CARE RIGHT IN URUGUAY OF THE PANDEMIC: MAXIMUM FAMILIARIZATION AND FEMINIZATION

O DIREITO AO CUIDADO NO URUGUAI DURANTE A PANDEMIA: FAMILIARIZAÇÃO E FEMINIZAÇÃO NA SUA MÁXIMA EXPRESSÃO

EL DERECHO AL CUIDADO EN EL URUGUAY DE LA PANDEMIA: FAMILIARIZACIÓN Y FEMINIZACIÓN EN SU MÁXIMA EXPRESIÓN

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ABSTRACT: In 2015, Uruguay recognized the right to care when implementing the National Integrated Care System (SNIC). The pandemic coincided with the inauguration of a right-wing government that promoted reducing the fiscal deficit as a central objective of its government program. This article addresses what happened to the right to care during this period, based on the analysis of official documents produced by the SNIC, news related to the measures implemented in the country, and regional data sources such as the COVID-19 Observatory in Latin America and the Caribbean of ECLAC. The existence of a cutting-edge law guaranteeing the right to care and an integrated care system was not enough to implement measures to protect this right. A residual conception of the role of the State and an approach to care associated with family and private responsibility prevailed, contrary to the framework of the meaning of the law.

KEYWORDS: Care right. Pandemic. Uruguay. Gender inequalities.

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RESUMO: *Em 2015, o Uruguai aprovou uma lei que reconhece o direito ao cuidado ao criar o Sistema Nacional de Atenção Integral (SNIC). A pandemia coincidiu com a assunção de um governo de direita que promoveu a redução do déficit fiscal como objetivo central de seu programa de governo. Este artigo aborda o que aconteceu com o direito ao cuidado durante esse período, a partir da análise de documentos oficiais produzidos pelo SNIC, notícias sobre as medidas implementadas e fontes de dados regionais, como o Observatório COVID-19 da CEPAL na América Latina e o Caribe. É evidente que ter uma lei de ponta sobre cuidados e um sistema em vigor não foram suficientes para que o governo implementasse medidas para proteger esse direito. Prevaleceu uma concepção residual do papel do Estado e uma abordagem do cuidado associado à responsabilidade familiar e privada, contrariando o quadro de sentido da lei.*

PALAVRAS-CHAVE: *Direito ao cuidado. Pandemia. Uruguai. Desigualdades de gênero.*

RESUMEN: *Uruguay aprueba en 2015 una ley que reconoce el derecho al cuidado creando el Sistema Nacional Integrado de Cuidados (SNIC). La pandemia coincidió con la asunción de un gobierno de derecha que promovió la reducción del déficit fiscal como objetivo central de su programa de gobierno. El presente artículo aborda qué sucedió con el derecho al cuidado durante este período, a partir del análisis de documentos oficiales producidos por el SNIC, noticias sobre las medidas implementadas y fuentes de datos regionales como el Observatorio COVID-19 en América Latina y el Caribe de CEPAL. Se evidencia que contar con una ley de vanguardia en cuidados, y un sistema en funcionamiento, no fueron suficientes para que el gobierno implemente medidas para proteger este derecho. Primó una concepción residual del rol del Estado y un enfoque del cuidado asociado a una responsabilidad familiar y privada, contraria al marco de sentido de la ley.*

PALABRAS CLAVE: *Derecho al cuidado. Pandemia. Uruguay. Desigualdades de género.*

Introduction

Care and its unequal distribution are of crucial relevance for understanding gender inequalities and their impact on social disparities. Alongside the advancement of knowledge about its complex nature and its rigid and unjust distribution, Latin American states have been incorporating the role of care in various ways and at

different paces, primarily through direct services, economic benefits, and regulations governing allowable work absences for caregiving.

Through their policies, states play a significant role in the redistribution of material resources and the recognition of gender differences (Fraser, 1997). Their actions (and omissions) are colored by certain conceptions of the responsibilities expected of different family members in providing social welfare, as well as those that the states themselves should assume and those that are consequently assigned to families and the market.

Since 2005, after implementing significant social reforms (in health, social security, and taxation), Uruguay began in 2010 to design a National Comprehensive Care System (hereafter SNIC). This system was announced as a priority policy in the last two leftist governments, during which specific regulations were approved, and care was identified as the fourth pillar of social welfare, alongside education, health, and social security. The term "social co-responsibility in care" was incorporated into this debate to collectively assume responsibility for caregiving. Similarly, the concept of gender co-responsibility, referring to the shared responsibility between men and women in caregiving within families, was also integrated (Perrotta, 2020).

Starting in 2015, the system began its implementation with the approval of the law that created it and defined its central components (No. 19.353). Several factors combined to bring about this qualitative leap in recognizing care as a public issue and as a right to be guaranteed by the state. Among these factors was the left's arrival in power, with an intense agenda of redistributive policies that improved the critical social situation resulting from a deep socio-economic crisis triggered in 2002. Another relevant factor has been the generation of empirical evidence, primarily through time-use surveys, which highlighted inequalities in the contribution of men and women to unpaid domestic and caregiving tasks (Aguirre, 2009; Batthyány, 2015). A virtuous circle was produced between feminist academia, the feminist movement, and authorities, facilitated by a government that utilized academic production as input for public policy design, as well as by the emerging institutionalization of a gender perspective in the Uruguayan state (Aguirre *et al*., 2014).

In March 2020, a government formed by a right-wing coalition with a different conception of the state's role in social protection took office. In this context, the SNIC was weakened and reduced in scope and was not included in the instruments implemented to address the social crisis arising from the pandemic.

This article analyzes the progress made in guaranteeing the right to care in Uruguay before the pandemic and the actions taken by the new government in this context of excessive demand for caregiving for families. Based on secondary information, it addresses the non-linearity of the process of strengthening the right to care in Uruguayan society, despite having cutting-edge instruments. The first

section presents the theoretical foundations of the right to care, drawing on feminist theory contributions and evidence generated by academia in Uruguay. The following section describes the SNIC, its main features, and services implemented during the period 2015-2019. Next, the difficulties in advancing the right to care in the context of the pandemic and the ideological shift of the government are analyzed. Finally, concluding reflections are presented.

1. Development

1.1 Theoretical Foundations of the Right to Care

The theoretical debate on the decommodification of welfare, as influenced by Esping-Andersen (1993), has been enriched by feminist perspectives that highlight the role of families and women in contributing to welfare (Orloff, 1993; Hobson, 1994; Jane Lewis, 1997). These authors observed that the processes of commodification or decommodification of welfare discussed by Esping-Andersen (1993) occur in gender-structured societies and have a differentiated impact on the lives of men and women. They pointed out that state intervention in the allocation of resources can transform or maintain the sexual division of labor and emphasized that when essential services, such as care, are not recognized as citizenship rights, they are assumed by women in an unpaid capacity, affecting their rights adversely.

The residual participation of states in caregiving functions has given rise to what feminist scholars have termed family care regimes (Saraceno, 1995; Sainsbury, 2000; Aguirre, 2007), where the primary responsibility for this function is assumed by families, and fundamentally by women. These regimes are predominant in Latin America and began to be rethought about a decade ago, based on evidence regarding the social and gender inequalities generated by the current care provision.

Feminist scholars introduced the notion of the "care crisis" (Hochschild, 1995) into the public agenda, initially due to the tension in caregiving resulting from the new role women played in developed societies at the end of the 20th century (Carrasquer Oto, 2013). This initial notion has been supplemented by various sociodemographic and cultural transformations that reveal the exhaustion of the current social protection matrix concerning the social distribution of care in the Latin American region (Arriagada, 2007, 2008; Aguirre, 2008; Batthyány, 2004; Montaño, 2010).

Latin American states are reviewing the components of their social protection systems, with care assuming an increasingly prominent place and being recognized as a right. Conceptualizing care as a right guaranteed by the state allows it to be disconnected from formal wage labor and its consequent work-family reconciliation

measures. It also enables it to be detached from belonging to a group defined by socio-economic, gender, ethnic, or age vulnerability, positioning it as an individual, universal, and inalienable human right. This approach requires the adoption of legislative and jurisdictional measures to make the exercise of the right to care effective and to be implemented in the realm of public policies (Pautassi; 2016, 2010).

In Uruguay, academia has widely highlighted gender inequalities related to care. Among the main inequalities identified are gender disparities in labor participation, with the evolution of the activity rate for men and women showing that approximately half of women of working age did not participate in the labor market during the period 2006-2019. Similarly, it was observed that when women and men do not live with children, the gender difference in the activity rate is smaller (11.5 percentage points), while it increases with the presence of children in households (33.3 percentage points for households with three or more children) (Perrotta, 2020).

Specifically regarding gender inequalities in the distribution of time spent on paid and unpaid work, the 2013 Time Use Survey showed that women spent two--thirds of their time on unpaid work (64.6%) and one-third on paid work (35.4%), while the opposite occurred for men, who dedicated two-thirds of their time to paid work (68.1%) and one-third to unpaid work (31.9%) (Batthyány, Genta, Perrotta, 2015). These data demonstrated apparent inequalities concerning income generation at the expense of women's economic autonomy.

Regarding child care, the two national time use surveys (2007 and 2013) conducted up to 2020 showed clear trends regarding the quantitative and qualitative division of this work (Batthyány, 2015, 2009). In 2013, approximately one-third of Uruguayan women participated in daycare (31.5%), compared to one-fifth of men (21.7%). One-third of men living in households with children under three years old did not participate in their care, whereas only one in ten women did. In terms of weekly hours dedicated to caring for children aged 0 to 3 years, the weekly average for women was 22 hours, and for men, it was 13 (Batthyány, 2015). Data from the ENUT 2021 shows similar trends: while 15.6% of men participate in daycare, 26.2% of women do. Regarding weekly time spent caring for children aged 0 to 3 years, men spend 7.4 hours, and women spend 16 (Inmujeres, 2022).

A Pesquisa Nacional sobre Representações Sociais do Cuidado (Batthyány, Genta, Perrotta, 2013) buscou descobrir quais formas de cuidado a sociedade uruguaia considerava adequadas para crianças pequenas e idosos. Para 75% da população uruguaia, a situação mais desejável para o cuidado de crianças menores de dois anos durante a jornada de trabalho é o cuidado em casa. Dentro dessa modalidade, quase dois terços da população (65%) estavam inclinados a cuidados prestados apenas pelo parceiro (mãe e pai) e por um familiar próximo (Batthyány, Genta, Perrotta, 2013).

For more than half of the Uruguayan population (55.4%), mothers are required to personally care for their children under one year old throughout the day, while only one-third (34.5%) believe that fathers have the same obligation. In contrast, six out of ten people believe that male parents are obligated to ensure good care but do not necessarily need to be directly involved, while only four out of ten believe the same about mothers. Thus, this study shows that the direct caregiving obligation predominantly falls on mothers of children under one year old, while for fathers, the predominant obligation is to ensure care (Batthyány, Genta, Perrotta, 2013).

These valuable contributions supported the need for the future System to incorporate among its goals the transformation of the sexual division of labor, which implied the defeminization and defamilialization of care, as well as the social valorization of this work. Undoubtedly, Uruguay has taken a transcendent and pioneering step in the region by announcing the creation of a National Integrated Care System (SNIC) as a government programmatic priority. Symbolically, and at the normative level, this step has placed Uruguay in an advanced position by addressing care and gender co-responsibility as a public issue (Perrotta, 2020).

1.2 SNIC in Uruguay: Main Features and Services Implemented (2015-2019)

The general objective of the SNIC was to guarantee the right of people in situations of dependency to receive care under conditions of quality and equity, promoting the development of their autonomy. It aimed to promote a model of co-responsibility in care between families, the state, the market, and the community, as well as between men and women (SNIC, 2015).

The Care Law creates its institutional structure and provides for the generation of a specific budget program that allows all involved agencies to prepare the Care Plans required by law, which are formulated at the beginning of each government term. The institutional framework of the SNIC consists of three public bodies. The National Care Board is the political governing body of the System, chaired by the Ministry of Social Development and composed of several ministries and agencies, such as the National Administration of Public Education, the Social Security Bank, the Congress of Mayors, the Uruguayan Institute for Children and Adolescents, and the Office of Planning and Budget, the National Institute for Women, and the National Care Secretariat (SNIC, 2019).

The technical body is the National Care Secretariat, integrated into the structure of the Ministry of Social Development, with the goal of coordinating and executing the System's objectives based on the guidelines established by the National Care Board (SNIC, 2019).

Finally, the SNIC establishes an advisory body, the Care Advisory Committee, which ensures social participation in policy through advising the Care Secretariat and, through it, the Board, regarding the adherence to the principles granted by the law to the System. This Committee is working to incorporate a gender perspective into policy implementation. It is composed of representatives from the Workers' Federation (PIT-CNT), academia, social organizations, and private care providers (SNIC, 2019).

The System is defined as central components of services, training, regulation, information and knowledge management, and communication (SNIC, 2015). The main actions developed during the first implementation period (2015-2019), prior to the COVID-19 pandemic, will be outlined below.

Regarding services, a significant expansion in the public provision of care for young children in early childhood has been notable. There was a substantial increase in coverage due to the expansion of Early Childhood Care Centers (CAIF) and public kindergartens managed by the National Administration of Public Education. This increase was 53% for children aged 0 to 3 years during the period. However, this attention is concentrated at the levels of 2 and 3 years, with the vast majority attending part-time (4 hours per day). Part-time care necessitates additional family caregiving for these children during the remainder of the workday, primarily provided by women in an unpaid capacity. It should also be noted that coverage for girls and boys in their first and second years of life (0 and 1 year) is substantially lower. By 2019, 38% of children aged 0 to 2 years attended a care center (public or private) (MIDES, 2020), meaning that six out of ten were cared for in a family setting. On the other hand, CAIF centers prioritize the most socioeconomically vulnerable populations and are not universal policies. Innovative services were created, such as Community Reception Houses and SIEMPRE Centers. In the first case, these are early childhood care services provided by individuals authorized by the System, who deliver care at home or in association with up to three workers in a community space. They focus on children aged 45 days to under 12 months and provide care to approximately 200 children nationwide. The SIEMPRE centers are care spaces managed by unions and companies in agreement with the State. These centers aim to coordinate workers' professional and family lives and operate with a schedule of up to 12 hours daily, ensuring that each child does not stay for more than 8 hours. Although they have a notable approach, their scope covers a very limited proportion of children (522 as of March 2019) (SNIC, 2019). Socio-educational inclusion grants were also implemented to cover private schooling for children aged 0 to 2 years from families integrated into public family support programs residing in areas with insufficient public service provision, where coverage is minimal.

In summary, for early childhood, care coverage has expanded but primarily on a part-time basis for children aged 2 and 3 years, focusing on lower-income sectors

without promoting the integration of work and family life. Although the System has created services for infants under one year old to promote this integration, its coverage is too low to approach its goals of universality.

Regarding the dependent population, both the elderly and people with disabilities who require daily support, three types of services have been created, all with very low coverage in relation to the population in need of care. The Personal Assistants service provides 80 hours per month of home care to individuals with severe dependency, and is budgetarily restricted to people aged 30 to 79 years. Approximately 6,000 people currently receive this service. Tele-assistance is a service for individuals with mild or moderate dependency living at home. Through a bracelet or necklace, they can alert their family, neighbors, or medical service in the event of an incident such as a fall or health issue. Day centers cater to the elderly with mild or moderate dependency three, four, or five times a week. In 2019, there were 12 centers, which does not cover one per department. Uruguay lacks sufficient public long-term care centers to meet the needs of individuals requiring long-term care. The few available public centers are overcrowded. Therefore, most long-term care centers are private, for-profit, and unauthorized. Actions developed by the System in the period from 2015 to 2019 have focused on strengthening oversight, with the Ministry of Social Development taking a more prominent role in this area. However, the vast majority of the population faces serious difficulties in affording quality residential care, an aspect that remains the exclusive responsibility of families and the private sector.

In summary, regarding the component of services for dependent individuals, the creation of innovative services with shallow coverage that have not addressed continuous care is evident, indicating that the de-familiarization of care remains far from being achieved.

Regarding the training component, the System has been active in three areas: creating and implementing courses for child and dependent care, validating prior training, and certifying competencies for work.

To conclude this section, it should be noted that Uruguay has begun the process of building a national state care policy with significant weaknesses. The primary issue lies in the lack of a budget aligned with the objectives and principles established for the System and mandated by law, particularly those related to the universalization of services and the transformation of the sexual division of labor. The most significant advances in terms of coverage have been in part-time care for 3-year-olds. The other services created represent a crucial symbolic contribution, as the state, in coordination with the community and the market, takes on new services for children aged 0 to 2 years, as well as for individuals in dependent situations. However, their sparse coverage and indeterminate segmentation mean that only a small fraction of families requiring these services have accessed them.

Concerning the gender approach, targeting caregivers as a population group has been a notable action of the SNIC, significantly influenced by feminist academia, feminist organizations, and the National Institute for Women in the design of the System. Unfortunately, this transformative action has not been reflected in management, from the weak institutional support assumed by the Care Secretariat, through the symbolic role played by the National Institute for Women, to the modest concrete actions in terms of strengthening the care sector in creating decent employment. Additionally, there is an absolute lack of indicators to measure the progress of the System's actions on women's economic autonomy.

1.3 The Pandemic and Government Change: Difficulties in Advancing the Right to Care

In most countries in the region, measures taken in response to the rapid spread of COVID-19 involved isolation in domestic settings and the search for individual solutions by families for care, mediated by the various resources each family could access. The closure of educational and care institutions led to an exponential increase in the burden of various types of care in households, especially for women.

The Uruguayan government did not decree mandatory quarantine, so work responsibilities were not reduced, while all educational and care centers were closed. Issues related to care and employment under vulnerable conditions were rendered invisible, with women predominantly affected in many cases. Messages circulated about the pleasure of being at home and spending time with family, without considering the burden of unpaid work and care that this situation imposed on women. Thus, the burdens of care and the associated tensions were absent from the public discourse. Additionally, the burden of educating children due to household tasks required significant time and effort from families to fulfill these responsibilities (GISG, 2020). Middle-class workers who had the possibility to work from home experienced the tensions of coordinating care within the same physical spaces. Their paid work, in most cases, was maintained or increased, while care work, rather than being reduced, grew considerably.

The pandemic revealed that the labor market has limited tools to support workers with dependents. With the exception of specific instances such as childbirth and the first few months of life, and in some cases, care due to illness, the vast majority of workers do not have support mechanisms for child care or for situations of severe family dependence due to disability or aging. The state should provide clear signals to the labor market to protect the right to care and the income of workers with caregiving responsibilities, but no measures have been taken in this regard.

Women who were required to continue working outside the home (such as healthcare professionals, nurses, domestic workers, and those in commerce, among others) faced the problem of finding ways to care for their children in the absence of any type of support for caregiving. Not only were the usual care institutions and educational centers unavailable, but in many cases, it was also impossible to rely on caregivers or grandparents, who are typically central to caregiving strategies (GISG, 2020). Despite these warnings and recommendations in line with those of international organizations, the Uruguayan government left these considerations to the goodwill of the employer sector, ignoring the guarantee of the right to care.

As mentioned, the arrival of the pandemic in the country in March 2020 coincided with a political shift in government, ending three terms of progressive governments with the assumption of a right-wing coalition government. The new government aimed to address the fiscal deficit, refine the state's responsibility for social protection, provide more space for the private sector, and emphasize personal effort to obtain income through employment (Baráibar, Bevilacqua, 2021). During the pandemic and despite the severe socioeconomic crisis, the government focused on emphasizing freedom and individual responsibility to ensure health care.

According to the COVID-19 Observatory of ECLAC in Latin America and the Caribbean, among the 14 countries that reported on assistance actions during the pandemic, Uruguay performed the worst with only 1 action, alongside Paraguay, the Dominican Republic, and Trinidad and Tobaug. The country with the highest number of actions in the field of care is Argentina, with 14 actions implemented, followed by Cuba with 4, Ecuador, Costa Rica, and Chile with 3 measures each, and finally Bolivia, Colombia, El Salvador, Mexico, and Peru with 2 actions each (ECLAC, 2020). The only reported action in Uruguay regarding care is Resolution No. 143/2020 and Resolution 1622/020, which includes domestic workers as another target group for a special partial unemployment benefit, covering 25% of the average monthly nominal remuneration received in the six months immediately prior, as well as establishing a special unemployment benefit regime for multi-employment, particularly for domestic workers (ECLAC, 2020).

Among the actions guaranteeing the right to care implemented by Argentina, Resolution 207/2020 stands out, which justifies the absence of a parent or guardian whose presence at home is essential for the care of a child or adolescent while school classes are suspended. Similarly, another measure highlighted during the pandemic relates to the Legal Regime of Telework Contracts, which established that people working in this modality with dependents had the right to compatible hours with their caregiving tasks or to interrupt their day. The government also warned that any act, conduct, decision, retaliation, or obstruction by the employer that infringes on these rights would be considered discriminatory, and the provisions of Law 23.592 would apply. Furthermore, it was established that specific guidelines

for the exercise of this right could be set through collective bargaining (CEPAL, 2020).

With 3 reported actions, Chile implemented a special paid leave through Supreme Decree 4196 to protect the health of individuals with underlying health conditions, the elderly (aged sixty and above), pregnant women, and children under five years old. The beneficiaries of this special leave are the father, mother, or guardian. Chile also conducted an awareness campaign regarding the rights of domestic workers in the context of the COVID-19 health emergency (CEPAL, 2020).

Costa Rica continued to provide services to the child population to ensure that mothers and fathers could continue working while not overburdening the care of the elderly or at-risk groups that make up their family support networks. The virtual course on responsible parenting, "As Parents, We Fulfill," was also promoted by the National Institute for Women. Additionally, an information campaign about the rights of paid domestic workers was implemented during the COVID-19 period. A website was created to disseminate contact phone numbers and emails for the National Institute for Women and the Joint Institute of Social Assistance so that domestic workers could receive support and guidance on their rights (CEPAL, 2020).

These examples of good practices in shared responsibility for care demonstrate that Uruguay, despite being the only country with a National Integrated Care System, excluded care from the agenda of measures adopted by the right-wing coalition government during the socio-sanitary crisis. Its sole action pertains to the protection of basic income for domestic workers, among other affected sectors, who lacked measures to protect their right to work, health, and care for their dependents, among other needs.

Unfortunately, the recognition of the right to care and the obligations of the state to guarantee it were not assumed by a government that appealed to "responsible freedom." In this ideological framework, President Luis Lacalle Pou relied on the goodwill of the private sector through exhortations to employers to offer their employees the possibility of working from home to prevent the spread of the virus[1]. Owners and managers of large commercial establishments were also urged to close them preventively and temporarily, excluding those selling food and pharmacies (Espino; De los Santos, 2020).

It should be noted that this exhortation to telework does not apply to a large portion of jobs in Uruguay, as at least 59% of Uruguayan workers are employed in occupations incompatible with this mode (Espino; De los Santos, 2020). Likewise, this exhortation did not consider the tensions associated with balancing telework and care responsibilities. Among workers whose occupations would allow telework,

[1] *SUBLINHANDO. Governo apela à implementação do teletrabalho*. 16 de março de 2020. Available at: https://www.subrayado.com.uy/gobierno-exhorta-implementar-el-teletrabajo-n611176. Accessed on: August 19, 2024 2024.

35% live with at least one child under 12 years old at home. For female workers, this number is 37%, with 13% living with more than one child under 12 years old (Espino; De los Santos, 2020). Thus, all the evidence provided by feminist movements and specialized academia, as well as by international organizations, was ignored, and no measures were implemented to ensure that those with caregiving responsibilities were not disadvantaged in their work and income, among other potential costs.

Various studies conducted during the pandemic (Farré, González, 2020; ENGENDRA, 2020; IFS, 2020; Del Boca *et al*., 2020) highlighted the exacerbation of gender inequalities. Regarding domestic and caregiving work performed within households, there was an increase in time and participation from both men and women due to confinement. However, these differences affected women heterogeneously according to educational and economic levels, with women from middle and upper economic levels dividing unpaid work time more equally with their male counterparts compared to women from lower economic levels, who faced higher workloads. This also showed that the cumulative effect of jobs led to a more significant overall workload for women (Batthyány et al., 2022).

In the case of Uruguay, the pandemic intensified the unpaid work hours of both women and men, and gender differences were particularly pronounced in sectors with fewer economic resources and regarding the specific task of supporting school activities, as shown by a 2020 survey from UN Women and UNICEF (Batthyány *et al.*, 2022).

Regarding telework, although it allows for a more harmonious balance between paid work and family care, it can also be seen as a contemporary form of reproducing the sexual division of labor and, in this sense, a trap for women (Moreno Colom *et al*., 2021), as they continued to assume a greater share of the task of balancing care and work (Batthyány *et al.*, 2022). Various studies have shown the exacerbation of gender inequalities with telework during the pandemic. In England, mothers working from home were interrupted 50% more frequently than fathers (Andrew *et al.*, 2020). In Chile, 42% of women and 32% of men reported difficulties with telework during the pandemic, with compatibility with domestic and caregiving responsibilities being the main difficulty reported by women, while the main difficulty reported by men was internet quality (Kreutzberger, 2020).

In Uruguay, women teleworked more than men, at 14.5% compared to 8.6%, and women with children teleworked more than women who live alone or in childless couples. In households where a couple lives with children from both partners, for every 100 men who telework, 194 women do so. In households where there is at least one child of the person surveyed or of the couple, 220 women telework for every 100 men (Batthyány *et al.*, 2021).

In addition to the absence of specific government measures to reduce the impact of the pandemic and confinement on gender inequalities resulting from the sexual division of labor in caregiving, the National Integrated Care System (SNIC) has been paralyzed and has exhibited several weaknesses in management. From March 2020 to June 2021, three different individuals were appointed as heads of the Care Secretariat. The National Care Plan for the new period was supposed to be drafted three months after the new government took office, that is, in June 2020. However, it was published in July 2021, without a budget, goals, or actions agreed upon with all institutions that make up the System within the National Care Council (Red Pro Cuidados, 2020). At the start of the administration, the Care Secretariat was merged into the National Disability Program, which represented a clear regression in the conceptual advances made by dissociating care from disability as distinct phenomena, each with its own agendas and institutional frameworks. Similarly, the Undersecretary of the Ministry of Social Development, the body that chairs the National Care Council, indicated in 2020 that the System was a "very good program for wealthy countries[2]". This assessment reflects that the government did not understand the systemic conception of this policy—far from being a concrete program—and also failed to acknowledge that the State should take on care as an integral part of its social protection matrix. These statements jeopardized the coverage extensions planned for the different services that comprise the System (Red Pro Cuidados, 2020), as evidenced to date. For instance, according to the Annual Report of the SNIC published in 2024, only 1,501 children were added to public services over four years (SNIC, 2024).

In this context, the Personal Assistants Program ceased conducting visits to assess the entry of new users for two years, as it was reviewing potential changes in the legal forms of hiring caregivers. Simultaneously, social participation was minimized, with only Advisory Care Committee meetings being held. These meetings, far from being advisory and citizen monitoring bodies, were limited to spaces where authorities provided partial information about steps and decisions already made. In summary, the functioning of the System has been weakened in its components, objectives, and focus on gender and rights since the new right-wing government took office in 2020.

Final considerations

Uruguay is recognized as a pioneer in acknowledging the right to care through a law approved in 2015 that established a National Integrated Care System. This law

[2] O DIÁRIO. Mides anunciou que unificará o Sistema de Atendimento com o Programa Nacional de Deficiência. Available at: https://ladiaria.com.uy/politica/articulo/2020/6/mides-anuncio-que-unificara-el-sistema-de-cuidados-con-el-programa-nacional-de-discapacidad/. Accessed on: August 19, 2024.

stands out for incorporating a gender perspective, defining one of the guiding principles of the System as transforming the sexual division of labor by first increasing the State's responsibility in caregiving but also by increasing the responsibility assumed by the market and the community. Feminist studies on caregiving recognize that the State is the primary guarantor of the right to care, as it is the only actor that can allocate resources among others and can compel third parties (such as the employer sector) to assume their caregiving responsibilities.

Uruguay's progress in recognizing the right to care can be explained by several factors related to a series of social reforms implemented by the progressive government since 2005, which have significantly reduced poverty and promoted social equality. In this context, social and gender inequalities resulting from the unfair distribution of caregiving have been on the public agenda, due to the pressure exerted by the feminist movement and specialized academia.

Despite these advances and the political consensus achieved through the approval of a care law endorsed by all parliamentary parties, when declaring a health emergency due to the COVID-19 pandemic in Uruguay, the new right-wing government disregarded the mandate that the Uruguayan State had assumed as the guarantor of the right to care for those with caregiving responsibilities, without, for example, harming their income, employment, or mental health.

Having a leading-edge law in terms of recognizing the State's caregiving responsibilities and a functional care system was not sufficient for the government to assume shared responsibility for caregiving during the pandemic. The focus remained on care associated with family and private responsibility, where the State did not mediate between workers and employers to ensure the right to care in the context of the closure of all services, shifting the costs of care to families and, primarily, women. The government urged the employer sector to adopt telework and to close commercial establishments without considering that women have fewer opportunities to negotiate whether they want to telework or attend their jobs in person, as they are employed in lower positions and in more precarious working conditions than men, as well as fewer opportunities to choose whether and how much they want to care for within their homes. The situation of shifting care 24/7 to households was not addressed by the government in terms of gender impacts, which appealed to individual freedom and responsibility in a context of structural social and gender inequalities.

At the same time, the new phase of SNIC implementation, which began in 2020, is characterized by a halt in expanding service coverage, the suspension of some services, the minimization of social participation, and significant conceptual regressions regarding the consensus achieved on the notion of care and its connection to social and gender inequalities. In summary, since 2020, Uruguay has entered a period of reduced State responsibilities in terms of caregiving, contrary

to the provisions of the law approved in 2015, which calls for the necessary strengthening of citizen demand for the right to care, which has yet to transcend feminist spaces.

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