Access to Justice and the Right to Care

A Roadmap from Latin America for a Global Agenda

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Introduction

Care has been part of the sustainability of life since the beginning of time: it permeates people's everyday lives, drives the economy, and sustains the social fabric. As a conceptual category, care was initially defined as "[…] everything that we do to maintain, continue and repair 'our world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" (Tronto and Fischer, 1990: 40).

The complexity of care is linked to the different levels of intensity and demands that arise throughout the life course, organized around three basic dimensions: receiving care, providing care, and caring for oneself (self-care). The question that feminist scholars and the women's movement have highlighted for decades is how the expression of gender relations has shaped the sexual division of labor, consolidating women's subordination in the public sphere (in social, political, and economic life), while simultaneously structuring their almost exclusive dedication to care responsibilities.

Care involves both physical and biological as well as emotional elements, all of which are necessary to sustain everyday life: food, hygiene, and clothing are part of direct care activities; and managing all the preconditions necessary for direct care to take place constitutes indirect care, including tasks such as shopping, transportation, and waste sorting (Rodríguez Enríquez and Pautassi, 2014).

Feminist theoretical developments were central because they emphasized the need to make visible the time and effort that care inevitably requires. Summarizing this in the assertion that care is (a form of) work rather than (an act of) love (Federici, 2013) helped simplify its complexity and advance awareness of its importance. The critical point that still requires recognition is that, because these tasks are essential, they have become invisible, without due consideration for the time, skills, and dedication they demand from those who perform them silently. Of course, caring for and receiving care involve emotions and affection, but these should not be considered at the expense of the effort involved or the economic value generated. Without care, there can be no reproduction of the labor force: it is through people's rest, nutrition, and hygiene that the modern capitalist system is sustained—and reproduced (Fraser, 2023).

Meeting the multiple dimensions of care requires skills, resources, infrastructure, and time. The State, public or private institutions, communities, or families—or a combination thereof—will be responsible for meeting this range of concurrent, systematic, and indispensable needs and activities, both for the sustainability of life (Pérez Orozco, 2014) and of the planet (ECLAC, 2022). What the literature refers to as the "care diamond" (Razavi, 2007) combines responsibilities and obligations distributed among the State, the market (or private sector), families, and social and community organizations.

Empirical evidence from Latin America shows that skills, resources, infrastructure, and time are not distributed equitably. In fact, care work takes up twice or three times as much of women's daily time as it does that of their male counterparts. At the regional level, women devote between 12% and 24% of their time to care, while men devote only between 5% and 9% (ECLACa, 2025: 44). This time commitment increases in contexts of vulnerability: limited access to basic services such as water, sanitation, and electricity, which affects 17% of the population of Latin America living in informal settlements or inadequate housing, has a direct impact on the amount of time women devote to these tasks (ECLACa, 2025: 85). There is a need to further explore the link between care and the right to the city (Rico and Segovia, 2017), a concept that helps synthesize many of the demands articulated through the legal empowerment of informal-settlement communities, where the interdependence of rights reveals the complexities of urban life as a collective right with political, civil, economic, social, and cultural dimensions (Di Giovanni and Bercovich, 2025; Falú, Rico, and Segovia, 2026).

The market assumes a share of care through paid services. These are highly feminized occupations, often racialized and shaped by colonial biases, which tend to offer poorer employment conditions and receive little social recognition. At the regional level, 27.4% of employed women work in care-related occupations, including 10.9% in domestic work, 9.3% in education, and 7.8% in health care (ECLACa, 2025: 49). Labor informality affects women more severely, as they are overrepresented in occupations associated with care (including education, health care, personal care, and cleaning). In addition, approximately 23.6% of women in Latin America have no independent monetary income, compared with only 10.2% of men (ECLACa, 2025: 48). The unjust distribution of care work by gender is transmitted across generations: girls and adolescent girls take on care responsibilities that affect their exercise of the right to education, play, and leisure, as well as, later on, their entry into the labor market and their future prospects (ELA-UNICEF, 2024).

Care not only meets needs but also generates economic value, as it contributes directly to countries' gross domestic product (GDP). According to data from the International Labor Organization (ILO), women's unpaid work in Latin America and the Caribbean contributes, on average, approximately 21.4% of GDP, exceeding the 15% average contribution in OECD countries (Organization for Economic Co-operation and Development) (ILO, 2019). In other words, women subsidize a large part of government action and public policies (Pautassi and Marco Navarro, 2020) through their invisible labor.

The “privileged irresponsibility” enjoyed by older men in society, insofar as they enjoy the “privilege” of going through adulthood without assuming an equal share of care work (Tronto, 2013), is a consequence of the unjust sexual division of labor, entrenched in traditional social values concerning gender, ethnicity, race, and social class. The analytical and theoretical field of feminist research, both globally and particularly in Latin America, has defined and characterized care (Batthyany, 2020 and 2024), alongside the active demands of the feminist movement and various proposals developed in each country in the region.

The shift from the individual and feminized nature of care to its collective and societal dimension occurred first through its identification as work (paid or unpaid) and subsequently as an autonomous human right. Care is a need and a form of work that entails assuming responsibilities as a public good and that extends beyond the realm of interpersonal relationships to encompass commitments within the field of human rights. Applying the human rights approach methodology (Pautassi, 2007) made it possible to identify specific obligations relating to care. The recognition of care as a human right is part of a historical and political framework that incorporated care into various international covenants and treaties, establishing obligations without explicitly referring to them as care. This reinforced its historical invisibility, but at the same time demonstrated its indispensable nature for life in society (Pautassi, 2023).

In the twenty-first century, as this conceptual development progressed, it became possible to identify the scope and substance of the right to care, reaching regional political consensus and advancing its judicial recognition at both the national and regional levels. From Constitutional Courts and Supreme Courts to the recent intervention of the Inter-American Court of Human Rights (IACHR), the substance and scope of the human right to provide care, receive care, and exercise self-care have gradually been delineated.

This document addresses that process: the initial definition of the right to care; the interpretive development led by legal scholarship as well as by Latin American jurisprudence; and, finally, the standards through which the IACHR established obligations for its implementation. Based on the obligations established for the various actors involved in care, including support measures to ensure independent living for persons with disabilities, the document proceeds to identify the enforceability of the right to care within the framework of guarantees of access to justice from a people-centered approach. Effective realization of the right to care requires not only strengthening the legal empowerment of people who can demand its fulfillment, but also promoting the integration of justice services with broader social interventions and public policies, such as care infrastructure, transportation, and basic health services. Finally, the document puts forward an agenda proposal aimed at strengthening coordination with political actors

capable of driving a rights-based intervention agenda, drawing on the Latin American experience of defining the right to care from the foundations of the feminist movement, both in academia and in the social sphere.

1

The Human Right to Care: A Process of Social and Political Construction

a. From Social Movements to Political Negotiation: The Regional Construction of Political Consensus

Care, in all its dimensions, is an autonomous right protected under the principal international human rights covenants and treaties in force in the Americas, as well as under international human rights instruments within the universal human rights system. This understanding of the "right to care, to be cared for, and to self-care" (Pautassi, 2007: 18) was recently reaffirmed by the Inter-American Court of Human Rights (IACHR) in Advisory Opinion 31/25 of June 12, 2025, marking a paradigm shift at the global level (IACHR, 2025).

In exercising its interpretive powers, the highest regional human rights court took up an agenda that academia and the feminist movement had been advancing in terms of conceptualizing care as work and as a human right. This demand was further advanced by governments in the region through the implementation of care systems and the development of various public policies.[1] By unequivocally reaffirming that care is an autonomous, universal, and interdependent human right, interconnected with other economic, social, cultural, and environmental rights (ESCR), the Court gave impetus to a transformation in the way a social need and one of the most cross-cutting socioeconomic issues is addressed.

From a legal perspective, this approach moves toward integrating filial and parental relationships with the State's obligations to respect, protect, and guarantee a right, thereby contributing to its exercise under conditions of equality and nondiscrimination. At the same time, it establishes the interdependence of this right with other social rights and outlines the standards necessary for its implementation. In this way, it moves beyond the fragmentation of traditional labor and social security regulations, not only by expanding the scope of rights-holders (this is not a right derived from one's status as a worker or from particular social or personal circumstances), but also because it entails a reconsideration of the conceptualization of paid and unpaid work, interpersonal ties and relationships, and the corresponding obligations.

These dimensions, reflected in legislation and the body of human rights law, have transformed the rigid approach and opened the door to reconsidering the scope of obligations related to care. As defined in law, the right to care is held both by care providers and care recipients, linking the concepts of a dignified life, well-being, protection of families, maternity, children and adolescents, persons with disabilities, older persons, among others.

1 For an overview of the development of care-related demands within the feminist movement in Latin America, see Marco Navarro (2025); for developments at the level of United Nations bodies, see Staab (2025).

Recognizing care as a human right breaks with the normalization of women's role as caregivers based on socially imposed expectations and instead places it within the condition of being a person, which concerns all of us as human beings (Pautassi, 2023). This recognition not only incorporates a powerful definition grounded in its status as a human right, but also establishes responsibilities, guarantees, and means of fulfillment; it assigns a central role to the State (through all three branches of government), while also establishing obligations for the private sector, markets, and community settings. It also positions men, as human beings, as direct bearers of responsibilities related to care and as active participants in promoting well-being, both within their families and in the community.

Theoretical developments recognizing the fundamental right to care are particularly significant. Marrades Puig (2023: 33) defines care as a multifaceted or multidimensional right, which includes the right to receive care as well as the right to provide care, separate from the obligation to provide it, as in the case of family members, parents, or the State. The author identifies two dimensions: the right to receive care and the right to provide care, distinguishing between legal obligations concerning care, such as the civil obligation to provide support, and the freedom to provide care. It is a right to services, encompassing both the activity and duty of providing care and the obligation to provide the economic and material means necessary for caregiving to be a genuinely free act. Accordingly, the social-rights nature of care is reaffirmed within the framework of a social state governed by the rule of law (Marrades Puig, 2016).

Fredman (2024) emphasizes that the right to care is as important as freedom, dignity, and equality as constitutional values or principles (*"constitutional commitments"*) and stresses that it is not an issue affecting women exclusively but rather one that concerns society as a whole. Among the various effects of constitutional recognition, the author notes that it would first affect legislators and judges in their roles as interpreters and enforcers of the law and, second, legitimize political activism. One of the author's various arguments in favor of constitutional incorporation is that it would help transform the perception of care as a private matter and move away from the notion that constitutions impose obligations only on the State or public sector. She promotes a transformative perspective through what she calls *"positive constitutionalism"* (Fredman, 2024: 744), while making visible the androcentric component of constitutions and the ways in which they have historically been shaped by patriarchy and by the failure to recognize care. It would also entail defining the role of judicial review without encroaching upon the powers of the legislative and executive branches, particularly when care policies require the allocation of resources, as a means of bringing care into decision-making processes. This is particularly relevant

because the State must be able to justify the disproportionate burden of care responsibilities and costs borne by women.

From a gender perspective and based on the principle of equality and nondiscrimination, judicial protection of economic, social, and cultural rights (ESCR) has been reaffirmed by making visible the structural inequality embedded in societies, where both the causes and the mechanisms that reproduce it affect people's ability to exercise their rights on equal terms. Authors such as Alfonso Sierra and Alterio (2021: 1074) highlight the importance of judicial analysis effectively interpreting and applying the commitments established in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), thereby contributing effectively to overcoming structural inequality. In the case of care, this inequality is not only paradigmatic but is also sustained by a set of stereotypes that reinforce the assignment of care responsibilities to women. Being a rights-holder with respect to care is a prerogative that requires protection, guarantees, and concrete entitlements, while at the same time requiring compliance with the obligations inherent in that right (Gherardi and Pautassi, 2020). The possibility of separating the need to provide or receive care from the means through which that need is met entails a transformation in how care is addressed. Specifically, recognizing care as a human right held by every person allows it to be considered as work while also enabling anyone to invoke it autonomously, regardless of whether they need to provide care, need to receive care, or meet any of the conditions that have traditionally enabled access to care arrangements (for example, being formally employed or living in poverty, having a medical condition, or being at a stage of life when more intensive care may be required, such as early childhood). Moreover, recognizing care as a human right enables guarantees related to access to justice, understood as a mechanism for making rights enforceable.

This process was reflected in the Inter-American Convention on Protecting the Human Rights of Older Persons (2015), a regional human rights instrument that clearly establishes care as a human right. The Convention specifically states that "older persons have the right to a comprehensive system of care that protects and promotes their health, provides social services coverage, food and nutrition security, water, clothing, and housing, and promotes the ability of older persons to stay in their own home and maintain their independence and autonomy, should they so decide" (IACPHR, 2015, art. 12).

The principle of universality, interdependence, and indivisibility of human rights, enshrined in the 1993 Vienna Conference's Program of Action[2], serves as

2 https://www.ohchr.org/sites/default/files/vienna.pdf.

a standard for State action and drives the promotion of comprehensive public policies that provide systemic responses. At the same time, it promotes the development of progress indicators to measure the fulfillment of rights. This commitment to mainstreaming had already been explicitly assumed by States in Latin America and the Caribbean, as reflected in the various Regional Conferences on Women in Latin America and the Caribbean (RCW) through a process that developed progressively over the years.[3] From the identification of care as a human right (Pautassi, 2007: 18), progress was made toward its recognition within this regional body and the subsequent implementation of care policies, including the development of national care systems in some countries and care policies or responses at the local level in others.[4]

It was at the Tenth Regional Conference on Women in Latin America and the Caribbean, held in Quito, Ecuador, in 2007, that care was first presented not only as work (paid and unpaid, performed primarily by women) but also as a human right (Pautassi, 2007). Applying the human rights approach methodology, the existing obligations under international covenants and treaties that impose responsibilities on States with respect to care were identified. Although the language of human rights instruments does not use the concept of care (instead, references are made, for example, to the protection of maternity or persons with disabilities), it is nevertheless possible to identify its three central dimensions: "the right to care, to be cared for, and to self-care" (Pautassi, 2007: 18). The political force with which the feminist movement articulated this demand, together with governments' recognition of the social and economic value of women's unpaid domestic work, brought about a fundamental shift in the regional agenda. Reaching consensus that care is a public matter concerning States, local governments, organizations, businesses, and families, and establishing the need to promote shared responsibility between women and men within families, represented a foundational moment in the regional agenda.

At the subsequent RCW, this regional agenda was progressively consolidated. The next commitment was the Brasilia Consensus (2010), which explicitly recognized care as a human right. The subsequent consensuses—the Santo Domingo Consensus (2013), the Montevideo Strategy (2016), the Santiago Commitment

3 This is a subsidiary body of the Economic Commission for Latin America and the Caribbean (ECLAC), established in 1977, with the organization's Division for Gender Affairs serving as its technical secretariat. At the conclusion of each conference, a consensus or commitment is adopted, setting out the policy agenda for the countries of the region (https://www.cepal.org/en). It should be noted that, since the most recent Conference in 2025, its name has been changed to the Regional Conference on Women in Latin America and the Caribbean. The consensus documents are available at: https://www.cepal.org/en/subsidiary-bodies/regional-conference-women-latin-america-and-caribbean.

4 According to the Gender Equality Observatory (OIG-ECLAC), 16 countries in Latin America have made progress in developing care policies and systems, while 9 countries (Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, Panama, Uruguay, and Venezuela) have already enacted legislation.

(2020), the Buenos Aires Commitment (2022), and the Tlatelolco Commitment (2025)—reaffirmed, with increasing emphasis, the human-rights nature of care in its three dimensions and expanded the foundations for designing rights-based care provision systems. Since the Buenos Aires Commitment, the region has reaffirmed its commitment to promoting the development of care societies, with a view to achieving a horizon of sustainable recovery with gender equality (ECLAC, 2022d).

Within the framework of the Fifteenth Regional Conference on Women in Latin America and the Caribbean, whose theme was the promotion of a care society, the recognition of the right to care was further strengthened (section 8), requiring the adaptation of regulatory frameworks (section 9) and the establishment of public policies that promote co-responsibility (section 10).

Buenos Aires Commitment (2022)

8. Recognize care as a right to provide and receive care and to exercise self-care based on the principles of equality, universality and social and gender co-responsibility, and therefore, as a responsibility that must be shared by people of all sectors of society, families, communities, businesses and the State, adoptin gregulatory frameworks and comprehensive care policies, programs and systems with an intersectional and intercultural perspective that respect, protect and fulfil the rights of those who receive and provide paid and unpaid care, that prevent all forms of violence and workplace and sexual harassment in formal and informal work, and that free up time for women, so that they can engage in employment, education, public and political life and the economy, and enjoy their autonomy to the full.

9. Adopt regulatory frameworks that ensure the right to care through the implementation of comprehensive care policies and systems from a gender, intersectional, intercultural and human rights perspective, and include joined-up policies on time, resources, benefits and universal, good-quality public services in the territory.

10. Design and implement State policies that favor gender co-responsibility and make it possible to overcome harmful sexist roles, stereotypes and norms, through regulations aimed at establishing or broadening parental leave for the diverse forms of families, as well as other types of leave to care for dependent persons, including inalienable and non-transferable paternity leave.

Source: RCW-ECLAC (2022), Buenos Aires Commitment.

The strength of the political consensus achieved made it possible for Argentina's Ministry of Women, Genders and Diversity—which was established in 2019 and remained in operation until December 2023, when it was dissolved by the current administration (ELA, 2025b)—to submit a request to the IACHR in January 2023 asking the Court to interpret whether care is an autonomous human right and to define its scope. This request paved the way for a process of major regional significance. Once the Court declared the request admissible, a large number of governments, specialized human rights bodies, universities, civil society organizations, human rights defenders, and advocates for sexual diversity, among others, participated in the proceedings. A total of 129 amicus curiae submissions were filed, providing strong arguments affirming that care is a human right.[5] According to the Court, this was the second most participatory process in the history of its advisory opinions, demonstrating the interest generated by recognition of this right. The IACHR itself highlighted the conceptual work developed by academia and civil society through an "orderly and strategic transnational coordination"[6] to promote the interpretation that was subsequently reflected in Advisory Opinion 31/25.

Just days after Advisory Opinion 31/25 was notified, the Sixteenth Regional Conference on Women was held in Mexico City, with the right to care as one of its central themes. The Tlatelolco Commitment welcomes the Advisory Opinion issued by the Court and encourages "Governments to respect and ensure this right, and to adopt legal and other measures to ensure its complete fulfilment" (ECLAC, 2025: sec. 6). By establishing "a decade of action, 2025–2035, in Latin America and the Caribbean to advance the achievement of substantive gender equality and the care society through political, economic, social, cultural and environmental transformations" (ECLAC, 2025: sec. 7), the Commitment sought to chart a roadmap to maintain and deepen this agenda amid uncertain political circumstances.

5 The content of the Advisory Opinion, concurring opinions, and hearings is available at: https://www.corteidh.or.cr/OC-31-2025/index-eng.html.

6 Concurring opinion of Judge Verónica Gómez, pp. 1–2. She adds that "the most challenging phase in terms of public policy development is only just beginning and deserves continued support and sustained efforts by States, civil society, academia, and society as a whole, as a paradigm of sustainable development, equality, and peace" (Gómez, 2025: para. 5).

Tlatelolco Commitment (2025)

With the aim of promoting the construction of a care society that places care at the center of life and the planet, governments commit to:

4. Recognize the human right to care, which comprises the right to provide and receive care and to exercise self-care, based on the principles of equality, universality and social and gender co-responsibility, and which therefore constitutes an obligation of the State and a responsibility that must be shared by persons of all sectors of society, men and women, families, communities and the private sector.

5. Adopt regulatory frameworks and comprehensive care policies, programs and systems with an intersectional and intercultural perspective that are sustainable over time, that respect, protect and fulfil the rights of those who receive and provide paid and unpaid care, that prevent all forms of violence in formal and informal work, ensure women's full, equal and meaningful participation in public and political life and the economy and free up time for women, so that they can engage in employment and education, and enjoy their autonomy to the fullest.

Source: RCW-ECLAC (2025), Tlatelolco Commitment.

These advances were also consolidated within the international human rights protection system. In 2023, the United Nations General Assembly designated October 29 as the International Day of Care and Support, calling for transformative global action. That same month, during the 54th session of the Human Rights Council, a resolution was adopted on the centrality of care and support from a human rights perspective—the first of its kind specifically addressing care. Among other measures, it called on States to implement "all measures necessary to recognize and redistribute care work among individuals […] in a manner that promotes gender equality and the enjoyment of human rights by all" (United Nations, 2023). In July 2024, the United Nations Economic and Social Council (ECOSOC) addressed the right to care, highlighting the importance of the issue and the need to incorporate it into efforts toward global recognition (ECOSOC, 2024).

In November 2025, the Bi-Regional Pact on Care between Latin America and the Caribbean (LAC), the Community of Latin American and Caribbean States (CELAC), and the European Union (EU) was signed. The Pact promotes a cooperation mechanism to establish comprehensive care systems, improve

working conditions, and reduce gender inequality in unpaid domestic work.[7] It recognizes care as a human right and proposes a permanent forum for dialogue and cooperation on the legal, social, and economic dimensions of care systems, establishing focal points in countries to promote their implementation. On July 5, 2026, the Ibero-American Charter on Care and Support was signed in Avilés, Spain.[8] Like the previous instrument, it reaffirms that care is a need, a form of work, a human right, and an essential public good, positioning transformative change around universality and the binding nature of its fulfillment. In both cases, the agreements are intergovernmental, with the collaboration of specialized United Nations technical agencies (ECLAC, UN Women, ILO, among others) and the Ibero-American General Secretariat (SEGIB), and with the support of civil society organizations, particularly the feminist movement. These instruments go beyond establishing a series of common principles: based on gender and human rights approaches, they move toward agreeing on an action strategy, with focal points to promote implementation in signatory countries and a strategic agenda for implementation. These are among the many resolutions and initiatives advanced on the multilateral agenda that strengthen the recognition of care as a human right.

In summary, the 20 years of regional advocacy and policy development outlined here in broad terms have brought together theoretical developments concerning care, recognizing its nature as both work and a right that are unequally distributed, and have generated a sequence of actions that now make it possible to affirm that Latin America is the region of care. As discussed in the next section, the political commitments made by governments in regional and global forums have progressively translated into concrete public policies.

b. From Commitments to Public Policy: The Role of Courts in Recognizing the Right to Care

During these years, significant progress was made both at the legislative level and through constitutional reforms incorporating the right to care in various countries across the region, alongside cross-jurisdictional responses stemming from the creation of national care systems, subnational or local initiatives, and laws and regulations that address the three dimensions of the right to care. To mention just a few examples, Uruguay was a pioneer through Law No.

7 Signed in November 2025 during the Fourth CELAC-EU Summit in Santa Marta, Colombia, and ratified in Berlin, Germany, in May 2026 at the meeting of the focal points.

8 https://segib.org/wp-content/uploads/2026/07/Carta_Iberoamericana_Cuidados_Apoyos.pdf.

19.353 of 2015, which established the National Care System (SNC) based on the understanding that care is a right, a social function, and a shared responsibility among the State, families, communities, and the market.

As noted above, approximately 16 countries in the region are currently in the process of designing or implementing public care policies based on comprehensive systems or, in other cases, at the local or subnational level, demonstrating the importance of the care agenda and progress toward fulfilling obligations arising from the right to care. In addition to Uruguay, notable progress has been made in Costa Rica, Colombia, Cuba, Chile, Brazil, Paraguay, and Mexico. At the local level, progress has been made in cities such as Bogotá and Mexico City, as well as in Bolivia through the enactment of municipal laws, and in Panama and Colombia at the national level (Marco Navarro et al., 2026).

Prior to the IACHR's ruling in Advisory Opinion 31/25, constitutional jurisprudence in several countries had already recognized the right to care. In 2020, a decision by the Constitutional Court of Ecuador broadly recognized the right to care of women workers whose labor rights had been affected by discriminatory acts. According to the Ecuadorian Court, gender-based social relations reproduce the stereotype of women as caregivers and men as providers, a situation that was exacerbated by the pandemic to the point of placing women at a clear disadvantage because of the care responsibilities they had to assume. The case concerned public-sector workers who were pregnant or breastfeeding. The Court identified and developed concrete examples of productive and reproductive tasks, reaffirmed the importance of the right to provide and receive care, and introduced the concept of "good living" (sumak kawsay) as applied to care, establishing standards and determining obligations for the State.[9]

For its part, the First Chamber of the Supreme Court of Mexico[10] addressed the right to care for persons with disabilities, older persons, and persons with long-term or chronic conditions. It grounded recognition of the right to care in the Constitution and international covenants and treaties, recognizing care as a fundamental good and reaffirming that all people have the human right to provide care, receive care, and exercise self-care, while emphasizing the State's leading role in protecting and guaranteeing that right. Along the same lines, it held that the State must adopt measures to ensure that care work does not fall disproportionately on families, particularly on women and girls. The Supreme

9 Constitutional Court of Ecuador, Case 3-19-JP and consolidated cases. Review of Guarantees (JP). Rights of Pregnant and Breastfeeding Women, Quito, August 5, 2020. Available at: https://www.corteconstitucional.gob.ec/sentencia-3-19-jp-20-y-acumulados/.

10 On October 18, 2023, First Chamber of the Supreme Court of Justice of Mexico, Direct Amparo Proceeding 6/2023. Available at: https://transparencia-ciudadana.scjn.gob.mx/resoluciones-relevantes-de-la-scjn/derecho-al-cuidado/amparo-directo-6-2023.

Court further stated that care should be provided by various sectors of society and must be provided under dignified, high-quality conditions, regardless of socioeconomic circumstances, with the State playing a leading role.

In Colombia, the Constitutional Court has addressed care in several decisions. In Decision T-583 of 2023, it defined the right to care as a right grounded in the pillars of the social state governed by the rule of law. In considering the care and health situation of a child with Down syndrome, the Court incorporated concepts related to the guarantee of a dignified life, personal autonomy, and the interdependence of the right to care with the right to health, particularly for persons in vulnerable situations. The decision emphasizes the State's obligation to guarantee access to public policies that ensure the exercise of the right to care, while also taking into account paid and unpaid care workers and providing and guaranteeing the resources, infrastructure, and support necessary to ensure well-being. In subsequent decisions, such as the case involving an application for recognition of a special old-age pension for the parent of a child with a disability (Case T-447/23), the Court again addressed the scope of the right to care and determined that the applicant's right to care had been violated, as had the rights of the person requiring care (the child) and the applicant's wife. In contrast, in Decision T-159/23, the Court examined the case of 24 women in vulnerable situations who, in 2020, were excluded from the Solidarity Income Program (PIS), a cash-transfer program for households living in poverty that was implemented during the COVID-19 pandemic. The decision recognized care work and the rights of caregivers, ordering the State to implement a set of measures, from an intersectional perspective, to ensure that caregivers are prioritized in other programs developed in the future. In 2024, the Court also issued four decisions addressing the right to care. Decision T-446/24 addressed the duty to guarantee rehabilitation treatment for children and adolescents with disabilities and the necessary home-based care. In particular, the Court distinguished among different types of services, including nursing, home-based care, and the services of a shadow teacher, and established parameters for addressing each of them.[11]

In the Dominican Republic, the Constitutional Court ruled on paternity leave, ordering the legislature to review and amend the duration of paternity leave established in the Labor Code, setting a longer period consistent with the principles of equality and reasonableness, which "shall be progressively adjusted, as socioeconomic circumstances permit, until reaching a period that guarantees responsible parenthood under conditions of gender equality."[12]

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11 The various decisions are available on the Court's website: https://www.corteconstitucional.gov.co/. See also Ramírez et al. (2025).

12 Constitutional Court of the Dominican Republic, Decision TC/0901/23. This decision declared Article 54 of the Labor Code—Law 16-92—unconstitutional (2023: 43–44).

These are some of the judicial precedents that have enriched theoretical developments and demonstrated the service-based nature of the right to provide care, to receive care, and to self-care. These cases have given rise to claims brought by diverse actors—both individuals and collective entities—representing different types of interests, including the right to receive benefits and the recognition of certain employment conditions for care workers, in response to rights violations resulting from exclusion from certain programs or limitations in coverage. These decisions illustrate the diversity of social and legal relationships at stake when enforcing the right to care in its different dimensions. They also demonstrate the potential of this right in connection with the guarantee of access to justice, as discussed below.

In some countries, efforts to enforce the right to care have also been accompanied by legislative reforms promoting changes to leave regimes within labor regulations and expanding social security benefits through the specific recognition of care (Marco Navarro and Huertas, 2025). In others, reforms have been initiated in civil and family law that, from an intersectional perspective, have modified gender biases concerning family responsibilities for care, incorporating diverse family structures arising from diverse sexual identities, same-sex marriage, and the resulting shared responsibilities. In other cases, the debate has focused on women's economic autonomy through the review of legal mechanisms such as economic compensation in marriage or the calculation of support payments following divorce.

Another area in which progress has been made concerns the right of persons with disabilities to live independently, in line with the Convention on the Rights of Persons with Disabilities. Although the concepts of "care" and "support" overlap, each has distinct elements. The concept of care includes activities that go beyond addressing people's needs to also encompass caring for society and the environment. The concept of "support" is different and focuses on how assistance is provided, emphasizing the autonomy of persons who need such support and their ability to decide what assistance they seek and receive. Support may be provided through human assistance as well as assistive devices, technologies, and support infrastructure, including sign language interpreters, alternative means of communication, decision-making assistance, domestic assistance, community services, and specific support to access general services such as health care, education, or justice (Special Rapporteur on the Rights of Persons with Disabilities, 2016). The term "care and support" encompasses both concepts (OHCHR, 2025).

Traditional care systems often focus on the caregiver, positioning care recipients as passive recipients without the agency to control and direct the care they receive, which can lead to loss of autonomy, segregation, and isolation from the

rest of the community through institutionalization. Consequently, the concept of care, with its historical connotations of oppression and the denial of agency, carries significant weight for the disability rights movement and may appear to conflict with the support system promoted by the Convention on the Rights of Persons with Disabilities. Therefore, the way forward is not to exclude the needs and rights of persons with disabilities from care systems, but rather to rethink these systems based on the core principles of the Social Model of Disability: autonomy and independence, participation, and inclusive equality.

Reexamining these concepts from a common perspective means bringing these two dimensions together: recognizing care and support as vital forms of work, but also as rights that must guarantee autonomy, agency, and inclusion for all people. The goal is not merely to free up the time that women have traditionally devoted primarily to care tasks—as emphasized by the women's and feminist movements—but also to do so while addressing the needs, interests, and expectations of persons with disabilities, creating the conditions for them to exercise their autonomy and agency, with whatever support they may require to exercise their rights (ELA, 2025a).

In Latin America, community-based work has a long tradition, with specific ethnic and racial dimensions given the region's cultural and territorial disparities. In this regard, it is increasingly being reaffirmed as a central component of the care diamond (Razavi, 2007), while incorporating longstanding and far-reaching demands. One valuable example is the process being carried out in Colombia through intergovernmental dialogue in local territories and engagement with Indigenous and Afro-Colombian peoples. The proposal forms part of the National Development Plan, Colombia: World Power of Life, developed by the national government in collaboration with ethnic communities, and is intended to serve as a key input for the creation of the ethnic chapter of the National Care System.[13] In other cases, territorial movements associated with the right to the city organize collective demands through the legal empowerment of communities and the promotion of public discussion and community participation spaces, where a focus on gender inequalities has been key to highlighting the unequal impact of exclusion and vulnerability on women.[14]

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13 "Contributions to the Development of the Ethnic Chapter of Colombia's National Care System Based on Knowledge-Sharing Dialogues with Indigenous, Afro-Colombian, Raizal, and Palenquera Women Caregivers for the Identification, Recognition, Representation, and Compensation of Their Own Care Practices"; GRADE Fund; August 2025.

14 A recent study by Catalina Marino analyzes various experiences of community legal empowerment from a gender-equality perspective, highlighting the importance of considering at least three elements: the concrete identification of community needs in relation to gender inequalities; the promotion of the agency of women leading these strategies; and the need to ensure access to resources that enable participation in implementing the actions identified (Marino, 2025).

Although progress has been uneven across countries, significant results have been achieved that must be translated into institutional commitments for which the State is responsible, establishing the conditions under which care must be provided and received. In particular, IACHR Advisory Opinion 31/25 advances not only definitions of what the three dimensions of care entail, but also the standards according to which care must be provided. In other words, it establishes concrete obligations, recognizing that States must undertake three types of action based on their role as regulators of social relations, providers of services, and promoters of cultural change (Marco Navarro, 2025).[15]

With regard to this last point, Advisory Opinion 31/25 is not merely an interpretive document; it also establishes the mandates necessary for the exercise of the right to care. It sets out implementation guidelines addressed to States and their three branches of government and addresses the other actors involved in care (markets and the private sector, social and community organizations, and families). It emphasizes the need to eradicate stereotypes surrounding care within families, especially those affecting girls and adolescent girls, from an intersectional perspective, as well as in relation to the business sector and other areas such as education and health care. The Court begins by recognizing that unpaid care work and caregiving duties affect the enjoyment of economic, social, cultural, and environmental rights (ESCR). In particular, they affect girls' and adolescent girls' right to education, emphasizing that prevailing stereotypes concerning the concentration of responsibilities on women and the role assigned to them within the family affect the exercise of their autonomy—physical, economic, and political—and fail to guarantee them sufficient time to exercise their right to education, thereby reinforcing a cycle between income poverty and time poverty.

The Court states that unpaid care work in the home must not prevent girls and adolescent girls from attending school. It is therefore essential to promote co-responsibility between men and women within families, as well as public investment in services and infrastructure, particularly for women experiencing adolescent or early motherhood, in order to effectively address the sexual division of labor and care. More specifically, Advisory Opinion 31/25 provides examples of progressive measures for States to adopt concerning the distribution of care responsibilities, together with the necessary broad-based training and professional development measures, grounded in the principle of equality and nondiscrimination. The intersectional approach is also reflected in the IACHR's proposal, which recognizes the value of local and Indigenous knowledge,

15 Defining these roles is relevant when evaluating, for example, childcare policies and services at the local level (ELA, 2026).

including knowledge concerning environmental care, as key standards to be applied at the local level.

The Court reminds States that they

> "have the obligation to take measures to remove barriers – for example, by awareness-raising campaigns – so that families cease to differentiate the treatment they accord to their sons and daughters, and to provide safety measures for access to education by girls" (IACHR, para. 525).

These are just examples of the various issues addressed by Advisory Opinion 31/25, but throughout the Opinion the Court reaffirms that the right to care is a right subject to immediate fulfillment[16], thereby reinforcing the public policy agenda currently being advanced in countries throughout the region.

16 Concurring opinion of Judge and President of the IACHR, Dr. Nancy Hernández, p. 3.

2

Interpretive Standards and Scope of Advisory Opinion 31/25 Regarding the Right to Provide Care, to Receive Care, and to Self-care

The IACHR unanimously recognized that care is an autonomous right grounded in the provisions contained in international human rights covenants and treaties, as well as in comparative constitutional law (IACHR, 2025). The Court draws upon and reaffirms the responsibilities and rights related to care included in all human rights instruments, reviewing their scope in each instrument and in dialogue with the Court's own jurisprudence.

Based on the pro persona principle, the Court recognizes the existence of an autonomous right to care, derived from a joint reading of Articles 4, 5, 7, 11, 17, 19, 24, 26, and 1.1 of the American Convention on Human Rights (ACHR).[17] It further affirms the right to comprehensive protection of the family established in Article 17 of the Convention, which requires States to take "appropriate steps to ensure the equality of rights and the adequate balancing of responsibilities of the spouses," including the rights of children born out of wedlock and those born in wedlock, based on respect for equality before the law and without discrimination of any kind.

This is an autonomous right that must be guaranteed on an equal basis before the law and without discrimination (Article 24), grounded in the right to honor and recognition of the dignity of the person (Article 11), requiring the adoption of domestic measures to guarantee the right (Article 2), as well as judicial protection and the availability of effective remedies (Article 25). The IACHR also recognized that the right to care derives from rights recognized in the American Convention, Articles 34 and 35 of the Charter of the Organization of American States (OAS), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the Protocol of San Salvador. In other words, compliance with this right is mandatory for all States in the region.

The IACHR then defines the three dimensions of the right to care. First, it establishes that

> "The autonomous right to care includes the right of every person to have the time, space, and resources necessary to provide, receive or procure conditions that ensure their comprehensive well-being and allow them to freely develop their life project, in accordance with their abilities and stage of life […] This right is governed by the principle of social and family co-responsibility, since care is the joint responsibility of the individual, the family, society and the State; by the principle of equality and non-discrimination, which requires that men and women should have the same rights

17 IACHR, 2025, para. 112, p. 41.

> and responsibilities in caregiving; and that children and adolescents, older persons, and persons with disabilities and illnesses that compromise their autonomy and independence, should receive care appropriate to their condition" (IACHR, 2025: para. 113).

The highest regional court further states that

> "this right protects both those who receive care and those who provide it, and has three fundamental aspects: to receive care, to provide care and to self-care" (IACHR, 2025: para. 132).

The Court also considers that

> "the guarantee of the right to care and its content are closely related to other rights by virtue of the principles of interdependence and indivisibility of human rights, and acquire specific characteristics based on the requirements and needs of vulnerable groups" (IACHR, 2025, para. 133).

Finally, the Court concludes that

> "States have a margin of discretion in designing public policies aimed at the progressive implementation of the right to care. However, the Court notes the particular relevance of creating National Care Systems as a structural instrument for guaranteeing the right to care, insofar as they allow for the regulation, coordination, supervision and oversight of different types of care services based on the aforementioned principles and obligations" (IACHR, 2025, para. 132).

One of the central implications of recognizing the three dimensions of the right to care is their translation into concrete obligations for States. These include positive obligations (to take action) and negative obligations (to refrain from interference), as well as the identification of third parties with obligations (subject to State regulation) and, ultimately, the obligation to produce information and ensure accountability, including mechanisms for access to justice to enforce rights. Another highly significant consequence is that this is a human right held by every person, regardless of whether they are formally employed, have access to a social protection system, or are in a situation of vulnerability.

The IACHR defines the standards applicable to the right to care based on the principles of universality; minimum core content of rights; progressivity and non-regression; equality and nondiscrimination; access to justice; access to information; empowerment and social participation; and intersectionality. These

are supplemented by specific standards defined in relation to care, reaffirming that States have a duty to progressively fulfill the right through measures that guarantee the quality, availability, and adaptability of benefits and services, as well as the time associated with leave entitlements, understanding care in general as a central component of overall well-being.

By virtue of the commitments established in international covenants and treaties and constitutional mandates, these standards must also guide the actions of legislative bodies and the decisions of judicial bodies. In Advisory Opinion 31/25, the IACHR reinforces the development of standards in its own jurisprudence, reaffirming that they had already been established in relation to other economic, social, cultural, and environmental rights (ESCR), including the rights to health, education, work, and social security, and that they must be applied to the right to care. The following table presents, in schematic form, some of the principal standards identified. Far from being an exhaustive list, it seeks to illustrate how these standards should be taken into consideration in the design, planning, implementation, and evaluation of public policies or care systems.

Table 1. Standards Applicable to the Right to Care

Principle	Description	Reference to Advisory Opinion 31/25
Universality	Foundational basis of human rights. Principle based on the status of every person, without discrimination. Operates as a rule of action *vis-à-vis targeting*.	*Pro persona* principle."The social valuation of care constitutes a legal obligation derived from the principle of solidarity, insofar as care represents a human activity with intrinsic value and an essential element for strengthening bonds between people and social cohesion" (para. 120).
Minimum content	Irreducible core that must be guaranteed. Core elements required to ensure a dignified and adequate life. Includes human, material and financial resources, as well as infrastructure.	"States have a margin of discretion in designing public policies aimed at the progressive implementation of the right to care" (para. 132).
Progressivity and non-regression	Principle enshrined in international treaties and conventions. Requires States to advance and not regress in the level of fulfillment of rights. Prohibits the elimination of rights already acquired. Progressive obligations and effective implementation.	"States must adopt measures and provide the means and resources necessary to respond to the demands for the effectiveness of the rights involved, always to the extent permitted by the economic and financial resources available to them for the fulfilment of their respective international commitments" (para. 126).

Principle	Description	Reference to Advisory Opinion 31/25
Equality and non-discrimination	Rights must be guaranteed without distinction of any kind. Prohibits discrimination based on sex, gender, sexual orientation, language, religion, or social or economic status, among others. Persons in situations of vulnerability.	Core standard for guaranteeing care in all its dimensions. "The State must guarantee that caregiving work is performed without discrimination, respecting the greatest possible degree of autonomy of the persons receiving care and ensuring their active participation in decisions that affect them" (para. 116 and 136). "In the Court's opinion, poverty and extreme poverty place those who suffer from these conditions in a particularly vulnerable situation, inter alia with regard to their right to provide and receive care, as it is difficult for them and their families to provide care and imposes on society and the State a reinforced duty to assist in guaranteeing this right. Accordingly, this Court finds that, in cases of poverty, extreme poverty and destitution, the principles of co-responsibility and solidarity are intensified with regard to care and its immediate enforceability, as a corollary of the principle of non-discrimination" (para. 135).
Access to justice	Guarantees effective judicial or quasi-judicial mechanisms. Ensures adequate, expeditious and impartial proceedings, without undue delay. Care is a right in itself and a means of accessing other rights.	Interdependence with economic, social, cultural and environmental rights (ESCR). Inter-American public order. Conventionality control. Broad application (para. 124). Binding nature. "This Court considers that, when resolving disputes and legal issues that may arise in the area of care, the competent authorities must carry out due control of conventionality with the standards developed by the Court in its jurisprudence and, in particular, in this Advisory Opinion, in order to ensure the adequate protection of human rights. These standards also derive from the American Declaration and the OAS Charter, and are therefore applicable in all member countries of the inter-American system" (para. 124).
Access to information	Right to be freely informed. Obligation to produce information. Access to relevant information held by the State. Essential for monitoring and enforcing rights.	"States also have an obligation to advance in the recognition of unpaid care work, for which reason, they must implement or continue implementing statistical systems for measuring, appraising and quantifying unpaid care work and its contribution to the economy" (para. 162).
Empowerment and social participation	Promotes citizen participation in public decision-making. Promotes active involvement in the exercise of rights. Empowerment strengthens the capacity to exercise rights.	People's agency (para. 116). "Access to care is not merely a welfare measure, but rather an essential normative condition for the effectiveness of human rights" (para. 108).

Principle	Description	Reference to Advisory Opinion 31/25
Gender perspective	Elimination of negative gender stereotypes relating to care.	"States must guarantee that, in practice, men and women enjoy all their rights in equal conditions and without discrimination on account of their participation in unpaid care work. In this regard, they should adopt measures, in accordance with their obligations of progressive development, to reverse the conditions that perpetuate discrimination against persons who perform unpaid care work" (para. 160).
Autonomy	Recognizes each person's capacity for self-determination with regard to their body and the full development of their personality and life project.	"Recognition of the right to care presupposes its normative and functional autonomy, insofar as it protects a specific set of material and relational conditions that are essential for human well-being and dignity, and whose omission or neglect may compromise the effective exercise of several interdependent rights" (para. 114).
Solidarity	Principle based on the existence of a common humanity and the interdependence of people as members of society. Duty of mutual respect and cooperation among people for the effective exercise of their rights and the achievement of common goals.	"Reinforces the obligation of individuals, families, communities, civil society, businesses, and the State to assume, respectively, a dual responsibility: on the one hand, to assist, support and care for those who are dependent to some degree; and, on the other hand, to support those who perform these tasks, ensuring that they have the necessary conditions to provide care properly, that their work is recognized, and that they have support to alleviate the burdens of caregiving" (para. 120).
Intersectionality	Recognizes multiple and simultaneous inequalities. Analyzes how factors such as gender, class, ethnicity, disability, etc. intersect. Makes visible particular forms of rights violations.	"In certain cases, factors of discrimination may converge to increase the disadvantages faced by particular individuals or groups of individuals. In relation to the right to care, this can lead to situations of intersectional discrimination, understood as a 'cross-cutting' form of discrimination that causes a specific type of prejudice due to the convergence of multiple factors" (para. 158).
Quality	Must be guaranteed in connection with the principle of a dignified life and the highest attainable level of overall well-being. Linked to full respect for the person's human rights, dignity and privacy, as well as their agency. Must also provide for mechanisms to monitor and oversee effective compliance.	Three dimensions of the right: para 116 *et seq.* Mandatory for the public and private sectors. "It also involves progressively implementing, in accordance with the principle of co-responsibility, quality care services that are accessible to all. This includes services for those who do not have family or community networks, as well as services aimed at contributing to the provision of care beyond the exclusive sphere of the family. This is especially important in the case of the right to care for persons living in poverty, extreme poverty or destitution, or those who have no support network, and persons living alone or in abandonment" (para. 151).

Principle	Description	Reference to Advisory Opinion 31/25
Co-responsibility	Care responsibilities must be distributed equitably among all those responsible for care: the State, the market, families, and social and community organizations.	"According to this principle, caregiving is a responsibility shared between individuals and the social spaces in which they live: family, community, civil society, business, and the State. This principle imposes joint and separate responsibilities on various social entities to ensure the management and sustainability of daily life, which may be understood as a care network, whose scope is determined by the needs of individuals and the areas of action specific to each social entity. This principle has a specific scope —understood as family co-responsibility— with regard to the need for a fair, equitable and supportive distribution of unpaid care work between men and women within the family. This element establishes that men and women have equal responsibilities in caregiving 119).

Source: Authors' own elaboration based on Pautassi (2023) and IACHR (2025).

In Advisory Opinion 31/25, the IACHR also addressed the interdependence of the right to care with the rights to work, social security, health, and education with respect to both persons who provide care and those who receive care, as well as self-care, within the framework of the protection afforded by the American Convention and the other instruments of the international human rights system.

With regard to paid care work, the IACHR recognizes that it is often performed in the informal economy, whether in settings such as childcare facilities or nurseries, schools, medical centers, facilities for older persons, or within private homes, and whether performed by trained or untrained workers.[18] The IACHR therefore emphasizes the need for States to adopt measures that facilitate the transition of women workers from the informal to the formal economy, while also adopting the positive measures necessary to ensure the full exercise of their labor and trade union rights during this transition. This also includes strengthening mechanisms for monitoring informal employment and creating jobs through policies involving the private sector.[19]

Even for those who provide paid care under formal employment arrangements, the IACHR recognizes social security as a tool that can assist in the transition of these workers into the formal economy. It therefore urges States to guarantee

18 IACHR, Advisory Opinion 31/25, para. 219.

19 IACHR, Advisory Opinion 31/25, para. 378.

access to contributory social security schemes under the same conditions and with the same benefits available to persons in formal employment relationships.

In particular, the Court recommends taking into account developments in international labor law. In developing these standards, the Court considers the ILO Conventions concerning Home Work (Convention No. 177), Domestic Workers (Convention No. 189), and Nursing Personnel (Convention No. 149), drawing from them standards[20] that provide for special measures to guarantee the rights of these workers, taking into consideration the conditions under which they have historically performed their work. These standards include fair and equitable remuneration; employment stability and administrative and judicial remedies to seek redress in the event of violations of their rights; measures to ensure occupational safety and health; reasonable limits on working hours; maternity, sick, and study leave for workers; the right to freedom of association and collective bargaining; and measures to address structural discrimination and workplace violence.

The foregoing is necessary not only to respect and guarantee the rights of paid care workers, particularly their right to provide care, but also to ensure the quality of the services they provide and, consequently, guarantee the right to receive care.

At the same time, the interrelationships between women's exercise of autonomy, access to education and training (particularly in new information and communication technologies), and the changing demands of the labor market, together with shifting care responsibilities, remain unresolved. A new division must be established, since women will have access to leave and other protections if they are covered by a protected employment regime (formally employed workers), while those working in the informal economy will have no such mechanisms.

It must also be acknowledged that the lack of a fair division of labor and responsibilities with spouses and other members of the household—and the longstanding critique of the "naturalization" of care work as women's work and its exclusive and intensive assignment to women—has not been sufficiently challenged in public debate. Even less forceful has been the argument for the need to redistribute these responsibilities and establish shared responsibility with men in their families. The reference to a "cultural change" supposedly required of men, and also of women so that they can "delegate" care responsibilities, ultimately becomes a symbolic and self-congratulatory narrative that provides

20 IACHR, Advisory Opinion 31/25, paras. 220 et seq.

room for delaying specific measures. Hence the central importance of the right to self-care, which constitutes

> "a cross-cutting dimension that enables the enjoyment of other rights and must be understood as a necessary condition for a fulfilling life."[21]

The three dimensions of the right to care reflected in legislation and the corpus of human rights transform the static view of care and make it possible to reconsider the scope of obligations related to care, since the legal definition and entitlement to this right encompass care providers, care recipients, and persons who are themselves rights-holders. The central point is that all actions aimed at guaranteeing this right must be universal in nature and comply with standards of quality and cultural appropriateness, as well as principles of intersectionality, progressivity, sufficiency, and corresponding human rights standards. In particular, they must respect the principle of each person's autonomy and independence, which, in the case of persons with disabilities, includes access to support for independent living and public policies grounded in the Social Model of Disability.

In summary, with the adoption of Advisory Opinion 31/25, we now have an instrument whose application is binding within the regional public-law framework, and which provides key elements for reshaping responsibilities and obligations concerning care. The issue that must now be explored in greater depth is its effective implementation, which requires ensuring meaningful access to justice and to appropriate services.

21 Para. 7, Concurring Opinion of Judge Eduardo Ferrer Mac-Gregor Poisot, IACHR, 2025.

3

Access to Justice and the Right to Care

The IACHR has dispelled any doubts regarding the universal, indivisible, and inherent nature of the right to care, which guarantees that, based on the exercise of their autonomy, every person can receive, provide, or secure quality, sufficient, and dignified care in order to live independently throughout all stages of life. Therefore, no personal, social, economic, or migration-related circumstance, nor factors such as sexual identity, race, origin, disability, or gender identity, may limit the exercise of this right. This is a key starting point for building the foundations for its enforceability.

Although this is not a new right, but rather one that remained invisible until recent years, the legitimacy conferred by its recognition enables a process of learning and consolidation toward its effective exercise.[22] Since care encompasses a range of activities that are indispensable to human existence and reproduction, they cannot be addressed through a single, uniform approach. On the contrary, they involve physical, material, and emotional elements that enable social integration and everyday life. Yet because care is not distributed or organized neutrally, its provision is shaped by a culture that reproduces negative stereotypes and conditions its provision on the intensive involvement of women.

With regard to the standard of access to justice, the IACHR considers that, when resolving disputes and legal issues that may arise in the area of care,

> "the competent authorities must carry out due control of conventionality with the standards developed by the Court in its jurisprudence and, in particular, in this Advisory Opinion, in order to ensure the adequate protection of human rights. These standards also derive from the American Declaration and the OAS Charter, and are therefore applicable in all member countries of the Inter-American system."[23]

Unanimously, the IACHR emphasized the binding nature of its Advisory Opinions: the Court's interpretations form part of the relevant *corpus juris* for giving substance and effectiveness to the protection of human rights, both internationally and domestically, and they are also a source of law on which States must rely in fulfilling their international obligations.[24]

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22 In his concurring opinion, Dr. Eduardo Ferrer Mac-Gregor notes that this is a lost or unnamed right in the American Convention on Human Rights (para. 11), which, through a process of integrating the provisions of that Convention and other human rights instruments, allows for the jurisprudential recognition of the right to care as an autonomous right.

23 IACHR, 2025, para. 124, pp. 45–46.

24 See Advisory Opinion OC-26/20 of November 9, 2020, concerning the denunciation of the American Convention on Human Rights and the Charter of the Organization of American States and its effects on State obligations concerning human rights; and Advisory Opinion OC-32/25 of May 29, 2025, concerning Climate Emergency and Human Rights.

How should the challenges of access to justice relating to the right to care and support be addressed when the same unequal distribution of care responsibilities in terms of gender, class, and intersectionality limits women's ability to exercise their rights? Establishing, even at the constitutional level—as has been the case in countries such as Mexico—that care is an enforceable right is not enough to guarantee its effective exercise.

A people-centered approach to access to justice entails reorganizing the system around the experiences and needs of those who use it, rather than around the internal logic of institutions (UNDP, 2025). This means recognizing that justice is not limited to the formal existence of institutions, courts, or legal rules, but is measured by people's actual ability to resolve their legal problems in a timely, accessible, appropriate, and sustainable manner. For this reason, it is necessary to understand people's needs and the unresolved problems that affect their everyday lives and place them at the center of justice policies and services. Information gathered through surveys, interviews, and qualitative studies, complemented by data from administrative records of the various services that show which issues are actually addressed through the wide range of available procedures, provides the evidence needed to understand the dimensions of access-to-justice problems (Gherardi, 2012).

The report on access to justice in Ibero-America (Ibero-American Alliance, 2023) draws on the available evidence to provide an overview of the situation in the region. It indicates that unmet justice needs are part of everyday reality for more than one-third of the population of Ibero-America. Among people experiencing legal problems, at least one in five cannot find adequate information and advice in their country. For those facing legal problems, access to legal assistance is extremely limited: more than four in ten people in the region report that they cannot find adequate legal assistance. Lack of access to justice has very tangible consequences for people's living conditions and well-being: at the regional level, at least one in four people with legal problems experienced an adverse impact on their finances or health as a result of those problems (World Justice Project, 2023).

A people-centered justice approach focuses on resolving concrete problems that affect everyday life, such as access to services and benefits, housing, recognition of labor rights, access to social protection and public services, and the conditions under which people migrate and live in different territories, among many others. It also takes into account the actual pathways people follow in seeking solutions and examines the very different circumstances in which those pathways affect people based on their gender, age, ethnic or racial origin, social or migration status, or disability. This entails adopting a broad conception of access to justice that encompasses not only traditional justice systems but also administrative

justice, community-based and alternative dispute-resolution mechanisms, complaint mechanisms for public services, and social protection systems.

In the context of Latin America and the Caribbean, this approach can strengthen the democratic legitimacy of the judicial system and its alignment with international human rights standards. To this end, it combines institutional support (top-down) with community-based interventions (bottom-up) aimed at resolving problems while identifying and reducing the various barriers to access. These barriers include direct costs (such as court fees and attorney fees); indirect costs (such as transportation expenses, lost workdays, and the cost of securing replacements for family and care responsibilities); geographic distance (the travel required between communities and the locations of administrative or judicial offices); lack of information and low levels of legal literacy (lack of knowledge of laws, procedures, technical terminology, required documents and evidence, connectivity problems, or lack of familiarity with digital tools); procedural complexity (the length and stages of proceedings and the fragmentation of procedures); and structural discrimination (based on gender, age, poverty, disability, migration status, ethnic or racial identity, rurality, etc.) (Birgin and Gherardi, 2011).

An access-to-justice perspective and the incorporation of strategies such as legal literacy and legal empowerment can expand the range of tools and participation mechanisms available to bring people closer to the effective exercise of their rights. These strategies can promote spaces for citizen participation involving the different branches of government—including through public hearings, engagement with institutions such as ombuds offices, advocacy for legislative changes, and the implementation or expansion of public policies—that go beyond judicial strategies for enforcing rights in cases of noncompliance or violations.

In the face of a right so intrinsically linked to each person's everyday living conditions, ensuring participation mechanisms to achieve the effective realization of the right to care helps amplify the voices of those who are otherwise unheard. In the words of the IACHR, empowerment strengthens people's agency so as to ensure that care can be provided without discrimination, respecting personal autonomy and ensuring the active participation of individuals in decisions that affect them (para. 116 of Advisory Opinion 31/2025).

Although the Advisory Opinion does not focus on responsibilities directly assigned to justice administration systems, it does establish that care is an autonomous right protected by the ACHR and that it is fundamental to a dignified life and to the ability to enjoy other rights, including the right of access to justice. It is therefore essential to consider factors that may exacerbate barriers to access to justice, including the costs associated with providing direct care and, where

necessary, arranging for someone else to provide it in order to comply with required proceedings and administrative processes, as well as the availability of childcare or care services during court hours or when carrying out procedures related to access to justice.

The disproportionate burden of care responsibilities borne by women affects their ability to access justice in ways that are often underestimated, such as travel time, transportation costs, and the management of care or support responsibilities for family members. The connection between the justice administration system and other public policies is therefore essential to addressing these challenges, while also recognizing the human right to provide care, receive care, and self-care.

The role of the judiciary in relation to care extends not only to identifying structural barriers to women's access to justice resulting from their disproportionate care burden, but also to addressing the barriers to justice faced by women who perform paid care work and/or provide support under conditions of exploitation, informality, or precarity, particularly with regard to recognition of their rights as workers. The IACHR's recent Advisory Opinion opens up a fundamental agenda for the region in this area, which will need to be further developed through appropriate strategies to ensure full respect for women's rights on an equal and nondiscriminatory basis.

An access-to-justice agenda is linked to a broad conception that focuses not only on the justice administration system but also on public administration, at all levels of government and across all areas of the State. This is where proximity to citizens can foster full and substantive participation.

The various lines of action could be organized into a framework that includes:

→ Citizen participation with a gender, intersectional, and intergenerational perspective, creating opportunities to influence the diagnosis, definition, implementation, monitoring, and evaluation of public policies related to care and support in their various dimensions;

→ Mechanisms for oversight and enforceability to ensure nondiscriminatory access to public policies related to care and support;

→ Spaces for coordination between communities and opportunities for legal support to litigate cases involving violations of individual or collective rights, including those of care recipients and care workers;

→ Strategic litigation before national and international jurisdictions that contributes to further developing the conceptualization of the right to care in line with international human rights law, strengthening the empowerment of rights-holders across its various dimensions: the right to provide care, to receive care, and to self-care.

The unequal distribution of time, power, and resources resulting from the unequal distribution of care responsibilities affects opportunities to access justice, as reflected in unmet legal needs, lack of access to relevant legal information, and difficulties accessing appropriate justice services. These factors must be taken into account in organizing legal services for care workers—particularly migrant workers, informal workers, and domestic workers—as well as in mitigating the impact of care responsibilities as barriers to access to justice.

In experiences involving legal empowerment work with communities in situations of vulnerability, litigation strategies form part of a broader strategy aimed at promoting processes in which active community participation plays a central role. These strategies are more likely to achieve lasting results when they form part of comprehensive, long-term social and political interventions (Di Giovanni and Bercovich, 2025). In this regard, the IACHR reaffirmed in Advisory Opinion 31/25 that "States have the enhanced obligation to guarantee the right to care of children who are particularly vulnerable" (para. 182), providing examples in individual cases, and not only with respect to children but, more broadly, with respect to different persons in situations of vulnerability.

Access-to-justice strategies in this area could be linked to initiatives aimed at:

→ **Defending and protecting** the right to care and support, including the definition, implementation, and access to services that meet the standards established by Advisory Opinion 31/2025, based on appropriate assessments;

→ **Promoting citizen participation** in public processes—including debate, implementation, and enforcement—while seeking to mitigate the impact of inequalities among the parties involved;

→ **Seeking remedies for violations of rights**, particularly for populations in situations of greater vulnerability, including workers, migrants, older persons, and persons with disabilities, including through the definition and application of existing regulations governing the private sector in areas such as employment, health, and education; and

→ **Addressing structural issues** related to the right to provide care, to receive care, and to self-care, including the development and contribution of evidence; the allocation of public resources and budget execution; territorial organization and the organization of justice services themselves, including public transportation systems and childcare spaces within public offices; the definition of conditions for participation in public debates; and the enabling environment for interventions by organized civil society.

This is an evolving agenda closely linked to the framework establishing States' obligations to respect, protect, and guarantee rights. In complex contexts where the region has taken a pioneering role in defining the right to care and the resulting State obligations, the major challenge is to establish a roadmap that can define the obligations to guarantee this right across Latin American countries, moving from the definition of minimum core content toward the progressive realization of the right to care and support.

4

The Political Agenda: Care and Support Initiatives Driven by the Region

The evolution of the recognition of care in Latin America not only has its own distinctive features, but also aligns with the foundational global consensus of the current century, which identified the reduction of inequalities as one of its central goals. This includes SDG 10, which, in conjunction with SDG 5 on gender equality, creates a unique opportunity to place care firmly on the public agenda. Clearly, this entails efforts on the part of States not only in terms of democratic governance and their capacity to implement public policies, but also, and precisely, in terms of clear political will and social consensus.

In short, Latin America has a robust human rights protection framework, global agendas and, in many countries, political will together with a greater degree of institutional capacity and public investment. Nevertheless, so far this century, inequalities and discrimination have changed very little, and the transformative agenda remains absent in an increasingly complex context in which regressive measures are combined with a narrative that challenges the very existence of structural gender inequality and promotes austerity policies that constrain the role of the State.

Even in the face of leaders contributing to an authoritarian drift in the region, Latin America has reached specific consensuses, such as the Tlatelolco Commitment (2025), which establishes a decade of action for gender equality and introduces concrete commitments to the care agenda. The virtuous process developed at the regional level, promoted from the bottom up through collaboration among academia, civil society, feminist activism and spaces for policy advocacy, achieved the advances reflected in the highly participatory process leading to Advisory Opinion 31/2025 (Pautassi, 2025). This process now faces threats that are already translating into significant political setbacks, which not only promote cultural changes detrimental to women's autonomy, but also directly affect society as a whole by challenging the State's role as provider and regulator.

In contrast to the interpretation adopted by the highest regional court in Latin America, which focuses on State obligations, these threats center on denying the obligations incumbent upon the State, questioning the international human rights framework, and challenging the link between the promotion of well-being and the central mandate of welfare regimes and social States governed by the rule of law. In other words, they not only undermine the core of the distributive commitment and the role of the State within the care diamond, but also reinforce the unjust sexual division of labor and the concentration of care responsibilities among women.

At present, approximately 16 Latin American countries are implementing care policies, whether through policies promoted by the executive branches, legislative reforms or proposed constitutional reforms, while case law is

consolidating at various levels by incorporating conventional mandates and the standards established in Advisory Opinion 31/25 of the IACHR.

Today, the regional process is being driven by a significant number of relevant stakeholders and by the feminist movement. However, for the exercise of the right to care to become firmly established in concrete practices, further progress is needed in applying the relevant standards. These translate into mechanisms for enforcing the right, which should not be regarded as mere challenges, but rather as obligations that are directly enforceable against all those involved in the provision of care: the State; the market and private sector; the community sector; families; and, within them, men.

The multi-stakeholder and multi-level process developed in Latin America around the recognition of the right to care as an autonomous right, belonging to each and every person and grounded in a "common humanity" (IACHR, 2025, para. 120), provides the legal tools needed to demand its fulfillment. The binding nature of its effective guarantee, based on human rights standards, activates the obligation of the State's political and administrative authorities (the executive branch at its various levels), as well as deliberative and legislative bodies, to take the necessary measures to ensure compliance. It is the obligation of each State to establish the material foundations, put the necessary means in place and provide effective guarantees so that every person can exercise their right to care in accordance with their freely chosen life plan. The effectiveness of the right to care is directly proportional to people's actual ability to choose how to exercise it and to ensure its equitable distribution. Where people lack the time, infrastructure or resources to meet care needs, and where care continues to fall disproportionately on women, as remains the case today, the right to care cannot be effectively guaranteed, and States will fail to meet their international and domestic legal obligations.

Guarantees of access to justice, on an equal and non-discriminatory basis, must begin by dismantling the existing structural obstacles and barriers, moving beyond partial remedies towards processes of structural transformation. As standards are consolidated that guarantee administrative and judicial proceedings enabling equal access to rights, progress can also be made towards the effective exercise of the autonomous right to care. This is not merely a matter of establishing procedures, institutions and mechanisms to strengthen access to justice, but also of promoting the internalization and application of the relevant human rights standards to guarantee access to justice in relation to care, both for care workers and for rights-holders whose lives are affected by care responsibilities.

Against this backdrop, it is essential to strengthen the role of multilateralism, which has been instrumental in the process leading to the recognition of the right to care and has also played a central role in advancing the recognition

of access to justice as a human right per se. Multilateralism still has a decisive role to play in advancing the transformative agenda, together with cooperation agencies and philanthropy. United Nations agencies and bodies should broaden their scope for action in order to capture this transformative regional process and promote it as a fundamental component of gender mainstreaming.

The cross-cutting nature of care is the unifying element of the transformative agenda that must be promoted globally, while respecting local specificities, regional trajectories and an intersectional approach. The success of regional processes such as the one developed in Latin America should serve as a compass for agreements that transcend internal dynamics and consolidate new forms of cooperation. The autonomous nature of the right to care, in its three dimensions, and its interdependence with civil and family rights and economic, social and cultural rights should form the core of a transformative consensus for the coming decade.

In this process, strengthening mechanisms for people-centered access to justice is essential to guarantee the universality of the right. Guarantees of access to justice have the potential to provide practical opportunities not only to address individual cases in which the exercise of the right is restricted, but also to address oppressive structural arrangements that perpetuate inequality. Moreover, through public interest litigation and other forms of strategic intervention, local courts could initiate processes to identify responsibilities and forms of harm that remain invisible within analyses of other rights, such as civil and family law, including the impact of economic violence on family and intimate-partner relationships.

Furthermore, without funding through regular budgets, little progress can be made towards fulfilling the commitments undertaken at the regional level, in line with the provisions of the Buenos Aires Commitment (2022) and the Tlatelolco Commitment (2025). Public policies must therefore necessarily be formulated in accordance with human rights standards. Otherwise, they risk reproducing entrenched practices that, far from promoting institutional capacity and universality through sustained public investment, favor fragmented and sector-specific programs over comprehensive policies.

The reaffirmation that care is an autonomous human right enables public policy-makers at all levels of government and public administration, as well as legislators and judges, to overcome the patterns of discrimination that have remained invisible in relation to care through the 5R framework: Recognition, Reduction and Redistribution of unpaid care work, together with Reward and Representation of paid care workers, adopting an intersectional, gender and intergenerational approach.

This entails efforts on the part of States not only in terms of democratic governance and their capacity to implement public policies, but also in terms of clear political will and the building of social consensus. In this regard, Latin America's experience can provide valuable lessons for other regions, creating opportunities to share experiences and transform them into strategic alliances.

5

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