor at the School of Political Science and researcher at the Institute of Social Research, University of Costa Rica. Carmen Largaespada-Fredersdorff is a Nicaraguan sociologist working on social policy, childhood and adolescence, women and family in Nicaragua, Mexico and Canada. Karime Ulloa is a doctoral candidate in Social Sciences, Childhood and Youth at the University of Manizales, in Colombia. Koen Voorend is lecturer at the School of Communication of the Faculty of Social Sciences and researcher at the Institute for Social Research at the University of Costa Rica.

Résumé

Le Nicaragua est le deuxième pays le plus pauvre de l'hémisphère occidental. Son produit intérieur brut (PIB) est extraordinairement bas (\$958 par habitant), et les fonds envoyés par les familles émigrées aux Etats-Unis et au Costa Rica constituent sa principale source de revenu. Soixante-dix pour cent de la population vit en dessous du seuil de pauvreté, et deux personnes sur 10 sont analphabètes. De nombreux ménages ont pour chef des femmes, qui sont à la fois dispensatrices de soins et de revenus. De plus, le Nicaragua est très exposé aux catastrophes naturelles (et sociales) telles que les ouragans et les tremblements de terre. Dans cette réalité complexe, comment les pratiques sociales du ménage, de l'Etat, de la communauté et des marchés se combinent-elles pour fournir des services de soins et en particulier assurer la garde des enfants?

Le pays a un passé historique socialiste. Mais le nombre de ceux qui bénéficient d'une protection et de services sociaux est limité par l'insuffisance des fonds publics qui y sont affectés. Même lorsque le modèle appliqué était celui de la substitution des importations et que la protection sociale publique était en progression, seul un quart de la population en bénéficiait. Actuellement, le bien-être de la population dépend dans une large mesure des stratégies imaginées par les familles pour obtenir des revenus et se constituer des réseaux de protection sociale. La forte dépendance à l'égard de l'émigration et des fonds envoyés de l'étranger, la transformation des familles en unités de production et la confiance faite aux réseaux sociaux comme moyen de subsister en cas de maladie et d'autres circonstances imprévues montrent bien l'absence de lignes de démarcation nettes entre les marchés du travail, la politique sociale et la famille.

En trente ans, le système politique et économique du Nicaragua s'est radicalement transformé. La révolution sandiniste a été suivie d'un état de grâce au début des années 80. La deuxième partie de la décennie a été marquée par l'embargo des Etats-Unis, la contre-révolution, la guerre et l'introduction des programmes d'ajustement structurel. Les années 90 ont été celles de la reconstruction et de la transition vers la démocratie électorale et la libéralisation économique. Pendant ces trois transitions, le travail non rémunéré des femmes, le bénévolat et la participation des habitants ont tenu une place centrale dans la prestation des services de soins ou de garde.

Pendant les années 80, la révolution sandiniste a sensiblement étendu les services dans les domaines de l'éducation, de la santé et des soins ou de la garde des enfants. Elle était en effet animée par l'idée que les services sociaux devaient être fournis par un Etat fort et centralisé au service de la nation tout entière. Pour garantir cette expansion, elle comptait surtout sur les travailleurs bénévoles qu'elle entendait organiser et mobiliser. Tournant le dos à cette conception, les gouvernements libéraux des années 90 ont privilégié la subsidiarité de l'Etat, par rapport à la fois au marché et aux ménages, ce qui s'est traduit par la décentralisation et des services ciblés, ainsi que par une marchandisation accrue de l'accès aux services par des systèmes de partage des paiements. Ils ont aussi mené une action de grande ampleur pour faire travailler les femmes sans les rémunérer, recruter des volontaires et encourager la population à participer à la prestation des services.

Pendant la période examinée dans ce document—qui va des années 80 aux années 2000—le rôle de l'Etat a été, à bien des égards, subsidiaire par rapport au travail fourni par une main-d'oeuvre non rémunérée, les bénévoles et la population. Premièrement, en n'assurant que les services sociaux les plus élémentaires (par exemple, dans le domaine de la santé, les soins primaires uniquement), et encore à une population très limitée, l'Etat n'a apporté qu'un appui rudimentaire. Deuxièmement, la part prise par les ménages et les collectivités l'emportait nettement sur celle des institutions publiques. Troisièmement, la plupart des programmes publics comptaient sur une forte participation des familles et de la population en général.

A partir de sources statistiques, de documents officiels et de sources secondaires, les auteurs de ce document cherchent à dégager les grands traits des politiques sociales nicaraguayennes, en ce qui concerne tant les dépenses sociales que les principales composantes que sont l'éducation, la santé, la protection sociale et les services de soins et de garde proprement dits. Sur la base de 54 entretiens avec des femmes et des hommes de deux municipalités très différentes—Managua et Estelí—elles décrivent les pratiques les plus répandues en matière de soins et de garde, en les interprétant à la lumière des statistiques disponibles sur l'emploi du temps. Enfin, elles commentent, dans leurs conclusions, l'organisation des soins et de la garde entre le secteur public, le marché et la famille.

Juliana Martínez Franzoni est professeur à l'Ecole de science politique et chercheuse à l'Institut pour la recherche sociale de l'Université du Costa Rica. Carmen Largaespa-Fredersdorff, nicaraguayenne, est sociologue et travaille sur la politique sociale, l'enfance et l'adolescence, les femmes et la famille au Nicaragua, au Mexique et au Canada. Karime Ulloa est doctorante en sciences sociales et étudie les questions de l'enfance et de la jeunesse à l'Université de Manizales, en Colombie. Koen Voorend est chargée de cours à l'Ecole de communication de la Faculté des sciences sociales et chercheuse à l'Institut pour la recherche sociale de l'Université du Costa Rica.

Resumen

Nicaragua es el segundo país más pobre del hemisferio occidental. El producto interno bruto (PIB) es excepcionalmente bajo (USD 958 per cápita), y su principal fuente de ingresos son las remesas enviadas por familiares emigrantes que trabajan en los Estados Unidos o Costa Rica. Setenta por ciento de la población se encuentra bajo el umbral de pobreza y dos de cada 10 personas son analfabetas. Muchos de los hogares están encabezados por mujeres que están a cargo del cuidado al tiempo de trabajar remuneradamente. Además, Nicaragua es un país muy sensible a desastres naturales y sociales tales como huracanes y terremotos. Dentro de este contexto complejo, ¿cómo se combinan e interactúan las prácticas sociales dentro del hogar, el estado, la comunidad y el mercado para proporcionar servicios de cuidado, en particular a los niños?

Históricamente, este país se ha caracterizado por ser un estado social con niveles inadecuados de inversión pública en la protección social y servicios sociales que han resultado en una cobertura limitada. Vale decir, que aún bajo el modelo de la sustitución de importaciones y durante el periodo que el estado aumentó la protección social, únicamente una cuarta parte de la población estaba cubierta. Actualmente, el bienestar de la población depende en gran medida de estrategias familiares orientadas a generar ingresos y a construir redes de protección social. La alta dependencia de la emigración y el envío de remesas; el autoempleo mediante la transformación de las familias en unidades productivas; y las redes sociales para hacer frente a enfermedades y situaciones imprevistas, demuestran la ausencia de una división clara entre los mercados laborales, la política social y las familias.

Durante las últimas tres décadas, el país atravesó cambios radicales en su régimen político y económico. Durante la primera mitad de los 80 Nicaragua vivió la luna de miel de la revolución sandinista. La segunda mitad estuvo caracterizada por el embargo de los Estados Unidos, la contrarrevolución, la guerra y el inicio de los programas de ajuste estructural. Los años 90

fueron marcados por la reconstrucción, la transición democrático-electoral, y la liberalización económica. A lo largo de estas tres transiciones, el trabajo femenino no remunerado, así como el trabajo voluntario y la participación comunitaria tuvieron un papel central en la prestación de servicios de cuidado.

Durante los años 80, la revolución sandinista expandió notoriamente los servicios de educación, de salud y de cuidado bajo la visión de que los servicios sociales debían ser prestados por parte de un estado fuerte y centralizado, que se dirigía a la población en general. Esta expansión se llevó a cabo, en gran medida, mediante la organización y la movilización de trabajo voluntario. Fue en contra de esta visión del estado, que los gobiernos liberales de los años 90 promovieron una concepción subsidiaria del Estado, tanto con respecto al mercado como al hogar. Esto se hizo mediante la descentralización y la focalización de los servicios, así como un aumento de la mercantilización en el acceso por medio de los llamados copagos. Estas transformaciones de signo neoliberal se hicieron también a partir de una gran movilización del trabajo femenino no remunerado, el trabajo voluntario y la participación comunitaria.

Durante el período estudiado, la presencia estatal fue subsidiaria y residual al papel del trabajo no remunerado, voluntario y comunitario y eso en varios sentidos. Primero, porque los recursos y servicios sociales públicos disponibles fueron realmente básicos (por ejemplo, en materia de salud, sólo atención primaria) y la cobertura muy insuficiente. Segundo, porque la participación de los hogares y comunidades fue muy alta comparada con la del aparato público propiamente dicho. Tercero, porque la contrapartida familiar y comunitaria fue un requisito para el funcionamiento de la mayoría de los programas públicos.

A partir de fuentes estadísticas, documentos oficiales y fuentes secundarias, este documento presenta en primer lugar las características generales del régimen de política social nicaragüense, tanto en términos de gasto social como de sus principales componentes (educación, salud, protección social y servicios de cuidado propiamente dichos). Además, a partir de 54 entrevistas con mujeres y hombres de dos municipios contrastantes (Managua y Estelí), el estudio describe las principales prácticas asociadas al cuidado y las interpreta a la luz de las estadísticas disponibles sobre el uso de tiempo. Finalmente, en vista de los resultados, discutimos los principales rasgos que tiene la mezcla de prácticas públicas, mercantiles y familiares en materia del cuidado.

Juliana Martínez Franzoni es docente de la Escuela de Ciencias Políticas e investigadora del Instituto de Investigaciones Sociales de la Universidad de Costa Rica. Carmen Largaespada-Fredersdorff es una socióloga nicaragüense especializada y activa en temas relacionados con la política social, niñez y adolescencia, mujer y familia en Nicaragua, México y Canadá. Karime Ulloa es estudiante del doctorado en Ciencias Sociales, Niñez y Juventud de la Universidad de Manizales en Colombia. Koen Voorend es profesor universitario de la Escuela de Ciencias de la Comunicación Colectiva de la Facultad de Ciencias Sociales e investigador del Instituto de Investigaciones Sociales de la Universidad de Costa Rica.

Introduction

Nicaragua is the second poorest country in the western hemisphere. Its gross domestic product (GDP) is exceptionally low (\$958¹ per capita), and the main source of national income is remittances from family members who emigrated to the United States or Costa Rica. Seventy per cent of the population lives below the poverty line; two out of every 10 individuals are illiterate, and a high percentage of households (45 per cent) are headed by women. Furthermore, Nicaragua has been very vulnerable to natural and social disasters such as hurricanes and earthquakes. Within this complex reality, how do the social practices of families, the state, businesses and communities combine and interact to provide care services, particularly for children? This paper sets out to explore the mix of care arrangements—market, public, community or family-based (namely, the “care diamond”)—in Nicaragua through a combination of institutional analysis and focus group discussions with a cross-section of Nicaraguans. The analysis compares the care policy regime that was put in place between 1990 and 2006 against the legacies of the Sandinista revolution that led the country during the 1980s. In 2006, the Sandinista Liberation Front won the national elections and regained office. However, as shown by the social practices presented below, when it comes to care, policy shifts have not yet started to impact on people’s everyday lives.²

Historically, the country has been characterized by a social state with inadequate levels of public investment in social protection and services, with the result that coverage has been very limited (Filgueira 1998). Even under the import substitution model and during the period when the state was expanding the reach of social protection, actual coverage did not increase beyond one-quarter of the population. Currently, survival largely depends on family-oriented strategies to generate income and build social safety nets. The high dependence on emigration and remittances from migrants, 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 welfare regime with highly informal practices of resource allocation (Martínez Franzoni 2008), which is very different from both the state-centric welfare regimes found in some Latin American countries (such as Costa Rica or Chile), and the familial regimes of Mediterranean Europe.³

Reconstructing the care diamond requires a combination of two approaches: a social policy-oriented approach that is state-centric (following the tradition of social policy research on welfare states) with a more diversified or society-centric understanding of how social reproduction takes place where other social institutions often work independently of, or in conjunction with, state action. Here it is important to distinguish between the social policy regime and the care regime. While the two often relate to the same set of policies and are closely related, there are in fact important differences, especially in the context of Nicaragua, as will be shown below. While the social policy regime stresses the role of public policy, the care regime goes beyond public policy and rests largely on practices that are not directly related to the state. These include not only social programmes by the state or non-governmental organizations (NGOs), but also the role of the community and the family outside these programmes.

One of the main contributions of this paper is to bring together existing data and evidence on a country that has been little researched in the social policy area. This is especially important in light of the lack of data sources on the topic.

¹ All \$ figures refer to US dollars.

² It could be argued that the time lag has been too short to allow new policies to translate into actual practices.

³ In Mediterranean Europe, the state makes demands on the families for the provision of unpaid care, and not necessarily for employment and income-generation. In Nicaragua, however, families play a dual role, both in generating self-employment (both inside and outside of the country) and as care-providers to offset the weakness or absence of public social services.

Nicaraguan social policy and the care regime have some very unique features. The two that stand out are, first, the high levels of dependence on external sources of funding, mainly taking the form of overseas development assistance (ODA) which is channelled through both state and non-state actors (especially NGOs). This dependence brings with it institutional discontinuities, programme duplication and ultimately a waste of resources. An exception to this policy discontinuity can be found in the arena of health care provision, which has not relied on external sources of funding to the same extent. Second, throughout the past decades, and despite the many changes in political leadership, one constant fact has been the heavy reliance on unpaid work, which has been the main pillar holding up the social policy and care regimes. More specifically, voluntary work, mostly conducted by women, has been the essential ingredient of even some of the presumably publicly provided social programmes.

In characterizing the care regime and reconstructing the care diamond in Nicaragua, this paper first presents the general features of the Nicaraguan social policy regime, including changes in social spending, based on existing data sources. Second, using available institutional documentation and secondary sources, it addresses the main components of the social policy regime that relate to care—namely, education, health care, social protection and care services. Third, based on focus groups, it examines the social practices involved in childcare, and relates them to the care diamond by triangulating the qualitative study with the institutional analysis and statistical data on time use studied by Espinosa (2008). Finally, based on these findings, it discusses the nature of the care diamond in Nicaragua.

The Nicaraguan Social Policy Regime

This section describes the general features of the social policy regime, examining patterns of social expenditure over time, and across different subsectors. It considers four components of the social policy regime: education, health, fiscal transfers (including pensions) and care services.

General features

The design of economic and social reforms in Latin America over the past two decades has been heavily influenced by the ideas associated with the so-called Washington consensus. In terms of social policy, the reforms encouraged privatization, decentralization, targeting of social expenditure and greater participation by the private sector. Central to this approach were the concepts of limiting the state's social responsibilities to compensation 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 adoption of actual public policies reflects how these general policy principles have been mediated through power relationships and "domestic filters", in conjunction with the particular historical background and social policy trajectories.

During the 1980s the Sandinista revolution significantly expanded the provision of social services, including education, health and childcare, which was underpinned by the Sandinista vision that aimed to use a strong centralized state in order to expand social services to the entire population. This was carried out, in large measure, by organizing and mobilizing an army of volunteers. A sharp contrast with the Sandinista vision was that of the liberal governments of the 1990s, which promoted decentralization and the targeting of services, along with higher degrees of privatization through co-payments as requirements for access.

In the current exclusionary 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 health care rather than 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. Most of the current programmes require the

beneficiary populations, their families and communities, to contribute via volunteer work and, in some instances, to make co-payments. Most social programmes, including those that are formally universal, tend to be used by the poor. However, although the poor are the majority of the population, coverage is usually rather limited. In general, the familialistic nature of Nicaragua's exclusionary welfare regime means that a relatively small proportion of the population in need of services actually can access those services.

As elaborated in this paper, care provision is heavily defined by social practices that have little to do with explicit state policies. Nevertheless, to bring about transformations in care provisioning requires an appreciation of the potential role and importance of state institutions, including those which are explicitly aimed at care (such as childcare centres), as well as other institutions such as primary schools, which play an important care role, even if they are designed to meet other purposes (for example, education).

Changes in social spending

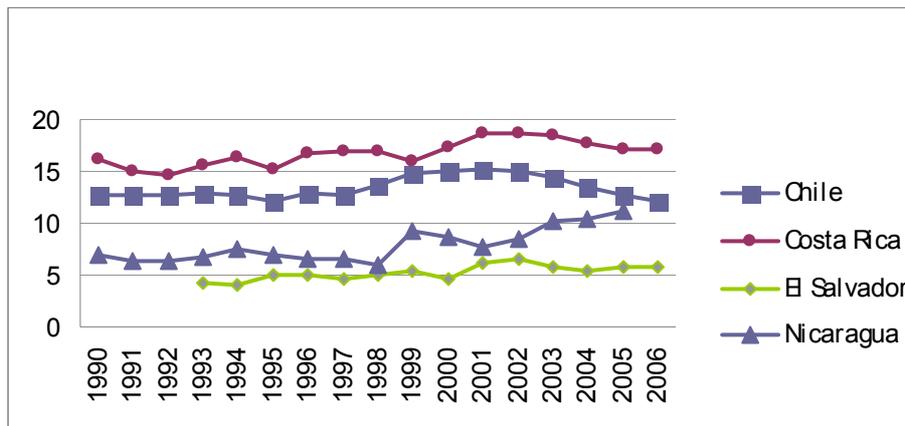
If the 1980s was the "lost decade" in terms of social development for Latin America, for Nicaragua it was the 1990s. However, even if the legacy of war affected the implementation of the state's vision, and the launching of a liberal political regime re-positioned the state as being subsidiary to both markets and families, the 1990s witnessed an increase in public social spending. Below, changes in public social spending are examined using three different indicators: first, social spending as a percentage of GDP; second, social spending as a percentage of total public spending; and third, public social expenditure per capita. In order to ensure that the figures were comparable with those of other countries in the region, data from the Economic Commission for Latin America and the Caribbean (ECLAC) were utilized. Nicaragua's public social spending is also compared to that of Chile and Costa Rica (which can be characterized as having state-centric social policy regimes) as well as El Salvador (with a more familialistic welfare regime, similar to Nicaragua's). These comparisons allow an evaluation of Nicaragua's performance not only in absolute terms, but also in relation to other countries in the region, including those with a similar profile (El Salvador).

Public social spending as a percentage of the GDP increased over the period, from 6.9 per cent in 1990 to 11.2 per cent 15 years later (2005), with the increase becoming sharper in 1998 (see figure 1). Having 1990 as the baseline is problematic: the country had been at war and in the midst of a deep economic crisis. As a percentage of GDP, Nicaragua's entire investment in social policy is comparable to what Costa Rica spends on one specific sector alone (for example, education or health). Given that Costa Rica is far from adequately dealing with social demands, the gap gives a sense of how insufficient Nicaraguan social spending is. In addition, because the Nicaraguan gross national product (GNP) is so small, in absolute terms, social spending is the lowest of all Central American countries.

Per capita social spending over the same period, however, doubled from \$45 to \$95 (see figure 2). Figure 2 shows that per capita public social expenditure dropped during the early part of the 1990s (under Violeta Barrios de Chamorro's government), remained constant during the second half of the decade (Arnoldo Alemán's government) and then increased sharply from 2001 (with the Enrique Bolaños government). Resources were allocated almost equally to education and health, while much less was spent on housing (see figure 2). There was a lack of data on social security (see below).⁴

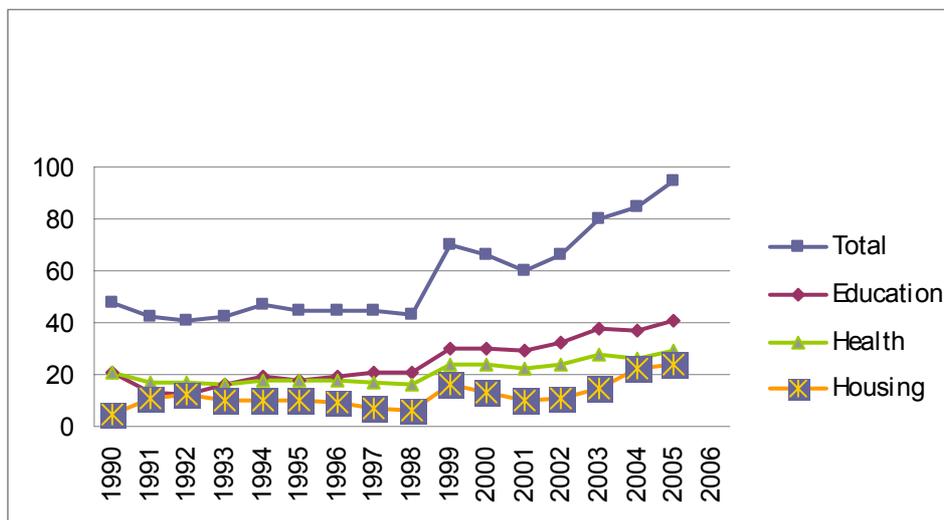
⁴ As a general rule, the components of social spending should be regarded with caution. An exhaustive review of official data preceding the Estrategia Reforzada de Crecimiento y Reducción de Pobreza (ERCERP) and the Plan Nacional de Desarrollo (PND), which is discussed later in this paper, showed, for example, that subsidies going to public transportation in the city of Managua were (and continue to be) classified as "poverty"-related expenditure under the more general rubric of social protection. This classification is questionable, since Managua has the lowest rate of poverty in the country (note by Largaespada-Fredersdorff).

Figure 1: Public social spending as a percentage of GDP, 1990–2006



Source: CEPALSTAT.

Figure 2: Nicaragua: Evolution of per capita social spending, 1990–2006 (in 2000 dollars)



Source: CEPALSTAT.

Also, in terms of per capita social spending on health, the country performs only slightly better than it did in 1990 (\$8), which might more appropriately be considered stagnation. The biggest changes occurred in the areas of education and housing—by \$20 and \$19 per capita, respectively. Both overall per capita social spending and the disaggregated figures are central to the assessment of the effectiveness of the large number of programmes that are 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-centric welfare regimes such as Costa Rica (which spent \$250 per capita in 2006), as one would expect, is enormous, but the gap with El Salvador is also vast. Indeed, in 2005, El Salvador spent close to \$63 per capita on education, compared to Nicaragua’s \$41.

During the period under consideration, external funds played an important role in financing social policy. First they decreased and then changed in composition (mainly with loans replacing donations). In health, external loans were received in the second half of the 1990s. A large part of the additional resources were used to finance reconstruction—first of health centres and later of hospitals. In education, loans were also directed toward the financing of a decentralized “Chilean” model of education. The increase in public social spending in the area of housing in 1999 was due to a loan from the Inter-American Development Bank (IDB) for the reconstruction of rural housing in the wake of Hurricane Mitch (1998).

As already noted, there is no data on social security spending. This reflects the absence of formal social protection mechanisms on a significant scale for risks such as old age, disability and death, despite an existing pay-as-you-go pension regime.⁵ Those who contribute to the pension plan are not automatically obliged to also contribute to health insurance, but are given the option to do so if the health care services provided by the Social Security Institute (INSS) are available in the area where they live. Thus, there are some individuals with comprehensive coverage for disability, old age, occupational risk and health care, while others have only limited coverage. During the period studied, there were no non-contributory 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 (for example, for war victims 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.

There is, however, data on the total population reached by the pension system. Although coverage was already low in 1993 (when data was first available), it had declined even further by 2001: from 22 per cent to 17 per cent for men, and from 28 per cent to 22 per cent for women. Women with formal jobs have continued to have higher coverage rates than men: provided with the opportunity, they seem to value coverage more. Pensions reach almost twice as many people as does the health insurance system, which in 2001 reached 7.9 per cent of the total population. For the purpose of this study, it is worth noting that health care provided under the social security system only targets children up to 12 years of age. Sixty per cent of Nicaragua's population relies on public, non-contributory, health services which can barely reach them with adequate care (Mesa-Lago 2008).

More recent data shows that this trend has continued. In 2004, private and public contributory pension systems were estimated to cover 16.4 per cent of the labour force, about twice as much as in the case of health care, which in 2001 covered 7.9 per cent of the labour force (Mesa-Lago 2008). In contrast to most countries in the region, the majority of the insured are workers in the private sector.⁷

Returning now to an analysis of total social spending as a percentage of total public spending, figure 3 shows that social spending rose considerably as a proportion of total public expenditure: from 32.5 per cent in 1990 to 40.2 per cent in 1994 and 41.8 per cent in 2004–2005, with a decline between 1995 and 1998 and another smaller decline in 2000–2001, when Nicaragua joined the Highly Indebted Poor Countries (HIPC) Initiative for debt forgiveness. Despite the overall increase in social expenditures over the period, they remain low in comparative regional terms.

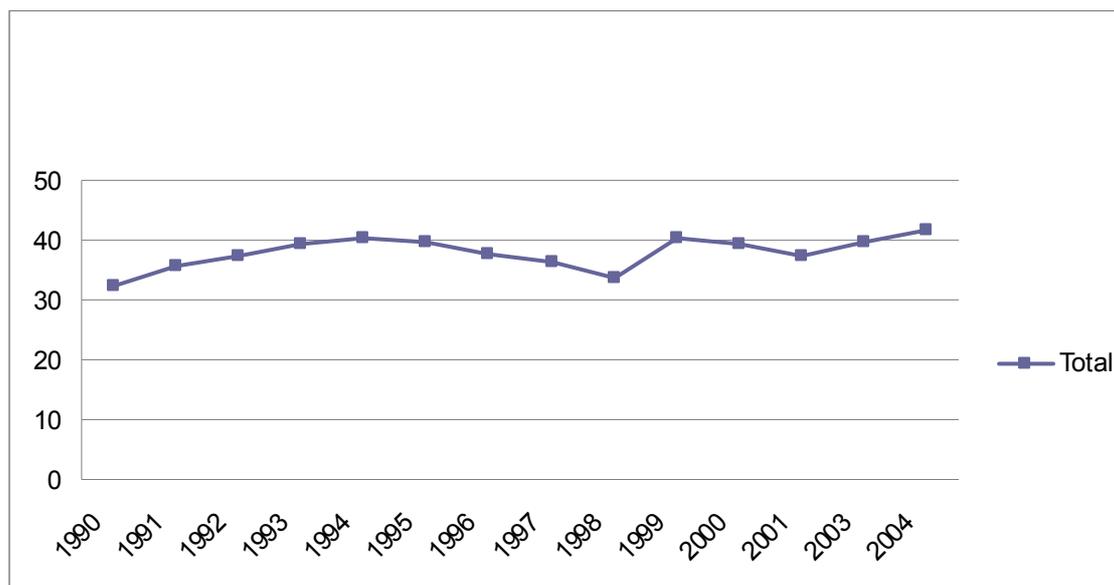
The country's educational system has a public and a private sector, financed respectively with public resources and out-of-pocket payments. The social security regime funds pensions and health care services. As will be shown, the nation's health care system combines social security with private sector services and public and community services, creating a highly stratified and uncoordinated system (Mesa-Lago 2008). Although the pension system includes a private component, it is inconsequential, leaving serious gaps in protection in many cases. Education, health care 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.

⁵ There was an attempt to replace the pay-as-you-go regime by an individual capitalization 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 their ministries (Rodríguez 2005).

Figure 3: Nicaragua: Public social spending as a percentage of total public spending, 1990–2006



Source: CEPALSTAT.

Institutional change and social policy

This section presents some of the key features of social policy in Nicaragua. Social policy is often placed within the context of externally imposed Structural Adjustment Programmes (SAPs). In Northern countries, studies on social policy, welfare and care regimes can assume that adequate and capable institutions exist, within which policies are embedded. However, in the South in general and in Nicaragua in particular, the appropriate public institutions for implementing public policies are often lacking. 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 precarious nature and instability of institutions was further exacerbated by the demands of external actors in shaping policies, which often came as “conditionalities” attached to the funds they were providing.

During the 1990s, policies clustered under the labels of “social protection” or “human capital” emerged, closely associated with the World Bank’s risk management approach, which was also shared by the government of Nicaragua. Minimal social investment – mainly in basic health and education services, and care of vulnerable children – was promoted. Social policy was to be residual and the state would intervene as little as possible. Instead, the market would be left to arrange social protection, premised on the idea that the generated revenues would bring about economic growth, which would in turn trickle down to the entire population.

Before focusing on policy components, the developments under each of the five presidential administrations that governed during the period summarized below in table 1 are briefly outlined. 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 Instituto de Bienestar y Seguridad Social (INSSBI) (Largaespada-Fredersdorff 2006a).

Table 1: An overview of the main changes in the Nicaraguan social policy regime

Programme/institution	Period	Components	Funding source	Formal coverage
Ministry of Social Welfare	Sandinista government, early 1980s	Implementation of the Revolution's social policy	Government	Universal
INSSBI	Sandinista government, 1983	Functions of Ministry of Social Welfare transferred, due to lack of financial sustainability	Government	Universal
National Human, Child and Youth Development Plan 1991–2005 (never formalized as law)	Barrios de Chamorro government, 1991–2005	Merging of social policy under a single strategy that united sectors and programmes, focusing on human capital	Government, with support from Sida, UNDP and UNICEF	Targeted to people living in extreme poverty
Creation of the Ministry of Social Action	Chamorro government, 1993	Coordination of activity of social institutions in the executive branch	Government	–
Social agenda Including: Nicaraguan Social Investment for Emergencies (FISE)	Chamorro government, 1993	Universal programmes, basic education and health services and activities targeting particularly vulnerable groups. Community involvement encouraged	Government	Universal combined with targeted
Social Policy (replaces Social agenda) Social cabinet formalized	Alemán government, 1997	Formulation of policies for institutional sectors. Proposed to eradicate extreme poverty, increase coverage and quality of public services and social investment to human capital. Community participation formalized	Government	–
ERCERP	Alemán government, 2001	Promotion of economic growth with jobs, focusing on human development, protection of the vulnerable, and institutional governance and development	Government, with support from the International Monetary Fund (IMF)	Targeted to population living in extreme poverty, mainly focusing on human capital
National Development Plan (as revision of ERCERP)	Bolaños government, 2002	Adjustments to the ERCERP, incorporating focus on other economic strategies (not only growth), a long term vision, and specific medium-term targets	Government	Targeted to population living in extreme poverty, mainly focusing on human capital

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 (Government of Nicaragua 1991). Although it was based on existing programmes, on identifying major institutional problems and taking advantage of institutional experience in the social sector, the plan was never formalized as law. According to the Minister of the Economy at the time, 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 administration 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 applied—social policy of the Sandinistas could not be financed.

Thus, there was a change of direction. Priority was placed on growth and employment, with social spending occupying only a supplementary and compensatory role.

With the advent of peace, the government faced demands for land, work, food and housing, especially from demobilized groups.¹⁰ The social agenda emphasized responding to these demands in order to achieve demobilization. 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 was created to coordinate the activities of social institutions in the executive branch, which were organized under the umbrella of the so-called Social Cabinet. The government's social agenda was presented that same year, formalizing the action that had been in progress for three years: universal programmes (namely, basic education and health services) and activities targeting particularly vulnerable groups, defined primarily in the post-war context and in relation to the ongoing peace efforts. The social agenda was closely related to the care of children, since in addition to poverty and vulnerability, priority was given to malnourished children and those living in especially difficult circumstances.

During this period the importance of health and education was underlined with the recovery of the educational infrastructure which had been destroyed during the war. The Fondo de Inversión Social de Emergencia (FISE) was created in order to finance the reconstruction of the social infrastructure. This fund was similar to others in the region, 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—became indispensable in the areas of health and child protection both from the point of view of the new administration and that of the Sandinista opposition. For the Barrios administration, the social agenda's vision of decentralization as the principal means of public policy implied a rapid and radical institutional reform in the education sector, and with similar features in the area of health. Due to the financial constraints (and the reduced size of the state) imposed within the framework of the IMF's SAP, community involvement was seen as vital. For the Sandinistas, on

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

⁹ A rejection of centralized power and of the politicization of state institutions accompanied this.

¹⁰ 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 them primarily through land distributions and repurchases of weapons (Armony 1997).

the other hand, community involvement defended the legacies of the revolution and effort in mobilizing the population “from below”.

During the Alemán government, in 1997, the social agenda was replaced by what is now termed “Social policy”, and the formulation of policies for each institutional sector began. Also, the existing Social Cabinet was formalized under this administration (Asamblea Nacional de la República de Nicaragua 1997). 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 toward 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, but the Programa de Servicios Básicos Integrados (PROSERBI) was eliminated and new programmes emerged, such as the Programa de Atención Integral a la Niñez Nicaragüense (PAININ) and the Red de Protección Social (RPS).

Community participation became an official policy element under the new Social Policy, which set forth the responsibilities of the state and those of civil society. It defined the government in its operational role as a “facilitator”, and established the rights and obligations of society in general and of 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 Estrategia Reforzada de Crecimiento Económico y Reducción de Pobreza (ERCERP 2001), in the framework of the HIPC Initiative. This approach rested on four pillars. The first pillar was economic growth with jobs, based on increased production and on promoting the rural economy. The second was social investment, with a focus on human development. The third was the protection of the most vulnerable groups, and the fourth, institutional governance and development. Thus, regardless of whether or not one agreed with the state’s vision of 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 analysing 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. Also, a critical review of existing programmes and projects was carried out in order to establish their relevance and to reorient public investment where necessary.

In 2002, the Bolaños administration carried out a review of the ERCERP, focusing particularly on the strategies used to promote economic growth for poverty reduction. The administration recommended a redefinition—instead of being based on a single macroeconomic approach, it suggested incorporating various methodologies, based on the productive potential of distinct regions of the country. In this context, social policy was to continue to promote the formation of human capital and social protection through interventions targeted at vulnerable groups. This review culminated in 2003 with the elaboration of the Plan Nacional de Desarrollo (PND).¹¹ For the first time in Nicaraguan social policy, at least on paper, a long-term vision (until 2050) was built in, defining medium-term targets and estimating their costs. For example, the existing gap

¹¹ The PND had a section on Human Capital Development and Social Protection which pursued a united protection of the most vulnerable population through education, health and nutrition, training and education, and social protection. This will be addressed below.

between the social policy sector demands and the available budget (under the SAPs agreed with the IMF) was estimated. By 2010, the financial gap between what would be required and what would be available was estimated to be \$180.5 million.

During the Bolaños administration, the contribution of voluntary health personnel was officially recognized through the payment of stipends (calculated on the basis of transport costs incurred by the volunteer to arrive at the worksite), mainly provided by NGOs. Recognition also came in the form of T-shirts, hats, rubber boots, basic medical equipment or stickers.

This section has outlined the successive efforts that were designed to orient Nicaragua's social policy regime since 1990. In sharp contrast to the most studied countries in Europe and North America, the state's reorganization was extremely fast in Nicaragua. It was not inhibited by the party system or by civil society organizations, and was heavily influenced by external actors such as the IMF.

Principal Components of the Care Regime

This section describes the principal components of the Nicaraguan care policy regime. It identifies and summarizes the major programmes and projects that have been carried out and that best reflect the state's role in the care regime. It first presents the programmes related to childcare, and then addresses complementary services in the area of food and health provision, as well as the latest programmes in health education, within the framework of the conditional cash transfer programme.

Care services for children under six years of age

It is important to distinguish two types of childcare programmes: preschools and programmes that are explicitly termed childcare services. The former cater for children between three and five 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 Centros de Desarrollo Infantil (CDI) or the Centros Infantiles Comunitarios (CICOs), and are dependent 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 coverage of these centres between 1993 and 2005. Data from the four measurements are only relatively comparable due to changes in the sample in 1998 and 2005.¹² In other words, absolute numbers cannot be compared.

Despite these limitations, the analysis of the data is very useful, demonstrating that only three out of every 10 children under the age of six have access to some form of childcare service. Data also shows a slight increase in coverage between 1998 and 2001, from 19 to 22 per cent. Here data is comparable, as the sample remained the same for the two years. Finally, findings indicate that coverage remained the same in 2005 (at 22 per cent). However, given the change in the sample that was introduced in 2005 (to make it more representative of each department), actual coverage may even have increased slightly.

¹² In 1998, the 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 2: Coverage of care centres among children below 6 years of age
(absolute numbers and percentage)

Care centre	1993		1998		2001		2005	
	Children	Per cent						
Total	601,811	100	787,375	100	762,993	100	653,876	100
Attend	74,931	12	151,854	19	167,152	22	143,829	22
Do not attend	526,880	88	635,521	81	595,628	78	509,958	78
Ignored	–	–	–	–	213	0	89	0

Source: Based on household surveys (1993, 1998, 2001, 2005).

Table 3 shows the relative importance of each type of institution between 1998 and 2005, the 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 seven years old. The figures demonstrate that there was no expansion in childcare coverage for preschools or CDIs. While the coverage of preschools remained between 17 and 18 per cent, coverage of CDIs remained around 1 per cent. Primary school coverage did not change significantly, going up slightly in 2001, but decreasing to 1 per cent again in 2005. This means that the highest rate of coverage was for children aged five (18 per cent for pre-schools, 3 per cent for school canteens and 1 per cent for schools), while only 1 per cent of children *under* five years of age was covered (infant care or CDIs with 1 per cent of coverage).

Table 3: Coverage of care centres among children below 6 years of age, by type of centres and year (absolute numbers and percentage)

Care centre	1998		2001		2005	
	Children	Per cent	Children	Per cent	Children	Per cent
Total	787,375	100	762,993	100	653,876	100
Infant care (CDIs)	6,926	1	7,075	1	5,010	1
Children's canteen	–	–	10,746	1	17,206	3
Preschool	128,205	16	128,875	17	116,028	18
School	16,723	2	20,456	3	5,585	1
Does not attend	635,521	81	595,628	78	509,958	78
Ignored	–	–	213	0	89	0

Source: Based on household surveys (1998, 2001, 2005).

Table 4 shows the evolution of the coverage of childcare centres according to families' income level and by rural and urban location. The distribution according to income levels has been fairly stable and remarkably uniform: in 1998 and 2001, coverage was distributed among the five income groups fairly equally (around 20 per cent). The results are similar for 2005, although there is slightly more variation across income quintiles (ranging between 18 and 23 per cent). However, the coverage varies considerably by location. In the urban areas coverage is better in the higher socioeconomic groups (in the top quintile it stood at 26 per cent in 1998 and rose to 30 per cent in 2005), while coverage in the bottom quintile was only 14 per cent in 1998 and dropped to 12 per cent in 2005. In contrast, in rural areas, the coverage reached 29 per cent in the lowest income quintile in 1998 and stood at 27 per cent in 2005, while in the higher income quintile it was only 8 per cent, both in 1998 and in 2005. In short, data indicate that coverage is progressive in rural areas and regressive in urban ones.

Preschool education and childcare centre programmes and the distinct paths are described below.

Table 4: Coverage of care centres among children below six years of age, by income and area of residence *(absolute numbers and percentage)*

	Household income in quintiles											
	Total		Lowest		2nd quintile		3rd quintile		4th quintile		Highest	
	Absolute numbers	Per cent	Absolute numbers	Per cent	Absolute numbers	Per cent	Absolute numbers	Per cent	Absolute numbers	Per cent	Absolute numbers	Per cent
1998												
Total	151	101	29,878	20	28,373	19	31,198	21	32,946	22	29,460	19
	854											
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	99	35,154	21	34,122	20	33,034	20	32,541	19	32,300	19
	152											
Urban	102	100	14,601	14	18,516	18	19,715	19	25,165	25	24,643	24
	640											
Rural	64,512	100	20,553	32	15,606	24	13,319	21	7,376	11	7,657	12
2005												
Total	143	100	25,965	18	32,568	23	29,174	20	26,028	18	30,092	21
	829											
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

Note: Some of the percentages do not add up to 100 per cent due to rounding. **Source:** Based on household surveys (1993, 1998, 2001, 2005).

Preschool education

During the 1980s, the government established the National Action Plan of the Main Project for Primary Education in 1983–1986, following the paradigm of promoting changes that “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).¹³ As part of this plan, preschool education for children up to six years was ardently promoted: the number of children in preschool increased from 32,706 in 1980 to 81,560 in 1988. To maximize coverage, diverse, flexible methods were implemented according to the distinct needs of both educators and communities. A common trait of the methods, however, was to unite parents and community actors. This alliance between families and communities, continued during the 1990s, albeit under a different ideology and statecraft.

Table 5: Overview of the preschool programmes implemented in Nicaragua

Programme	Year	Responsibility	Objective
National Action Plan of the Main Project from Primary Education in 1983–1986	1980s	Ministry of Education	Provide preschool education for children up to six years old
Centros de Extensión Preescolar No Escolarizada (CEPNE)	1980s	Social and community organization that remained after the National Literacy Crusade of 1980, with Van Leer Foundation and the Ministry of Education	Assistance to educators, improvement of educational infrastructure, with donations of food and furniture etc.
Learn project	1995	Government (Ministry of Education) with loan from the World Bank	Technical assistance, supply of materials and financial support to educators in formal and community preschools
PAININ	1998	Fondo Nicaragüense de la Niñez y la Familia (FONIF, later the Ministry of Family)	Continuation of the Learn project, and assumed the recruitment of educators for community preschools

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 Centros de Extensión Preescolar No Escolarizada (CEPNE) programme, using locally available educators with a low level of schooling and with minimum coordination and intersectoral participation requirements. At the onset, an organization called the Van Leer Foundation also participated, providing technical advice, and facilitating the improvement of infrastructure with donations of items such as furniture and food. The centres did not receive any money, and intensive volunteer work from parents was needed to keep the services in operation. The Ministry of Education’s sole contribution was to provide technical assistance and training to the preschool promoters.¹⁴ The education provided under the programme was developed, mainly based on the knowledge and experience gained during the process.

During the 1990s, major developments took place for children, particularly in terms of the formulation of legal and public policies. To a large extent, these changes took place within the context of the international paradigm shift on children, to protect children and establish them as

¹³ Characteristics of the “new man” were: *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; *social and moral*—the development of responsible, disciplined, creative, cooperative, hardworking and efficient individuals with high moral, civic and spiritual principles (Ministry of Education 1982).

¹⁴ Interview with Juan José Morales, National Preschool Education Director from the second half of the 1990s until March 2008, 24 April 2008.

individuals with rights.¹⁵ The recognition of rights, however, conflicted with the macroeconomic stability and subsidiary social policy that prevailed from the Barrios administration onward.

In the 1990s, preschool education increased and diversified its coverage with the involvement of new actors: civil society organizations. In terms of the care model itself, the basic content and implementation were defined¹⁶ with the family and community closely involved in the provision of education. Clearly, the real force behind “families” and “communities” was, and continues to be, mainly women and mothers.

In organizational terms, in 1994, the communal movement took charge of community preschools, while the preschools that functioned in school centres were converted into formal ones. The fundamental difference between the two types is that the latter is physically attached to a school. Their teachers usually have formal accreditation (typically teachers with a degree in primary education), and they receive a salary and benefits from the Ministry of Education. The community preschools, on the other hand, were created where there was a lack of formal preschools. They operate in classrooms attached to primary schools, community halls (for example, in lunchrooms) or in private homes. Teachers are chosen by the community and work as volunteers. They have less training than formal teachers, usually requiring a minimum of sixth-grade primary education themselves and some having eleven months of preschool training. In exchange for their work, they receive “acknowledgments” or “bonuses” that are not recognized as a salary and are typically below the minimum wage. However, there is no evidence to show that the better qualified teachers in formal preschools necessarily offer better care (the definition of good care being itself a complex matter). Both types of preschools are funded by the national budget (although this can also be informally supplemented by international funding bodies), and both are evaluated by the Ministry of Education—although in reality the follow-up is infrequent and ineffective.¹⁷

There is also 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 how to care for their preschool children. Finally, an alternative form of civil society care was to train mothers as educators in their own homes, caring for and providing basic education to their children and other mothers.

In 1995, the government resumed support to formal preschools through the project Learn. This project was financed by a loan from the World Bank and included technical assistance, supply of educational materials, and financial support to educators in formal and community preschools.¹⁸ The World Bank loan stipulated that each educator would attend to between 15 and 25 children, but in rural communities it proved difficult to meet this requirement (in particular, the more dispersed ones, which are also the most impoverished) either because there simply were 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 expanded to between three and six years of age, despite the fact that the institutional platform stipulated that support would be only for children in the third level of preschool (five- to six-year-olds). In order to send their younger children to preschool, many parents demanded facilities closer to home, which resulted in a decrease in the ratio of children to educators (8 to 1). In order to encourage attendance, courses aimed at parents on

¹⁵ Convention on the Rights of the Child. 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).

¹⁶ Interview with Juan José Morales.

¹⁷ This same weak supervision is seen in the private sector. Although, legally, there are established Ministry of Education requirements, in practice, there is no effective supervision.

¹⁸ Interview with Juan José Morales.

childrearing, hygiene, vaccinations, disease, and even prenatal and postnatal care were offered.¹⁹

In 1996, two distinct curriculums were developed: one for public schools, with qualified educators, and one for the non-formal programmes, 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 the Family and Ministry of Education n.d.:60, authors' translation).

In 1998, with the creation of PAININ of the Fondo Nicaragüense de la Niñez y la Familia (FONIF, later the Ministry of the Family), an overlap between programmes in preschool care emerged: PAININ operated on the same structure as that of the existing community preschoolers. In order to cope with the 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 (\$40 compared to \$15 per month, respectively) the majority of teachers wanted to work in the community preschools.²⁰ 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 employees. 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, and has improved its design, 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 partners, 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 regarding the CDI, which will be explained in further detail below, are more positive. It could also be that, in the view of parents and particularly mothers, preschools are not directly associated with childcare because they do not offer services beyond schooling.

Childcare services

In the early 1980s, care services, namely the CDI, were created as part of the social security system, rather than under social assistance. The goal was to increase coverage of infants and children needing care to help working mothers (Largaespada-Fredersdorff 2006b). By caring for children, these services freed the mothers to participate in the labour market. The CDIs offered care, food and early childhood stimulation for children, from almost immediately after birth through preschool age. The rural equivalents of the CDIs were termed Centros Infantiles Rurales (CIRs). In the early 1980s the system served as many as 37,000 children. The CDIs

¹⁹ Interview with Juan José Morales.

²⁰ Interview with Juan José Morales.

charged parents a nominal monthly fee, based on their income (as reported to the social security system).

Ten years later, along with a change in the conception of state responsibilities for the population's well-being, child and adolescent care was separated from social security. This change was reflected in 1993 in the division of the institution responsible for social security – the INSSBI – into two separate institutions: INSS and FONIF. The former focused on insured persons under the contributions scheme and primarily provided health care; the latter targeted the poor and vulnerable populations, and also dealt with complaints concerning child support – complaints that occur in families across economic strata.

Despite the lack of documentation on 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 did decline. According to data from the Ministry of the Family, there were 30 CDIs serving 3,774 children in 2005, a mere 1 per cent of all children under the age of six (Largaespada-Fredersdorff 2006b). A study conducted in 2003 showed that each school was serving only 123 students even though their capacity was much greater (Largaespada-Fredersdorff 2006b). Currently the CDIs care for children from 45 days old to six years, from 6 a.m. to 6 p.m. during the school year. They offer two different forms of early childhood stimulation and preschool education. They also provide lunch and two snacks (morning and afternoon). Children that attend the care centres normally live in families in extreme poverty or that are affected by unemployment, or where the parents work as labourers or domestic workers. Also, the centres accommodate children who have been abandoned by their parents or are at risk. Thus, while the programme was designed for the working population, it ended up targeting poverty and social vulnerability. That said, despite the government funding that programmes receive (transfers from the national lottery), in most cases parents are expected to make financial contributions as well.

Daycare centres were created in 1993, initially under INSSBI, and then under FONIF. They served children from 45 days old to six years, and offered early childhood stimulation, preschool education and food prepared by women volunteers from the community.²¹ The programme also provided for supplementary education and health care activities. In 1994, nearly 90,000 children were reportedly being served – over double the number served by the CDIs, a number comparable to that of PAININ at its peak in 2004. The programme has three care modalities, one for nursing-age infants (45 days to a year old), one for young children (one to three years old) and one for preschoolers (ages four to five) (Largaespada-Fredersdorff 2006b). Although mechanisms to select beneficiaries were not established initially, the high demand led to the following criteria for participation in the programme: the child must have parents with monthly incomes below a certain minimum level; or the child must 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 (Asamblea Nacional de la República de Nicaragua 1997). This defined children as full rights holders, and established the obligations of the state, the family and the community toward them. Second, FONIF became the Ministry of the Family. This change initially gave the organization's work a more moralistic and assistance-based character, rather than one oriented to the social protection of the vulnerable population. According to Max Padilla, one of the first ministers of the family, "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).

²¹ 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, Padilla 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 1998, under the ERCERP, PAININ was launched to look after children under six years of age living in poverty in rural and marginal urban areas. The programme has two modules: one functioning in the CICOs, where staff provide childcare, and the other in Casas Bases (CBs), where travelling staff and volunteer mothers provide care for children and their families (PAININ 2001). Funding came from the IDB,²² and the programme was executed through inter-institutional coordination by the Ministry of the Family, the Ministry of Health and the Ministry of Education. The Comisiones Municipales de la Niñez y la Adolescencia (CMNAs) formed the local entities that promoted and coordinated at the municipal and community level, and functioned as the society's monitoring agent for the projects: managing the 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; and 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 per cent of the children living in vulnerable conditions, defined in terms of exposure to malnutrition and inadequate schooling due to a lack of (preschool) services. PAININ's assessments have shown that the programme has had positive effects in terms of living conditions, childhood development (especially for those under three years of age), children's growth, and childrearing practices with regard to health care and disease prevention and treatment.

Most importantly, evaluations document the role of families and communities in this success: support networks have been key in terms of infrastructure,²³ food, and community and volunteer work. Involvement through support networks improved services delivered by CICOs and reflected the community's commitment to address caretaking as a social responsibility (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 consequent reduction in the fiscal costs of the programme. For example, it may explain the lower costs of PAININ between 1998 and 2001, compared to similar programmes carried out elsewhere in the region.²⁴ The implications of this volunteer support for families, and especially for women, who are already burdened with multiple demands on their time (in the form of wage earning, care responsibility and volunteer work in other state social programmes) is however more ambiguous (and not positive in a simple and straightforward sense).

²² A total of \$27.78 million was collected, of which \$25 million came from an IDB loan and almost \$3 million from the Nicaraguan government.

²³ This includes the construction of fountains, wells, latrines, remodelling of buildings, provision of land, and contributions of construction labour and materials.

²⁴ The average total cost per child was estimated at \$76.33, of which 60.4 per cent was direct costs.

The demand for volunteer work on the part of parents is being increasingly formalized in public policy plans. For example, the National Education Plan 2001–2015 formulated during the Alemán administration states from the outset, 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, the demand for and reliance on “volunteerism” can indeed exacerbate the existing familialism and feminization of care and welfare in the country, rather than representing the realization of citizen participation.

A cost analysis of the PAININ programme showed that there were significant variations in cost across the country, largely depending on whether there were NGOs present to act as “supporting service companies”. At one extreme, the cost per child was \$44.2, while at the other end of the spectrum it stood at around \$115. These variations reflect the inability and inefficiency of the organizations executing the programme, as well as the inadequacy of existing control and allocation criteria of the government itself. Given the important role that NGOs play in implementing various social programmes in Nicaragua, it is important to intensify the performance criteria of such organizations.

In 2006 NGOs cared for 4,437 children. This number increases to 6,000 children if those classified as comprehensive care organizations are considered, which represents only one-third of the number covered under the governmental social programmes (excluding PAININ). This is not a very extensive coverage, particularly if we consider the approximately \$3.37 million that these organizations have mobilized, a figure very close to that spent by the government on childcare programmes (again, excluding PAININ) (Largaespada-Fredersdorff 2006b). For this reason, its supporters argue that with fewer resources, PAININ reached a much larger population.

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 took place in a highly fragmented and dispersed manner. Unfortunately, it is impossible to ascertain the scope of these activities under different governments, since the statistics and systematization of information regarding the interventions are disaggregated and unreliable (similar to the interventions themselves). But we do know that the health and education sectors operated under serious budgetary constraints, which meant even greater limitations for the Ministry of the Family and therefore a considerable gap between words and actions.

A note on primary school services

Although this paper focuses on services that reach children under six years of age, a brief reference to changes in primary education is nevertheless in order. The increase in educational coverage is consistent with other available data. Despite improvements in educational outcomes under the FSLN during the 1980s, only 19 per cent of students satisfactorily completed primary school when Barrios was elected into office. Yearly primary school drop-out rates were as high as 19 per cent, and secondary school enrolment rate was only 25 per cent of the eligible population, with a 15 per cent annual drop-out rate (Government of Nicaragua 1996, cited in Gershberg 1999). Since 1990 services have been expanded, thanks to increases in public spending. Thus, primary level coverage increased and secondary level coverage remained the same. The primary school enrolment rate stood at 73 per cent in 1985, 72 per cent in 1990 and then rose to 90 per cent by 2006. Enrolment in secondary schools also saw a significant expansion from 18 per cent in 1985 to 43 per cent in 2006 (there is no comparable data for 1990).

Between 1985 and 2005 the relative importance of enrolment in private fee-paying schools increased only slightly at the primary level (from 13 to 15 per cent), and slightly more at the secondary level (from 20 to 26 per cent) (World Bank 2008). Unfortunately, national household survey data does not allow for a distinction between public and private centres, as both public

and private services are typically combined.²⁵ We do know, however, that private provision is scant, predominantly urban and largely used by those in the higher socioeconomic quintiles.

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

Even more marked than the increase in coverage is the notable increase in the proportion of children completing primary school: while only 51 per cent graduated from primary school in 1989, in 2006 this number had reached 73 per cent (World Bank 2006). Despite the fact that Nicaragua faces serious challenges of rebuilding the infrastructure damaged by war, fiscal constraints and lower social spending per student, the quality of education and the gap between private and public education seem to remain the same. 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 (between 31 and 35 students per teacher).

In addition to external loans, educational resources were 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).

Indeed, in the context of acute budgetary constraints, as of 1992 the government decreased the state's involvement and promoted an 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 administrative and other matters related to school management. The central government then assumed enabling 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, along with an increase in the proportion of teachers hired by school boards (Gershberg, 1999).

According to authorities at the time, the reforms were impulsive and lacked external resources during the first two years.²⁶ As a result, existing resources needed to be more efficiently utilized and community input into the maintenance and improvement of facilities needed to be

²⁵ In the four surveys, public centres under the Ministry of Education were included. In 1993, private and subsidized centres and the CDIs pertaining to the National Institute of Social Security were included. In 1998, private centres, those that pertain to work sites, community and other types of centres were added. In 2001 and 2005, centres related to the Ministry of Family, subsidized private centres (by the Ministry of Education), private non-subsidized centres, those that belonged to work sites, community and other types of centres were also included.

²⁶ Interview with Humberto Belli, Education Minister during the Chamorro Administration and during the first half of the Alemán administration, 28 March 2008.

increased. The model became increasingly inspired by the Chilean experience: the Minister of Education at the time travelled to Chile to assess the benefits, in particular economic ones, of shared administrative responsibility (between parents, teacher 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 which financed education in Nicaragua during the 1990s. The model was implemented first in urban high schools and was then extended to primary schools after 1995. It was carried out through two modalities, one in the urban areas through the creation of school boards, and the other in rural areas through the creation of municipal school “headquarters” where one school manages the bank accounts of the others, and with a municipal board of directors rather than a separate board for each school.²⁷

Under this model, autonomous schools were free to solicit “voluntary” contributions from parents and to carry out fundraising activities. This helped address resource gaps and explore solutions that encouraged shared responsibility among the various stakeholders linked to each school. The positive outcomes included greater involvement and more responsibility on the part of the parents. The negative outcomes included the excessive amount of time that teachers and parents, mostly mothers, had to devote to fundraising activities in order to improve economic conditions and secure staff salaries. In addition, the possibility of asking for voluntary contributions, which were in fact co-payments, was abandoned, 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 received from the central level, coupled with the economic and social constraints faced by the education sector in general, led to practices that had damaging results. For example, autonomous centres were known to alter records, reporting an inflated number of enrolments in order to obtain higher transfers.²⁸ The new management of schools also had obvious implications for labour relations. Rather than being part of the national payroll, the teachers were hired by a commission composed of four parents and three teachers who had “full hiring and firing power”.²⁹ This new recruitment method led to tensions with the unions and the Sandinista opposition whose support bases were precisely the union workers.

School feeding programmes

As part of their survival strategy, low-income families often reduce their food consumption, which carries the risk of malnutrition. When food is provided by the school or care centre, part of the family’s basic nutritional requirements is covered, at least for the day. Studies carried out by the World Food Programme (WFP) show that, in combination with the education offered, school feeding programmes have increased school enrolment rates and reduced drop-out rates (Chacon 2005). Table 7 summarizes some of the main school feeding programmes implemented in Nicaragua.

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 WFP and, as a result of policy changes in that organization (see above), the Community Kitchens for Children tailored their preschool education to incorporate components that would meet the organization’s eligibility

²⁷ Interview with Humberto Belli.

²⁸ Interview with Elizabeth Espinosa, 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, April 2008.

²⁹ Interview with Elizabeth Espinosa.

requirements for receiving food donations. Due to the lack of food, this programme ultimately ceased operations during the Bolaños administration. By this time the Milk Programme had begun its operations. It was initially implemented 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 children’s diet, reduce school drop-out rates and support academic learning in the first four grades. The target population was children attending state and community schools. Parents – but in reality mothers – were responsible for preparing and serving the milk.

Table 6: Overview of the school food programmes implemented in Nicaragua

Programme	Year	Responsibility	Objective
Community Kitchens for Children	1980s	FONIF, later Ministry of the Family, with donations from WFP	Reduce risk of malnutrition among children in communities with highest poverty indices
Glass of Milk Programme	1992 to late 1990s, resumed in 2003	Ministry of Education and Ministry of the Presidency	Improve children’s diet, reduce school dropout rates and support academic learning until fourth grade
School Biscuits Programme	1994	Ministry of Education, supported by National Autonomous University of Nicaragua and PAHO	Increase school attendance among enrolled students and improve diet of target population (preschoolers and first to fourth grades)
Construction and operational sustainability of lunchrooms	1995	Social Investment Fund, and an agreement between Ministry of Education and Ministry of the Family (2002–2004)	All community preschools would have food and all child lunchrooms would have preschool education
Comprehensive School Nutrition Programme	Late 1990s	Ministry of Education and Ministry of the Family, with support from WFP	Provide supplementary food to children living in poverty and conditions of food insecurity

The School Biscuits Programme was implemented in 1994 by the Ministry of Education and supported by the National Autonomous University of Nicaragua and the Pan American Health Organization (PAHO). The goal was to increase attendance among the enrolled students while improving the diet of the target population. The focus was on preschoolers and first- to fourth-grade students in departments primarily selected due to their high rates of poverty, high drop-out rates and malnutrition. Between this programme and the Glass of Milk programme, each child received 53 per cent of the daily protein requirement and 15 per cent of the daily calorie requirement. From 1994, some 112,500 children were beneficiaries of this programme.

After 1995, the building of lunchrooms was financed by loans channelled through FISE. However, just five years after they were started, lunchrooms showed a lack of financial sustainability. This demonstrated that resource constraint was not the only problem affecting Nicaraguan public policy: weak state management and multiple sources of external funding led to weaknesses in national planning and an inability to channel external resources in a more orderly fashion. To overcome the problems of coordination, the Ministry of Education (responsible for food programmes) and the Ministry of the Family (responsible for the Community Kitchens for Children), established that all community preschools would have food and that all child lunchrooms would have preschool education. Regrettably, this joint venture only lasted two years, between 2002 and 2004, and it is difficult to know what proportion of preschoolers actually benefited from it. However, it had an unintended effect: parents chose to withdraw their children from formal preschools and enrol them in community preschools where they received food. This, along with the analysis of the PAININ programme, shows how formal preschools were effectively undermined by donor-funded parallel programmes.

The Programa Integral de Nutrición Escolar (PINE) began in the late 1990s to provide snacks to children attending the preschool education programme (ages three to six) and some primary schools (ages six to 12), particularly in rural areas.³⁰ It aimed at providing supplementary food to poor children, as determined by the poverty map. Similar to the other programmes, it relied heavily on community participation. In its first year, PINE covered 137 municipalities in 16 departments in the country, serving more than 800,000 children. This represented 95 per cent of the children enrolled in preschools, formal preschools and primary education in the 137 municipalities (Nuevo Diario 2005). The programme has gone through several stages, the last of which was launched in 2002, supported by donations from the 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 the lunchrooms an education component, which would allow them to continue with the support of WFP.

In short, between the 1980s and 1990s, five different school feeding programmes were implemented. This showed a lack of coordination and overlaps in terms of the targeted population as well as services provided.

Health services

Health services in Nicaragua are characterized by a high degree of stratification between private sector care, public services, services provided by social security and community services.³¹ In theory, private sector care is mainly financed by patients' out-of-pocket payments; public services are financed 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 far from clear. Half of the total annual health expenditure is paid by households' out-of-pocket and co-payments (for doctors' visits, medicines or laboratory exams), even in public and social security institutions (Rodríguez 2005). In a country where seven out of every 10 people live under the poverty line, households account for 94 per cent of all private health spending, and only 6 per cent comes from insurance or other institutional budgets (PAHO/WHO 2005).

Social security gives contributors access to private health services contracted by INSS. Social security is only mandatory for the salaried population residing in areas with INSS health services.³² For the self-employed population, insurance is optional and provides only limited coverage. For domestic workers, insurance is legally mandated, but compliance is low. Pensioners and economically dependent family members have limited access to health services. Dependent wives, for example, can access social security-based on health care only during pregnancy, childbirth and postnatal care. Since 2004, children are covered up to the age of 12 (Mesa-Lago 2008).

During the 1980s, the Sandinista government had tried to unify the delivery and financing of health services in order to guarantee equal access. Social security contributions by the INSS-insured population were transferred to the Ministry of Health, and the entire hospital network was placed under its control. This meant that the population insured with INSS had to rely on health centres or public hospitals for medical attention, just like any uninsured person, if they could not afford private services. This resulted in the virtual disappearance of INSS as an insurer and health provider, reducing its role to that of a collection agency.

³⁰ It also supports the travelling component of the PAININ programme (for children up to age six).

³¹ There is no information on those insured through private insurance companies and health maintenance organizations (HMOs); however, they represent a small proportion of the total (Rodríguez 2005).

³² A bill has been pending approval since mid-2005, which would return mandatory coverage of independent and domestic workers and agricultural workers and transporters (Mesa-Lago 2008).

The 1993 health reform, however, restored the differentiation between public health and social security in both financing and service delivery. INSS regained control of contributions and with it the obligation to provide health services to the insured. As the network of services (or the financial ability to rebuild it) no longer existed, INSS opted for buying health care services from private and public providers, the so-called *Empresas Médicas Provisionales* (EMP).³³ The public providers were MINSAs, which controlled about 20 per cent of all the EMPs, the army and the Ministry of the Interior (Rodríguez 2005). The number of people assigned to these enterprises rose from 92,000 in 1995 to almost 300,000 in 2004, representing a significant improvement.³⁴ These companies are responsible for treatment of approximately 800 illnesses. This excluded acute illnesses, such as cardiovascular disease, for which treatment is very expensive.

The Ministry of Health is the main entity providing public health services. Formally, health is defined as a universal right under the Constitution (Article 58) and the Sanitary Code.³⁵ An estimated 60 per cent of the population depends on government services, but at least one-third of all Nicaraguans, typically those with low incomes, lack access to any kind of public service (Mesa-Lago 2008, 2005).

During the 1980s, there were significant efforts to improve primary care. Vaccination rates of children rose dramatically (from 47 per cent in 1987 to 82 per cent in 1990) and continued to increase, reaching 99 per cent in 2006 (World Bank 2007). The population with sustainable access to clean and safe drinking water and improved sanitation increased from 75 per cent to 79 per cent between 1995 and 2000. Access to curative health care, however, has not received the same level of attention. The proportion of hospital beds per 1,000 inhabitants, for example, declined from 1.2 in 1990 to 1.1 in 1995, and has remained stable at 1 since 2000.

In 1985, MINSAs organized the *Sistemas Locales de Salud* (SILOS), later known as the *Sistemas Locales de Atención Integral en Salud* (SILAIS), territorial units that replaced previous health divisions and operated without clear regulations. The SILOS comprised a community system composed of networks of *brigadistas*, midwives and others—all of them volunteers—who operated principally in health promotion and disease prevention in their respective communities. These community health services are a legacy of the revolutionary years, but remain active in community health promotion and disease prevention today.³⁶ The incentive for these groups of workers was social recognition by the community, although the volunteers gradually became “institutional *brigadistas*”, with a stipend from generally foreign-based NGOs.

In 1990, at the time of the transitions from the Sandinista administration to the Violeta Barrios government, MINSAs was the main provider of health services. The Ministry of Health served 85 out of every 100 consultations, while the Ministries of Defence and the Interior served 4.5 (by military and police forces, fire-fighters, immigration officials and so on), social insurance 6 and the private sector 4.5. Individuals who did not utilize any of these institutions used informal consultations and/or self-treatment. With the exception of some remote areas, MINSAs health service coverage was considered adequate, but accessibility was better in urban than in rural areas (Ministry of Health 2000). Furthermore, high coverage was accompanied by growing problems in service quality due to serious financial constraints. Spending had increased from 1.6 per cent of GDP during the 1970s, to 4.5 per cent at the beginning of 1990, but then oscillated between 4.2 per cent and 3.8 per cent for the rest of the decade.

³³ Each EMP is allocated a per capita payment (\$12.7 in 2005), based on the number of policy holders who have chosen it. 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, it must subcontract it. In the event of an employee being incapacitated, the EMP should pay a cash subsidy for illness.

³⁴ This achievement is even more important considering that there was an increase in labour market informality during this period.

³⁵ It states that all Nicaraguan citizens or residents will have access to health services that are both socially acceptable and compatible with the country’s development (MINSAs 1991).

³⁶ Interview with Jesús María Largaespada-Fredersdorff (currently Expert on Health at the Embassy of the Netherlands in Managua and National Director of Care for Children until 1991 in MINSAs), 20 March 2008.

In contrast to the profound changes in education and social security, there was some degree of continuity in the area of health.³⁷ Since 1991, greater decentralization of services and a shift toward preventive and primary care have been promoted. MINSA has decentralized authority and resources, and further increased social participation for solving health issues. The responsibilities of the SILAIS—as intermediaries between the central institutions and health care providers—were extended from heading health posts and centres to include clinics and hospitals in their respective departments (Rodríguez 2005). SILAIS emphasized primary care, disease prevention, health promotion and—to a considerably lesser degree—treatment. Although in principle this seemed like a good idea, it caused serious problems in the access to curative care in Nicaragua. Within a comprehensive health framework, primary, secondary and tertiary care (handled by clinics in primary and secondary levels and hospitals in tertiary care) cannot be separated. Instead, their relationship should be strengthened through referral channels from one level of care to another. However, Nicaragua lacks a functioning referral system, which can easily be attributed to the inadequacy of resources. However, it also reflects a minimalist vision of social policy, one that the middle and upper classes would never accept for themselves, but have enthusiastically promoted for the poor. Besides insufficient resources, this ideological orientation helps explain the situation.

Health decentralization in Nicaragua was characterized by 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 terms of funding. However, the scarcity of budgetary resources and budget cuts during the 1990s prevented this process from being successful. Indeed, public health spending fell from an already low \$23 per capita in 1990 to \$18 in 1996.³⁸ Reducing public health expenditure had been one of the requirements in the agreements with multilateral institutions. The situation was further aggravated by the fact that external cooperation funds decreased, which meant that external loans assumed a greater role in funding and households took on additional burdens.

If decentralization was the main policy of the Barrios administration, sector reform was the focus of the Alemán administration. It involved changes in services (around a basic package) and administrative arrangements (involving further decentralization), carried out through external loans (in particular from the IDB and the World Bank). It was based on the argument that it was necessary to adapt health services to new social conditions, including demographic and epidemiological changes as well as growing demand. A basic service package was established, including women's reproductive health and the detection and treatment of gynaecological cancers. Given the precariousness of funding during the period, diversification was sought through a greater involvement of external actors. In reality, however, the relative weight of external participation declined (Ministry of Health 1997), while private, out-of-pocket spending increased.

In 2004, the National Health Plan (2004–2015) established the priorities that govern current policy, including increased coverage, decentralization and the definition of target populations. Women, children and adolescents are now targeted through family planning, prenatal and post-partum medical check-ups, monitoring of growth and development, immunization, comprehensive care for childhood diseases, and sexual and reproductive health. Priority has also been placed on serving various minority ethnic groups affected by geographical, cultural and economic barriers, marginalization and lack of information.³⁹

National health plans were designed for women (as mothers and as a part of the mother-child unit), children (especially under the age of five), disabled people, workers, and demobilized

³⁷ For example, only discretionary staff members left the institution, and people in technical positions continued.

³⁸ www.eclac.org/estadisticas, accessed 20 July 2009.

³⁹ Providing accessible services for these communities faces serious difficulties. Service is provided principally by social service staff who have not been trained to work in these areas. Most of them are men who do not speak the languages of the communities along the Atlantic coast, creating distrust among the population, especially women.

and repatriated individuals. Interventions targeting women included immunization, promotion of breastfeeding, 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, MINSa implemented a domestic violence treatment model in 1995, emphasizing gender violence, and a maternal mortality monitoring system in 1996 (Ministry of Health 2000). Anti-violence measures were in place and functioning, and received ongoing support from PAHO (Márquez et al. 2005). The first draft of the National Sexual and Reproductive Health Programme was drawn up in 1997 and published in 2002. It led to the National Sexual and Reproductive Health Strategy, officially adopted in late 2006.

At least rhetorically, the National Health Plan seeks to mainstream gender equity, taking it into account in all its policies and sectors. Chapter IV of the Plan, dedicated to the functioning and reform of the health sector, proposes a sexual and reproductive health programme with a gender focus, recognizing the importance of fighting HIV/AIDS, reducing maternal mortality and preventing cervical-uterine cancer. The document also stresses prevention of gender-based violence and access to family planning services, as well as measures for preventing teenage pregnancy.⁴⁰ International agencies, such as the United Nations Population Fund and the PAHO, took leading roles in sexual and reproductive health, and national cooperation agencies, including those of Canada, the Netherlands, Norway and the United States, provided technical cooperation and financial resources for the implementation of the programme.

In addition to incorporating a gender focus into the health plan itself, gender was also included in 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, including women's organizations.

However, MINSa's actions were hindered by the gap between planning and available resources, including institutional capacities. In reality, short-term initiatives aimed at mitigating the effects of epidemics and natural disasters dominated the agenda more than the policies outlined above. The absence of a single nationwide health care management model resulted in a variety of different health care models, including internationally financed and managed projects and programmes.⁴¹ This made MINSa an institution characterized by differing health care schemes, which at times conflicted with each other as well as with the National Health Plan itself.

Doctors, nurses, hospital directors, SILAIS, and even donors agree that the quality of public health services has deteriorated, largely due to serious deficiencies in infrastructure and equipment (Sanigest 2004). Evaluations carried out during different administration periods since 1990 have detected two major weaknesses: insufficient budgetary allocation and poor promotion of government care measures among health-care personnel. Unofficially, privatization of public services has been suggested as an option, and there has been some degree of commercialization, including payments for private services and co-payments for public services (for example, the purchase of medicines that are depleted in the MINSa). This has serious consequences for access and affordability, especially among the most vulnerable groups.⁴²

Outcome indicators in health are ambiguous. On the one hand, infant mortality decreased from 45 to 31 per 1,000 live births in the first half of the 1990s, where it remained until 2001, the last

⁴⁰ Eduardo Sevilla (Nicaraguan Ambassador to the United Nations), Statement to the United Nations Commission on the Status of Women, 49th session, New York, 28 February–11 March 2005.

⁴¹ In 2003, donations and loans were estimated at 10 per cent of social spending in the sector (Rodríguez 2005), but the relative importance of both has been declining.

⁴² Interview with María Jesús Largaespada-Fredersdorff.

year for which there is data available (PAHO in the Estado de la Nación, 2008). On the other hand, under-five child mortality has decreased steadily, reaching 30.4 in 1996 and further declining to 24.4 in 2006 (PAHO in the Estado de la Nación 2008). However, in 2005, only 67 per cent of births took place in health institutions, which places Nicaragua among the five Latin American countries with the poorest performance. Maternal mortality also remains high, with 230 per 1,000 births (UNDP 2006).

Conditional cash transfers

During the 1990s and the early 2000s, programmes targeting vulnerable groups pointed to the need for improved coordination. In Nicaragua, this coordination was referred to as “social protection”. In addition to interinstitutional coordination, it included childcare, based on the notion that complementarities must be established between the responsibilities of families, communities and government. The idea was to interlink social protection programmes and projects executed by different institutions. However, for a long time, high sectoral compartmentalization, lack of continuity in government programmes and lack of funding (or the tendency to direct funding to specific programmes) stood in the way of initiatives to increase targeted programmes.

It was under the umbrella of the 2003 National Development Plan that the country first formulated a National Social Protection Policy (Government of Nicaragua 2003a). It 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, and not as an axis of overall social policy, as had been the case of the 1993 social agenda.⁴³ However, there are some elements of continuity with respect to ERCERP’s pillar of Social Protection for Vulnerable Groups. That said, at a rhetorical level, this policy represents a shift from emphasizing social assistance to a focus on social protection in which the poor and vulnerable population – that is, the majority of the population – must be part of socioeconomic development, rather than being just a target of social assistance. The general objective of the policy was to promote the social inclusion of vulnerable people, households and communities, replacing the previous emphasis on public assistance, training and empowering labour (Government of Nicaragua 2003a).

Consistent with the view promoted by the World Bank, Nicaragua’s social protection strategy emphasized social risk management and included conditional transfers. From a care point of view, the approach recognized the government’s responsibility for creating minimum conditions for access to education and health for poor children under the age of six. This approach served as the “umbrella” for initiatives to address crises and emergencies that constantly seemed to befall the country. The section below focuses on the conditional cash transfer (CCT) programme because of the importance given to educational services for children, and the visibility of such programmes as the “stars” of a new generation of social policy in Latin America (Molyneux 2007).

In 1999, Nicaragua created the RPS, a CCT programme similar to the ones that had been promoted by the World Bank in other Latin American countries. It was implemented during two consecutive administrations, Alemán (1997–2002) and Bolaños (2002–2006), and provides cash transfers to households in extreme poverty.⁴⁴ Transfers are conditional on school attendance of children under 12 years old as well as health controls of children under three years of age. Although direct care of children was not incorporated, the conditional transfers did stimulate families to make use of social services for children, including education and

⁴³ Interview with Elizabeth Espinosa, 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, March 2008.

⁴⁴ The idea of implementing direct transfers has existed since 1997. At that time, they were meant to support poor farmers in capitalizing on their assets (Largaespada-Fredersdorff 2006a).

health services. In addition, this programme collaborated with other existing programmes that targeted vulnerable groups in extreme poverty and situations of vulnerability, including, for example, boys and girls who had experienced extreme violence and neglect. The declared aim of this “micro-targeting” (Molyneux 2008) was to break the intergenerational transmission of poverty.

RPS started as a pilot programme launched by FISE. Its design was based on the experience of the Mexican Progresa/Oportunidades, and Mexico had offered technical and methodological support (Largaespada-Fredersdorff 2006a). Initially, the liberal Alemán government opposed the programme, arguing that giving money was a “return to the past (Sandinista way) of handing out money, encouraging paternalism, populism, and the inactivity of the extremely poor” (Largaespada-Fredersdorff 2006a:331). International cooperation agencies feared the political-partisan agenda of the programme and raised concerns about the implied costs and the lack of design materials. There was general agreement on the idea that the country was unable to meet the demand for cash transfers. In view of the financial constraints, higher social demand was expected to activate supply, pushing the respective ministries to expand services. It was also assumed that the HIPC Initiative would increase public spending on education and health in order to attend to that demand. In reality neither of the two happened, partly because HIPC did not come into effect until after the programme had started, and partly because domestic debt absorbed a significant portion of the resources that should have been directed to social spending. It was only in the second phase of the programme, in 2002, that the ministries received more substantial support for service provision.

RPS was expected to increase the demand for health services, education and food by subsidizing family income, thereby triggering social demand and advocacy for the creation and strengthening of health and education services for the extreme poor. During the first phase (2000–2002), RPS provided vouchers to encourage service supply and service demand. These benefits included vouchers for food (“food security vouchers”), education and school supplies. Vouchers encouraged health care and educational services offered by private providers (largely NGOs). In the second phase (2002–2006), the programme was expanded from six to nine municipalities. The benefits remained essentially the same, but health services were extended to include women of reproductive age, in the form of a complete vaccination plan. At the same time, provider vouchers came to include a component for occupational training and adult education, and a “productive empowerment voucher” was added to the user vouchers (for beneficiaries of the initial six municipalities). These components, largely directed to working-age adults, are worth mentioning because CCT programmes generally focus exclusively on children or young adults. During the first phase, the programme covered 10,000 households in six municipalities. During the second phase, coverage increased to more than 20,000 beneficiary households in nine municipalities.

Beneficiaries were selected in several stages. First, municipalities were mapped according to poverty and lack of education and health care coverage. In a second step, communities in these municipalities were selected based on indices of extreme poverty and the severity of the lack of resources. Finally, specific households were chosen within the selected communities on the basis of their poverty situation and the programme’s ability to provide services. The formal commitment by women—as recipients of the transfers—to participate in the health care plan was also evaluated.

In 2003, RPS came under the aegis of the Ministry of the Family. There was the desire to unify disperse and relatively autonomous initiatives, increase coherence and promote more comprehensive actions (Largaespada-Fredersdorff 2006a). Overall, RPS’s costs amounted to \$32.2 million and were financed through loans from the IDB.

In 2004, RPS was placed under a broader programme, the Sistema de Atención en Crisis (SAC), which grouped other existing social protection programmes and included, from the onset, an

occupational training component as well as the distribution of productive training vouchers aimed at improving employability.

RPS is likely to be one of the most extensively evaluated programmes in the history of Nicaragua.⁴⁵ To some extent, the evaluations agree that the fact that the money is transferred to women may have some positive effects in terms of their self-esteem and economic autonomy. However, there is important disagreement on the effect of conditionalities with respect to gender equity. Clearly, the RPS perpetuated traditional gender roles, through which women carry out “care” activities and men do not (Largaespada-Fredersdorff 2006a). In addition, women’s participation in the programme was largely confined to ensuring food and hygiene for their children, rather than as active subjects of policy in their own right (Bradshaw 2008). The programme basically excluded men and reinforced the notion that they are not the ones responsible for their children’s schooling and health. “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 someone who had 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, in Nicaragua, often abandons the home (Largaespada-Fredersdorff 2006a:353).

A second area of controversy evolves around the impact of transfers on women’s lives. Due to power relationships in the home, an increased level of control over transferred resources by women cannot be taken for granted. While one study highlights that 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 closer to home “rather than having to travel long distances in search of wage labour” (IFPRI 2005:2). This suggests that RPS transfers are used, at least to some extent, in order to compensate for men’s reduced waged labour (Bradshaw 2008).⁴⁶ However, since a high proportion of households do not have a permanent male presence, many women are likely to have greater autonomy over the use of transfers.

A third controversial aspect is whether the transfers increase women’s workload. The women belonging to the rather dispersed rural population that makes up the RPS target groups are generally responsible for domestic and productive activities in the home. Therefore, going out to collect the transfer and receive training opens up opportunities to interact with other women, a fact that was welcomed for increasing female autonomy and potentially empowering participants. Thus, while the conditional transfers perpetuate the gender division of labour in the household and make demands on women’s time, they can have a positive effect, prompting the mobilization and interaction of women (which, as explained in Molyneux 2006, is something much more specific than empowerment).

As mentioned, an adult training component was added to RPS during its second phase, an exceptional feature among the CCT programmes in the region. In and of itself, this component does not necessarily correct the problem of microtargeting, which is based on the belief that directing initiatives to children necessarily breaks the generational cycle of poverty (Molyneux 2007). However, the component constitutes a clear improvement vis-à-vis similar programmes, including Progresas/Oportunidades in Mexico.

Positive impacts were also detected in terms of access to health services. Even though services were mobile (that is, provided once or twice a month in each location) and mainly offered by

⁴⁵ Evaluations have included quasi-experimental studies. One of the most cited studies was funded by the World Bank and conducted by the International Food Research Policy Institute (IFPRI) and academics from various universities (IFPRI 2005).

⁴⁶ As Shahra Razavi pointed out in a previous version of this paper, a fundamental problem with Bradshaw’s critique is that it assumes complete separation of interest between spouses, as in neoclassical bargaining models, and no shared or joint interests or interconnectedness.

NGOs acting as private providers, they did make an – albeit small – difference in people’s lives. The school voucher, delivered in cash, was used to buy school uniforms and materials (once a year), and the food voucher was used for “collaborating” with the school. In some cases mothers also used these transfers to hire additional teachers for the operation of the school, as the Ministry of Education did not cover such deficiencies.

Finally, a World Bank–sponsored evaluation by the International Food Policy Research Institute (IFPRI 2005) found that the transfers did not increase domestic violence. It also found no evidence for the money being appropriated by male household members. The study concluded that the resources of the RPS were used mainly for their original purposes, namely to improve the food intake of children.

The main limitations of the RPS are its limited scope and inadequate public investment in the strengthening of public social services, as well as an ineffective component for supporting women’s economic independence. While the programme perpetuates a vision of female caregiving, it is also a reality that the vast majority of households are headed by women and generally lack a permanent male presence.

Analytic threads

Since the 1990s, social programmes have operated under the residual vision of social policy. Decentralization was one of the main policy mechanisms, which relied heavily on family participation, in particular on the participation of women (as in food preparation) and community organizations (such as school boards). Decentralization also led to a reduction in the number of state employees and created a high degree of job instability among social service workers, particularly among women in care-related occupations (such as nurses, teachers and cooks). Social policy was mainly organized in the form of programmes (rather than policies) funded through loans from multilateral banks and at times through donations. Each of the programmes pursued different objectives and operated different implementation cycles, leading to high degrees of instability, discontinuities, lack of coordination and duplication.

Throughout the entire period, community involvement was significant. There seem to be at least four contributing factors that account for the high level of community involvement. First, a change in the role of the state promoted by governments since 1990, which included downsizing, less funding and direct provision. Second, there is a strong tradition of solidarity as a means to confront crises, particularly in some sectors (such as health), coupled with an ingrained appreciation for community interventions in health care. Third, the attempt by the Sandinista opposition to “govern from below” and to “continue to defend the revolutionary achievements” strongly marked the Nicaraguan community movement. Last but not least, empirical observations indicate that even political parties that did not favour community participation ended up supporting it in the face of epidemics and natural disasters, both of which abounded in Nicaragua during the period.

Social Practices: How Evident is Social Policy?

In addition to the analysis of the care diamond (or diamonds) in Nicaragua, the present study seeks to make a methodological contribution. Pioneering studies on welfare and care regimes carried out from a gender perspective generally focus on public policies. However, in countries where the welfare regime relies on families and unpaid work, much more than on markets or public policy, it is crucial to combine institutional analysis with an examination of social practices when reconstructing the care diamond. Indeed, in welfare regimes characterized by residual social policies, low coverage and poor quality, one can expect a significant gap between public policy aspirations and the way these are actually accomplished in practice.

This effort to complement institutional analysis with qualitative research on social practices is exploratory in nature and does not pretend to be representative of the Nicaraguan population. However, it does provide an insight into care practices which helps to engage critically with the real relative importance of public institutions, rather than assuming that institutions simply perform their formally assigned roles and functions.

The main qualitative findings are presented below. The results are highly consistent with studies on time use (Espinosa 2008), and less consistent with the institutional analysis of social policies.

Methodology of the focus groups

The fieldwork for this qualitative study included eight focus groups—seven with women and one with men—each composed of eight individuals, lasting approximately two hours. All of the individuals were contacted by word of mouth. A total of 64 people participated, including 56 women and eight men. All participants were responsible for children under 13 years of age. This criterion was used in order to reconstruct practices and representations at a particular stage in the life cycle during which care demands are high and which are marked by differing degrees of public policy incidence, specifically in terms of educational coverage.⁴⁷ This study maximized the heterogeneity of each group in terms of sociodemographic variables such as age, schooling, head of household, type of family (nuclear or extended) and presence or absence of migrants among family members.⁴⁸ Four of the focus groups were held in Managua, the country's capital, and four in Estelí. The latter municipality was selected because of the strong interaction between urban and rural populations which in turn allows for a comparison with urban Managua. Box 1 summarizes the composition of the different groups.

Box 1: Make-up of focus groups	
In Managua:	<ul style="list-style-type: none">• Domestic workers: half of them were earning a monthly salary while the other half worked on an hourly basis• Professionals: half of them were salaried and the other half independent workers• Professionals/caregivers in education and health• Own-account workers, essentially merchants
In Estelí:	<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

Among the housewives, a number of women were engaged in some form of income-generation in order to cover their families' needs under conditions of economic hardship. Thus, they were not housewives in the strict sense of the word. However, other studies show that many women who define themselves as housewives also generate income, even if it accounts only for small amounts.

Three instruments were used to gather the information: a respondent's sheet and two guides, one for the female focus groups and one for the male group. The sheet focused on

⁴⁷ Thus, the age bracket (0–13 years) includes both children who are younger and older than six, the age at which children enter school.

⁴⁸ 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.

sociodemographic variables (for example, age, religion, economic activity and place of residence), care demand (number of children and presence of older adults in the household) and whether there were migrants among the family members (a central aspect of the structure of Nicaraguan families).

The guide sought to elicit care-related practices and representations in three steps. First, we reconstructed the daily routines of the group members and others living in their households, with an emphasis on exploring the degree to which domestic and care work reflect a gender division of labour. Second, we explored the conditions under which women delegate care of their children to others, either inside or outside the domestic circle, and the degree of satisfaction or concern with such arrangements. Finally, we examined expectations—specifically, with regard to the role private enterprises and the state are expected to play 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 does the choice of having more children depend on the circumstances under which care occurs?

Based on information gathered in the eight focus groups, this section first presents a reconstruction of the care diamond in Nicaragua, based on practices—that is, how people “resolve” the care demands imposed on them by children, the elderly, sick or fragile. This implies a distinction between the roles of women, their families (other women and men), the market, the community and public services. It then deals with representations—who is expected to do what in terms of both the gender division of labour and the role of family (versus that of public services and other collective services). Finally, it describes the tensions between practices and representations.

Profile of people interviewed

In total, 56 interviews were carried out—28 in the municipality of Estelí and 28 in Managua. Housewives were overwhelmingly from rural and professionals mostly from urban areas; the rest was distributed evenly among rural and urban areas. The breakdown by age was relatively evenly dispersed with the exception of the 55 years and older group (see table 7). The level of education was varied, with a predominance of incomplete primary school at one end, and complete university at the other. Education varied considerably by occupation: while half of domestic workers had incomplete primary education (and one had no schooling), most educators had incomplete university education.

Table 7: Interviewees by age range and level of education

Age range	<25	25–29	30–34	35–39	40–44	45–49	50–54	55–60
No. of interviewees	8	7	7	10	7	7	6	4
Level of education	Primary school			Secondary school		University		
	None	Incomplete	Complete	Incomplete	Complete	Incomplete	Complete	No data
Number of interviewees	1	14	4	7	5	7	14	4

Source: Based on interviewees’ records.

Just under half of the respondents (25) were married or living with their partners, the rest (29) were single (including those widowed). Equal numbers of housewives and professionals had partners in the home. Almost three out of every five respondents had at least one relative who had emigrated (generally siblings). The average number of children in this group was 3.13 (compared to a national average of 2.95 recorded in the 2005 population census).⁴⁹ The group with the highest average number of children were self-employed women in Estelí. However, it

⁴⁹ In www.inec.gob.ni/censos2005/ResumenCensal/Resumen2.pdf, accessed on 10 June 2008.

should be noted that this group included one woman from a rural area with 18 children and one woman from the city with eight children. The average age at first birth was 21 years. Domestic workers and housewives tended to be younger at the birth of their first child (17 and 18 years, respectively). While salaried women and professionals tended to be older, 23 years is still strikingly young for this group. This could be explained by the fact that professionals in our group were working in education, 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 respondent's sheet, and one was identified as a Jehovah's Witness.

Care practices

How can the daily life of the individuals interviewed be characterized? To what extent and in what way do the market, the state and unpaid care work play a role in satisfying care needs? The following describes the daily lives of respondents, placing particular emphasis on domestic and care work.

Regardless of whether or not they engage in paid work, women's daily routines begin in a similar way. A large majority carries out care work almost immediately after getting up in the morning. Getting children ready for school or early education facilities involves a range of tasks, such as waking them up, bathing, dressing them and serving them (and the spouse or partner) breakfast. Even where grandmothers provide care, it is generally mothers, or sometimes fathers, who prepare the children for school before leaving for work.

Housewives also typically make *tortillas*⁵⁰ and, in the case of those with partners at home, see their husbands off to work. The husbands leave for work after breakfast and—particularly in rural areas where work is far from home—take their lunches with them, prepared and packed by their wives. Housewives differ from the other female respondents in that they devote the rest of the morning to domestic work (cleaning, sweeping, washing clothes and dishes, and preparing lunch). After lunch and dishwashing, their activities diversify, turning to other domestic and care tasks (for example, helping with or monitoring homework), paid activity (such as doing other people's laundry for pay) or work in the field (for example, helping their spouses to plant, weed or harvest).⁵¹ In the evening the routine of most women is again similar, as they prepare the food, serve it to children and their spouses or partners, do the dishes and clean up the kitchen.

Within this relative homogeneity, the routine of women who do not consider themselves housewives follows two patterns according to whether their paid work involves leaving the house on a schedule or not. The schedule can be set by themselves, as is the case for 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 get up 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 some form of family support. A different pattern was observed among the self-employed, such as street vendors or consultants, independent of their socioeconomic level. These workers alternate care, domestic work and paid work throughout the day.

Two things stood out when the women described their daily routines. One is that a number of women included attending church as a part of their daily rather than weekly routine.⁵² The

⁵⁰ Some will use ready-made dough, while others go through the entire process of removing the kernels of corn, cooking and grinding the grain to make the dough, forming and cooking the tortillas.

⁵¹ Caring for chickens or other animals is part of the domestic work performed by rural women, and does not involve leaving home.

⁵² The role of the church was not considered in this study. Following studies should pay further attention to it, both as a service provider and as a key in shaping values, norms and practices among the Nicaraguan population.

second is that in reconstructing daily routines, few mentioned any recreational activity and, if they did, the most frequently mentioned activity was watching television. Only in one case did a woman mention conversing with neighbours.

National statistics indicate that a large number of Nicaraguan women are raising children on their own. Although this was not a selection criterion for the study, the majority of the respondents were single mothers or grandmothers. Men and women agreed that, in all circumstances, the responsibility of care falls primarily on the woman of the household, followed by their mothers and, to a lesser extent, older daughters, if these live in the same house. Sisters, mothers-in-law and sisters-in-law who live in the same house participate in care only in exceptional situations such as illness and birth. Domestic workers are predominantly involved in domestic work and not so much in the direct care of persons. Single mothers who live by themselves and thus lack support of other household members are in the most precarious situation. Only one such single mother 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 participate in domestic activities only when there was no alternative. There was only one case with 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 financial contributions were enough; being income providers was perceived as their primary mandate. Given the shortage of jobs in Nicaragua, not all men are able to fulfil this mandate. In either case, domestic work and care are not considered part of male responsibility. Thus, if it comes to domestic work and care, men used expressions such as; "I have to", "when I am unemployed", or "when I feel like it", reflecting the role that domestic and care work play in their lives.

In exceptional situations, some of the wives mentioned receiving their husbands' support for domestic and care tasks. 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 domestic or care work, and only in exceptional situations – when she was in fragile health following a birth.

Contrary to 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 coincided with working or study hours. Care support networks are not only run by women, but mostly by women relatives.

When asked to describe significant events that changed routines, the birth of children or grandchildren was mentioned as the primary one: those who did not have paid work had to find a job, and those who did were forced to reduce hours spent on paid work. Other important changes were marriage (which meant taking on the housework previously carried out by the mother), separation (which implied returning to the mother's home, ceasing to be a housewife, and going to work), and children growing up (which left more time for paid work). In all of these cases, the change in routine is related to care needs (as opposed to having finished studies, changed jobs and so on).

Consistent with the literature, the opposite was the case among men: significant events were related to changes in employment which directly affected the availability of time for the family. Switching from self-employment to wage-employment or to a higher paying job permitted a reduction in working time. Two of the eight men also mentioned giving up alcohol as significant, an issue which was raised by the men themselves (without being asked) and points to the existence of social practices that are generally ignored in the design and implementation of social policy, but seem to be addressed by other institutions, particularly religious ones.

Representations of care

What roles *should* men and women assume? Most women, independent of whether they are housewives or perform paid work, believe that they should carry out domestic and care work and feel obliged to do so. The main reason for this is simple: if they do not do it, no one will.

Teachers stressed that there are gender-related activities that *should* be performed by women, such as bathing children, getting their clothes ready and giving advice on sex-related issues. A couple of women mentioned activities only they *know* how to perform (such as cooking, preparing *tortillas* and saving money). This was preceded by a discussion on whether men are capable of carrying out domestic and care activities. Some women felt that even if the men were capable of carrying out these activities, they might choose not to learn how to do them because they did not want to do them. In addition, a few women mentioned activities they actually *enjoy*—such as cooking and cleaning the house—because they enjoy the outcome (such as a clean house).

Despite the fact that women generally believe that their partners are capable of carrying out care work, only one respondent said that her partner takes on care responsibilities for her daughter. The main problem they encounter is that the men either do not know how to carry out the activities properly or act as if they were incapable of performing them well, so that they will not be asked to do them. Men admit that housework is not exclusively a woman's responsibility. Even so, men only carry out these activities when they have nothing else to do—and when they want to. In addition, they generally refer to their role in domestic work as assistance (“helping”) rather than responsibility. It became apparent that, despite some efforts to change the gender division of labour, there were very few practical results.

Delegation of care: Concerns and requirements

Who can assume care responsibilities when mothers are unable to? Grandmothers are clearly the first option when a woman needs to find paid work but does not have enough money to hire help. Besides insufficient income, women also cite a feeling of unease when leaving their children with hired care as a significant reason for not doing so. They mention fears about physical safety, hygiene (illness), accidents and mistreatment. However, the circumstances under which they feel most secure vary. Some feel comfortable when the children are in school, while others feel quite the opposite since school is also associated with the threat of mistreatment by other children, and in one case even rape was mentioned. Some women as well as men said their main concern was when the children were on their way home from school. In one case, a girl was run over by a car, and in another a boy was a victim of street crime.

At home, there are fewer concerns about the safety of the child and, if there are, they have to do with the caregiver, and how she may put the child at risk. Where elderly people provide care, their health and age are of concern to mothers. In the case of hired help (family members or others), concerns include hygiene and proper food. Children generally stay at home up to the age of three (which is the minimum age for entering preschool), when there is no money available to pay for day care. To entrust the care of one's child to somebody else, that person must meet three basic—and crucial—requirements: the person must be responsible, he or she must attend to the child's needs, and he or she must care about the child and provide love, affection and patience. They also mentioned trust-related attributes—for example, that the person should be known and reliable.

Although childcare centres have the advantage of allowing parents to work, family-based care is the preferred option.⁵³ In general, women who did not use childcare centres did not need them because they had someone they trusted nearby, often in the same house. This reflects the

⁵³ Interestingly, “CDIs” is often used as a generic name for these centres, even though the present ones are not those that were created in the 1980s during the Sandinista revolution.

widespread idea that care is better carried out at home, a perception that becomes stronger as socioeconomic level decreases. The small number of women who used childcare centres did so largely because they had no alternative. In addition to this familialistic vision, reasons for not using childcare centres included limited accessibility, or non-existence (particularly in the rural areas), as well as affordability. Some private childcare centres even charge in dollars; but public CDIs require monthly payments, however minimal (for example, fees of \$11 per month). Two other drawbacks are the transmission of infectious diseases and the fact that opening hours do not match the schedules and needs of the mother.

Women—including professionals—yearn for the free-of-charge CDIs from the 1980s, especially now that private—rather than public—centres offer 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 they were highly valued by the population in general, regardless of whether they were used or not. When asked to compare private and public centres, the principal differences identified were costs (lower in the public centres) and conditions of care (better in the private centres).

Asked to comment on the advantages of sending children to institutional day-care, public or private, as opposed to leaving them at home, several interviewees mentioned socialization with peers, support from skilled staff, positive effects on learning and self-esteem, as well as language development and coordination skills. Some interviewees argued that the children may be better cared for in childcare centres than when left at the custody of strangers in the home. This seems particularly interesting, given the large number of households with domestic workers. Access to medical check-ups and food were cited as further advantages of institutional care. There were also some cases where resources were sufficient to have domestic helpers, and the women said that they preferred that the helper carry out domestic, rather than caregiving, chores.

Concerning the ideal conditions for centre-based care, interviewees emphasized the attitude and training of childcare personnel. In several groups, quality of training was associated with a diversity of professions such as doctors, nutritionists and psychologists. It is noteworthy that professional expertise is expected from childcare centres, while home-based family care—the preferred option among respondents—usually lacks this expertise. However, respondents apparently value the affection associated with “proper” care by a close relative at home. It is therefore not surprising that the interviewees expected caregivers to care for their children “as if they were their own”. Interestingly, this emphasis was put forward by the teachers themselves.

Respondents also mentioned that the facilities should be “in good condition” and—the most frequently cited factor—that centres should provide safety and food at low costs to parents. Cleanliness, supervision, availability of toys, games and appropriate furniture were also mentioned as desirable. Generally, teachers and those who had previously used childcare centres placed more emphasis on these non-staff related issues.

What should states and business 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 considered it is the state’s obligation to help with care, especially in the case of single mothers who need to work away from home, since private services are too expensive. They believe that this support would not only benefit them, but would also generate jobs and improve their job performance. Even though they refer exclusively to mothers (and make no mention of fathers), they have a very broad vision of who should be eligible. They concur that a larger and improved state participation is needed through the creation and maintenance of more CDIs, both for public and private workers, and for mothers who need to, or choose to, work. 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, interviewees stressed the importance of follow-up on situations of abuse or inappropriate care in schools and health centres. Much of the demand to the state focuses on the need for compliance with laws, particularly related to parental duties. In addition, educators cited the need to increase the resources available in schools, and to improve wages and working conditions. Beyond care, it was also noted that the state should monitor working conditions, and help women 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 and having a space of their own. In general, when the question focused on care, the expectations shifted to more general conditions regarding the state's role in providing access to resources and minimum living conditions that would permit mothers to meet their children's needs.

Regarding the responsibility of business in providing childcare, several women stated that businesses 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 the state. For example, medical care was mentioned as a responsibility in two of the groups. In addition, there were mentions of 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.

Expectations

Most women in the focus groups do not want to have any more children, mainly due to their difficult economic situation. Those who expressed the desire for another child did so with the expectation of a secure future, consistent with a family-based welfare and care regime.

It appeared difficult for people in the focus groups to answer question regarding changes they desired in their lives. After a long silence, the great majority—including 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 a better income or a fixed salary, and the wage-earners wanted better incomes. In other words, primary expectations are related to socioeconomic matters. In addition, some of the self-employed urban and professional women wanted more time for themselves.

Men were asked what they thought their wives would like to change in their lives. Only few men responded to this question, suggesting a more equitable allocation of domestic and care work which involved men as well as children.

Care practices and the care diamond

This section provides an overall assessment of the care regime and how it combines unpaid work with market and privately purchased services, public services, as well as community and neighbourhood relations based on the qualitative findings. These results are then triangulated with the statistical analysis of time use data, which also explores these practices. In contrast to the qualitative study, time use data has the advantage of being representative of the population, but the unit of time use analysis—the household—also restricts the information to those living within the actual household, thus omitting “family care chains” or “female care chains” that emerge from the qualitative study.

Table 8: Nicaragua's care diamond on the basis of data from focus groups

Occupation	Rural or urban area	How family is organized for income generation	Age of children (minors)	Spouse or partner	Female family members	Public services	Private services	Person(s) to whom care is delegated (in order of importance)	Care diamond	Number of cases
Housewives	Urban	Traditional	11 years	No	No	No	No	Children's grandmother and/or aunt (only in case of recent birth)	Familialistic, feminized	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 (self-employed and domestic workers working on piecework or daily basis)	Urban	Modified	8 months to 11 years	No	Yes	No	Yes	Immediate family and domestic worker	Familialistic, feminized, with private services	8
		Unified	2–10 years	–	Yes	Yes	No	Older son/daughter and, to lesser extent, CDI	Familialistic, feminized, with some public services	11
	Rural	Unified	10 years	–	Yes	No	No	Older son/daughter	Familialistic	1
Non-precarious 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, feminized, 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, feminized, and community	3
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, feminized, with private service	6
		Unified	1–5 years	–	Yes	No	No	Grandmother	Familialistic, feminized	3

Based on the comments of the women interviewed, table 8 formalizes the operative care diamonds that were identified. First, it presents the occupations of the respondents. Besides housewives, three occupational categories are used as a proxy for the respondents' socioeconomic level: vulnerable workers (a category that includes self-employed workers and domestic workers who work on a piecework or daily 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).⁵⁴

Second, the table classifies the respondents 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 the organization of income-earning within the family. The term “traditional” is used 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.⁵⁵ Although this classification method omits other important characteristics (such as nuclear versus extended household structures), it facilitates an examination of the gender division of labour, which needs to be reflected in the care diamond. Fourth, the table indicates the age of the child in the family, since this determines much of the family's current care needs. The care diamond is characterized as “solely familialistic”, or as “familialistic with involvement of other components” (public or private). The column termed “cases” lists the number of respondents in each category.⁵⁶ The table's rows deal with the features of the care diamond itself, referring to the role played by spouses or partners, other female family members, the state, and private service providers (including domestic workers).

As table 8 shows, Nicaragua's care diamond is clearly familialistic. However, whether women participate in the labour market or not leads to an important differentiation: the diamond is *both* familialistic and feminized—and devoid of support other than from other women in family—when women stay at home. When women engage in paid work, on the other hand, the familialization is not exclusively feminine and counts on the presence of public or private arrangements, even if it is only a secondary one.

There is no clear difference in the care diamonds of vulnerable workers, non-precarious workers and professionals. The explanation for this lies in their access to income. That is, professionals do not necessarily earn more than precarious or vulnerable workers, even though they receive a fixed salary and are covered by social insurance. Owners of small businesses that do not enjoy these benefits may actually earn more. Thus, for non-precarious workers, it may be necessary to perform other types of work to complement their insufficient primary incomes. In Nicaragua, female professionals typically work as taxi drivers or street vendors (for example, booksellers). Therefore, occupation—or at least the categories adopted—may not be the best indicator for a worker's income situation. The relative homogeneity of care diamonds shows that care arrangements are a function of income as well as the availability of other family members to care for children. At the same time, although the care diamonds may be similar in terms of the share borne by the different “corners”, differences can be expected in the type of private services used and in the amount of care time that depends on family support.

The community is a source of caregiving, mainly in the form of assistance from female neighbours. Although it is relatively marginal and associated with emergency situations, it does provide an alternative in both rural and urban settings within Estelí (not in Managua). The absence of more formal community arrangements, such as associations, or women who provide care for other children along with their own, is also worth noting. As the analysis of the social

⁵⁴ This is an adaptation of the categories of Pérez Sáinz et al. (2004), previously used in Martínez Franzoni (2008).

⁵⁵ This is an adaptation of the categories of Barbara Haas, previously used in Martínez Franzoni (2008).

⁵⁶ For a total of 54. One respondent, who could not fit into any of the categories, is omitted.

policy regime showed, NGOs play an important role in service provision for the state (rather than as autonomous expressions of civil society).

Apart from the social services, paid domestic work has been crucial for Nicaraguan women and families in coping with care. Two out of every ten women in the economically active population are employed as domestic workers. Less than 1 per cent, however, have live-in employment contracts. Domestic employment includes part-time, full-time and hourly arrangements (Palacios et al. 2008). Clearly, the importance of paid domestic work rises with increasing socioeconomic levels. While less than 1 per cent of households in the lowest income quintile have paid domestic workers, 20 per cent of the highest income quintile do (Palacios et al. 2008). This is indicative of the degree of socioeconomic stratification in the Nicaraguan care diamond(s). While both are predominantly private, higher income households' care needs are addressed through a combination of market and unpaid female work, while in lower income households, care relies almost exclusively on the unpaid work of female family members and female neighbours.

Triangulation with time use statistics

This section now relates the findings of the qualitative analysis to findings from the analysis of quantitative time use data by Espinosa (2008).

With regard to the commodification of the labour force, the qualitative study suggests that women are more likely to be in paid work if they have no spouse or stable partner. In different occupational categories, there are households classified as "unified" with women providing 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 spend time on other activities, that accounts for their dedicating some time to domestic tasks and caregiving. Consistent with the conclusions of the statistical study, it would seem that deviation from typical female and male roles occurs primarily as a function of economic need, and does not reflect changes in social or cultural norms that shape the gender division of labour.

Qualitative and quantitative analysis draws similar conclusions with respect to one issue, namely that paid work does not free women from their responsibility for unpaid care. The analysis showed that while women with paid work dedicated the least time to unpaid care among all women, they still spend approximately four hours per day on these activities. The qualitative study also confirms the statistical analysis' finding that, as the socioeconomic level rises, less time is dedicated to unpaid care work. The qualitative study shows that this burden is absorbed by other women in the family, including grandmothers, sisters and daughters, rather than by the market or by public social services. It also confirms that urban women dedicate more time to paid work than rural women, although this is due partly to the fact that rural activities usually centre on production for household consumption and are less commodified. This, in turn, can lead to the underestimation of time dedicated to productive yet unaccounted activities.

For example, the work involved in raising an animal that may eventually be sold for cash, which in turn could be used to purchase agrochemicals, is generally not considered equivalent to work (such as cutting cane or harvesting coffee) performed in the labour market, although they do share many characteristics.

Whether care is provided by mothers or by other female family members, the study shows a high degree of feminization in family care. The quantitative data show that the greatest number of hours is devoted to care by women over 17 who are married or have a partner and who are responsible for children under the age of six. However, because this analysis is centred on the household unit, it is unable to detect female "care chains" whose importance has been revealed by the qualitative study.

One finding from the time use analysis is the relatively small amount of time devoted to care of persons, particularly children, as opposed to other types of unpaid work, such as domestic work. Unlike other studies, which document that women “adjust” their time by reducing domestic work,⁵⁷ the time use data from Nicaragua shows that women devote an average of 4.2 hours per day to domestic work, while person care absorbs only 1.1 hours. 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, the pattern persists. The gap may also reflect the fact that when family members are present, it is easier to delegate care than to delegate domestic work. That said, in both cases, the data could reflect measurement problems, especially given the practical and theoretical difficulty of separating domestic work and care in a neat way. As mentioned before, this difficulty was discussed in the focus groups, and can be associated with social constructions of care. Is one engaged in recreation or care when watching television with one’s daughter? Does cooking constitute domestic work or care? Respondents found it difficult to draw the line between the two concepts. Just as the social construction of childhood or maternity may vary under different regimes, or from North to South, these variations may be attributable to differences in the social construction of “specialized” activities in caring for children.

With respect to the feminization of care, the qualitative findings confirm the quantitative study, which showed that women’s time for care increases when children under six are present in the home. This is not only because these children require more attention, but also because public social services are less available for these children than they are for children of school age. The time that men devote to care, on the other hand, does not vary in the same way, which goes to show that even if women perform paid work, family care remains predominantly feminized.

Analytical threads

In general, maybe partly because male income providers are not far from the norm among Nicaraguan families, women interviewed believed that a man’s primary responsibility is to provide the household income, while women are responsible for domestic chores and care work of their children, although they are sometimes supported by other (usually female) family members. Women tended to have a strong familialist vision of care, according to which girls and boys are better off at home than at childcare centres. These become an option when family care is unavailable, but are expected to stick closely to the ideal of family-based care, although education by professional teachers is highly valued (contrasting most households’ own educational climate). However, co-payments create difficulties and free-of-charge services are an important necessity. Despite familialistic and maternalist visions of care, most women have high expectations regarding the state’s role in care provisioning, in particular vis-à-vis women working outside of the home. These expectations seem to be a legacy of the Sandinista revolution of the 1980s, particularly of the CDIs implanted at the time, even though they currently cover only 1 per cent of children under six years old. According to the female respondents, these centres were an important and successful pillar of care in Nicaragua of which they would like to see more.

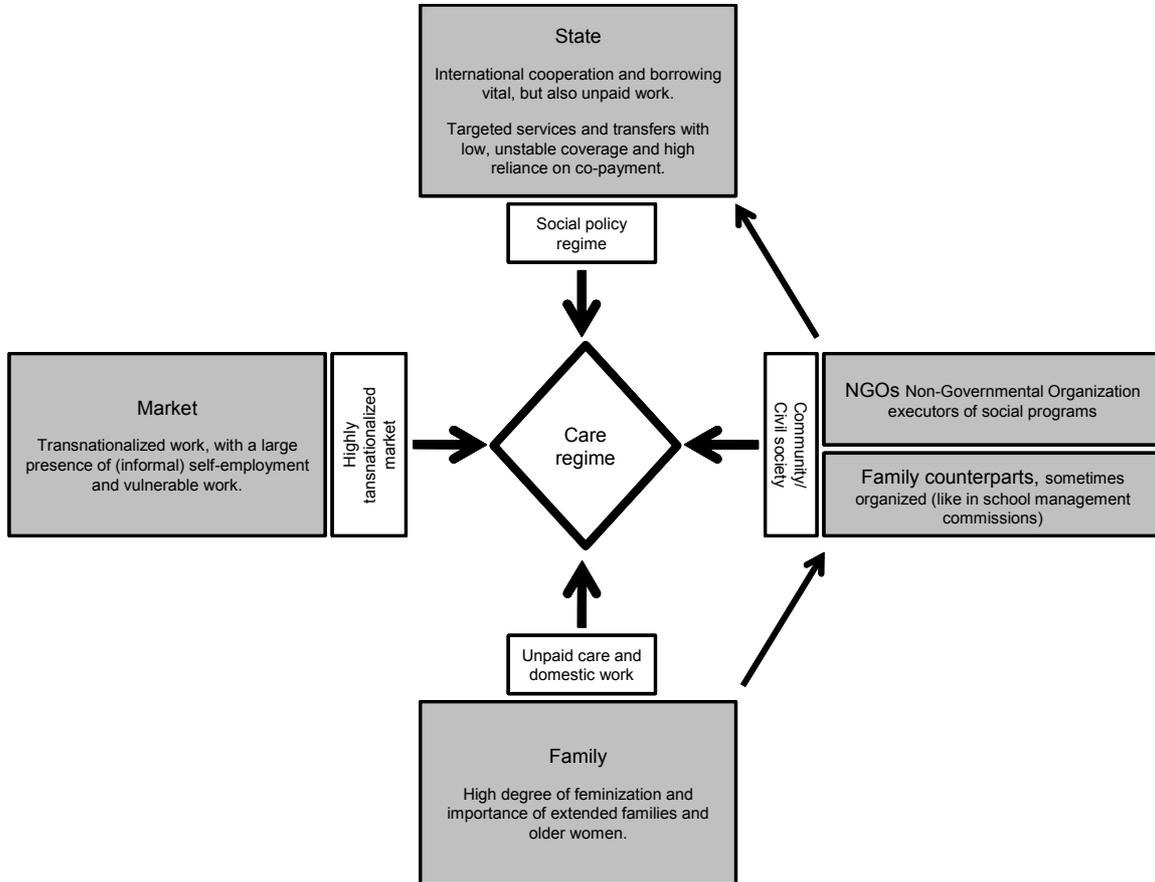
Conclusions: The Care Diamond and Gender in Nicaragua

This section discusses the shape of the care diamond in Nicaragua, presented in figure 4. With respect to the *labour market*, most people in Nicaragua find it difficult to commodify their labour within the country’s national borders. Hence, a large portion of the labour force commodifies its labour elsewhere, mainly in Costa Rica and the United States. This complicates care strategies further. Most families survive through self-employment, underemployment and the intensification of work by all family members (including children and adolescents). This

⁵⁷ For the case of Costa Rica, see a qualitative, exploratory study by Martínez Franzoni and Ramírez (2006).

struggle for survival changes family structures. Grandmothers, for example, become heads of households and extend their life cycle in terms of the responsibility for care and raising children (Largaespada-Fredersdorff 2006a).

Figure 4: The care diamond in Nicaragua



The analysis found a strong influence of the presence and nature of employment on the organization of care. This is true for how women organize their lives. Among men, on the other hand, participation in care and domestic work, no matter how marginal, is primarily determined by the lack of a job or other activities. Irrespectively of whether work is temporary or permanent, within or outside the national boundaries, grandmothers play an important role in providing care for their grandchildren.

This study did not find evidence that remittances translate into the purchase of private care services. In fact, market solutions to care appeared to play a relatively marginal role, even among higher income families. Yet remittances do play an important role in facilitating the subsistence of caregivers, and in shifting 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). This pattern allows a reduction in costs in times of need, and a solution to the problem of childcare by passing the care burden on to adults other than the biological parents—often grandmothers (Fernández Pacheco 2003).

For most people, family strategies are the predominant, if not only available way, to escape poverty and ensure subsistence in Nicaragua. Family relations do not necessarily depend on marriage but often involve mother-daughter relations. In the context of surviving strategies, these family relations tend to reinforce excessive work burdens, which are for the most part

unpaid (as in the case of caretaking by grandmothers). Families in general, and women in particular, thus end up compensating for the inability of labour markets to provide paid (let alone well-paid) employment within the country (Martínez Franzoni 2008). This also means that in the Nicaraguan case, familialism is not restricted to women's dependence on a male breadwinner, but extends to other (female) family members.

Regarding social policy, Nicaraguan levels of social spending are low and completely inadequate to address the existing social needs. Nicaragua is among the four Latin American countries with the lowest social spending per capita, and vastly unable to meet the demand for education, access to potable drinking water, electricity and other social services. However, the country has been trying to formalize and organize public social policy, both within and across specific sectors. This is reflected, for example, in a considerable increase in the coverage of primary education and the proportion of children completing primary school. This increase in the state's capacity to provide educational services is not only an improvement, because it expands boys' and girls' opportunities to accumulate human capital, but also because it shifts care responsibilities from households to schools.

Despite the increase in public social spending vis-à-vis the early 1990s, Nicaraguan social policy remains limited in terms of resources and institutional structure. The social policy regime is weakened by an ineffective state bureaucracy and the dependence on NGOs and parent associations that have assumed strategic state functions. In order to compensate for the lack of domestic resources, social policy depends on external funding (increasingly loans and decreasingly grants) by international organizations which in turn shape policy priorities. They often do so in inconsistent ways that do not necessarily strengthen public institutions. As a consequence, state provision—organized around programmes and with insufficient resources—is insecure, unstable, offers poor services and has serious difficulties in improving its capacity.

The high dependence of state programmes on unpaid, predominantly female work exacerbates these weaknesses. Mothers, who have not finished primary school, are managing educational institutions. They are expected to generate income, care for their children and be volunteer cooks or *brigadistas*. The extraordinary dependence on unpaid work cuts across social sectors, from health and nutrition to social protection and education. The line between community participation and unpaid work is extremely blurred, and unpaid work does not always lead to improved programming and strategic planning.

Parents' associations, non-governmental and other local organizations play an important role in compensating for the weakness of public policies. There are different modes of the implementation of social policies through unpaid work, from volunteers (in school boards or health brigades) to individual families (in food preparation). Depending on the area of social policy, "partners" can be more or less formalized, for example in the form of associations. However, given the blurred line between the public and the private realms, it is often hard to separate the actors. In terms of care, state programmes are funded by international development cooperation and executed in some measure by volunteer staff (such as food programmes), while others are financed out of the national budget and managed by civil society organizations (such as schools and high schools).

When a country is rebuilt after a war, as is the case in Nicaragua, some parts of the population, specifically those with access to money and power, find ways to generate income and access public social services while others do not. There are no defined parameters for resource allocation, and although resource allocation for social policy and family arrangements are theoretically separate, they are hard to distinguish in the Nicaraguan case. Social policy is residual, minimalist and highly dependent on the participation of families and women, even in sectors where progress has been made. And unlike in welfare regimes with strong formal labour markets, people's survival and an acceptable standard of living depend heavily on family networks.

In terms of gender, the analysis shows that women, much more than men, are responsible for the care of dependents (children and the elderly) *and* income generation. Social policy has been insufficient in general, but has particularly failed to address gender inequalities in care. To make things worse, many policies, including the different childcare centres projects and programmes implemented over the last decades, are implicitly or explicitly based on the assumption that the responsibility for care resides with women in general, and mothers in particular. Both on the paradigmatic level and in practice, it is women who are in charge of care and domestic work. At the same time, the difficult economic situation has led to permanent or temporary migration. In many cases, part of the family, often the mother, lives outside the country to earn income, while families on the home front are increasingly dismantled. This, in turn, produces the kind of female care chains emerging from the focus groups. These chains are generally familialized and female, but may include women outside of immediate family ties in cases of extreme economic necessity.

Social policy, especially with regard to care, does not sufficiently reflect these changed family structures and their needs. Rather, it builds upon traditional and still dominant ideas of maternalism. Gender equity does not appear as a prime objective, despite discourses of “mainstreaming”, with the exception of programmes related to reproductive health and domestic violence. However important these programmes are for women’s rights, they do not have a direct effect on care. There is, indeed, an urgent need to address the high degrees of familialization and feminization of the care regime, and social policy should have an explicit role in this. Social policy discontinuities and the high dependence on the resources and therefore also on the agendas of international agencies, complicate this endeavour.

During the 1990s, structural adjustment policies increased women’s hardships, but it also strengthened the women’s movement and its organizations (Metoyer 2000).⁵⁸ However, women’s organizations have focused almost exclusively on the provision of social services (primarily health care). The relationships between family, work and care have not received the same level of attention. Addressing these issues would be a precondition for helping women deal with the responsibility of carrying the country’s care regime on their already overburdened shoulders. Involving a wide range of social and economic actors is one of the major challenges for creating a different regime that does not leave the responsibility for care to Nicaragua’s women and families alone.

⁵⁸ As shown by Kampwirth (2004), in Nicaragua, this was a largely unexpected outcome of the revolution. It was also, in Nicaragua as much as in El Salvador, the outcome of women’s search for autonomy from male-dominated Left-wing parties.

Bibliography

- Agurto, Sonia y Alejandro Guido. 2001. *Mujeres: Pilares fundamentales de la economía nicaragüense*. FIDEG, Managua.
- Armony, Ariel. 1997. "The former contras." In Thomas W. Walker (ed.), *Nicaragua without Illusions: Regime Transition and Structural Adjustment in the 1990s*. Scholarly Resources, Wilmington.
- Asamblea Nacional de la República de Nicaragua. 1997. "Ley 290. Ley de organización, competencia y procedimientos del Poder Ejecutivo." *La Gaceta*, No. 102, 3.
- Bradshaw, Sarah. 2008. "From structural adjustment to social adjustment: A gendered analysis of conditional cash transfer programmes in Mexico and Nicaragua." *Global Social Policy*, Vol. 8, No. 108, pp. 188–207. <http://gsp.sagepub.com>, accessed in October 2008.
- Chacón, Judy. 2005. "Merienda escolar garantizada." *La Prensa*, 29 June.
- Espinosa, Isolda. 2008. *The Political and Social Economy of Care*. Research Report 2. UNRISD, Geneva. Mimeo.
- Estado de la Nación. 2008. *Informe del Estado de la Región*. Programa del Estado de la Nación, San José.
- Fernández Pacheco, Janina (ed.). 2003. *Género y mercado de trabajo: Honduras y Nicaragua San José de Costa Rica*. OIT, Proyecto Género, pobreza y empleo en América Latina, San José.
- Filgueira, Fernando. 1998. *El nuevo modelo de prestaciones sociales en América Latina: Residualismo y ciudadanía estratificada. Ciudadanía y política social*. FLACSO/SSRC, San José, pp. 71–116.
- Gershberg, Alec. 1999. "Decentralization, citizen participation and the role of the state: The autonomous school program in Nicaragua." *Latin American Perspectives*, Vol. 26, pp. 8–38.
- Government of Nicaragua. 2003a. *Política de Protección Social*. Managua. Mimeo.
- . 2003b. *Plan Nacional de Desarrollo*. Technical Secretariat of the Presidency, Managua.
- . 1991. *Plan Nacional para Desarrollo Humano, Infancia y Juventud 1991–2005*. Government of Nicaragua.
- International Food Policy Research Institute (IFPRI). 2005. *Nicaragua: Red de Protección Social Mi Familia, Rompiendo el Ciclo de la Pobreza*. IFPRI, Washington, DC.
- Kampwirth, Karen. 2004. *Feminism and the Legacy of the Revolution: Nicaragua, El Salvador, Chiapas*. Latin American Series No. 43, Ohio University Research in International Studies. Ohio University Press, Athens.
- Largaespada-Fredersdorff, Carmen. 2006a. "Nicaragua: Red de protección social y sistema de atención a crisis." In Ernesto Cohen and Rolando Franco (eds.), *Transferencias con Corresponsabilidad: Una Mirada Latinoamericana*. SEDESOL-FLACSO, Mexico City.
- . 2006b. *Igualdad de Género, Pobreza, Políticas de Conciliación entre los Ámbitos Productivo y Reproductivo. Un Estudio de Caso Sobre Nicaragua*. Prepared for the regional project on Fiscal Policy with a Gender Focus, UNFPA–GTZ, Mexico City.
- Martínez Franzoni, Juliana. 2008. *Domesticar la incertidumbre en América Latina: Mercado laboral, política social y familias*. Editorial de la Universidad de Costa Rica con el apoyo del PNUD, San José.
- Martínez Franzoni, Juliana and Guillermo Monge. 2007. "Políticas con efectos conciliatorios: Una región, distintos escenarios." In Judit Astelarra (ed.), *Género y Cohesión Social*. Working documents, No. 16. Fundación Carolina, Madrid. www.fundacioncarolina.es/NR/rdonlyres/DC30FB4E-3B52-40A0-863E-3AB41CDF4AEF/1799/DT17.pdf, accessed in May 2008.
- Martínez Franzoni, Juliana and Ana Catalina Ramírez. 2006. *Del trabajo al trabajo: Orientaciones hacia el trabajo remunerado de las mujeres en Costa Rica*. PNUD-INAMU, número 1, 55 páginas.
- Márquez, Margarita, Rosibel de los Ángeles Rodríguez and María de la Luz Kageyama. 2005. "Violencia de género: Actitud y conocimiento del personal de salud de Nicaragua." *Salud Pública de México*, Vol. 47, pp. 134–144.
- Medellín Torres, Pedro. 2004. "La política de las políticas públicas: Propuesta teórica y metodológica para el estudio de las políticas públicas en países de frágil institucionalidad." *CEPAL. Serie políticas sociales*, No. 93.
- Mesa-Lago, Carmelo. 2008. *Reassembling Social Security: A Survey of Pensions and Healthcare Reforms in Latin America*. Oxford University Press, Oxford.
- Metoyer, Cynthia. 2000. *Women and the State in Post-Sandinista Nicaragua*. Lynne Rienner, Boulder, CO.

- Ministry of Education. 2001. *Plan Nacional de Educación 2001–2015*. Ministry of Education, Managua.
- . 1990. *Líneas de Políticas y Medidas Educativa*. Plan Operativo MED 1990–1996. Ministry of Education, Managua.
- . 1982. *Plan Nacional de Acción del Proyecto Principal de Educación en Primaria, 1983–1986*. Ministry of Education, Managua.
- Ministry of the Family and Ministry of Education. No date. *La Educación Inicial en Nicaragua, Diagnóstico Situacional*. Programme for Integral Care of Nicaraguan Children, Managua. Mimeo.
- Ministry of Health (MINSAs). 2000. Análisis de la situación de salud en Nicaragua. First edition. Ministry of Health. PAHO/WHO. Managua.
- . 1997. *Plan Nacional de Salud, 1997–2002*. MINSAs, Managua.
- . 1991. *Nicaragua, Plan Maestro de Salud 1991–1996*. Ministry of Health, Managua.
- Molyneux, Maxine. 2008. *Conditional Cash Transfers: Micro-Targeting Human Development*. Paper presented at the Seminar on Production and Distribution in Latin America, San José, 3–4 July.
- . 2007. *Change and Continuity in Social Protection in Latin America: Mothers at the Service of the State?* Programme on Gender and Development, Paper No. 1. UNRISD, Geneva.
- . 2006. "Mothers at the service of the new poverty agenda: ProgresA/Oportunidades, Mexico's conditional transfer programme." *Social Policy and Administration*, Vol. 40, No. 4, pp. 425–449.
- Nuevo Diario. 2005, "PINE asegura merienda en las escuelas pobres", 20 de mayo.
- Pan American Health Organization (PAHO)/World Health Organization (WHO). 2005. *Estrategia de cooperación con el país, Nicaragua 2004–2005*. OPS, Oficina Regional de la OMS, Managua.
- Programa de Atención Integral a la Niñez Nicaragüense (PAININ). 2001. *Evaluación final al Programa PAININ, Informe Final. Documento de Consultoría para el Programa de Atención Integral a la Niñez Nicaragüense*. Ministry of the Family, Managua.
- Palacios, Martha, Gilma Tinoco y Rebeca Centeno. 2008. *El Trabajo Doméstico en Nicaragua*. COMMCA/AGEM, Managua.
- Pérez Sáinz, Juan Pablo, Katharine Andrade-Eekhoff, Santiago Bastos y Michael Herradora. 2004. *La estructura social ante la globalización: Procesos de reordenamiento social en Centroamérica durante la década de los 90*. FLACSO/CEPAL, San José.
- Ramírez González, Ximen. No date. Interview with Max Padilla. Revista Páginas Verdes, Report No. 44. Managua. www.euram.com.ni/pverdes/Entrevista/max_padilla.htm, accessed in June 2008.
- Rodríguez, Adolfo. 2005. *La Reforma de Salud en Nicaragua*. ECLAC/GTZ, Santiago de Chile.
- United Nations Development Programme (UNDP). 2006. *Informe anual 2006: Un aliado para el desarrollo*. PNUD, Managua.
- World Bank 2008. *Country Profiles*.
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTEDUCATION/EXTDATASTATISTICS/EXTEDSTATS/0,,contentMDK:21605891~menuPK:3409559~pagePK:64168445~piPK:64168309~theSitePK:3232764,00.html>.
- World Bank. 2006. *World Development Indicators 2006*. The World Bank, Washington, DC.

UNRISD Programme Papers on **Gender and Development**

- PP GD 8 **The Political and Social Economy of Care in Nicaragua:
Familialism of Care under an Exclusionary Social Policy Regime**
Juliana Martínez-Franzoni, with Carmen Largaespada-Fredersdorff,
Karime Ulloa and Koen Voorend, February 2010
- PP GD 7 **Harmonizing Global Care Policy? Care and the Commission on the
Status of Women**
Kate Bedford, February 2010
- PP GD 6 **The Political and Social Economy of Care: The Republic of Korea**
Ito Peng, October 2009
- PP GD 5 **A Debate on the Public Role of Religion and its Social and Gender
Implications**
José Casanova and Anne Phillips, September 2009
- PP GD 4 **The Statistical Evidence on Care and Non-Care Work across
Six Countries**
Debbie Budlender, December 2008
- PP GD 3 **The Political and Social Economy of Care in a Development Context:
Conceptual Issues, Research Questions and Policy Options**
Shahra Razavi, June 2007
- PP GD 2 **A Critical Review of Selected Time Use Surveys**
Debbie Budlender, June 2007
- PP GD 1 **Change and Continuity in Social Protection in Latin America:
Mothers at the Service of the State?**
Maxine Molyneux, May 2007

