THE NATIONAL INTEGRATED CARE SYSTEM IN URUGUAY:

AN OPPORTUNITY FOR THE ECONOMIC EMPOWERMENT OF WOMEN

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United Nations Entity for Gender Equality and the Empowerment of Women

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The cover portrays Soledad Rotella and her 2-year-old daughter Kiara. Thanks to the implementation of the Care Law, Soledad had access to a free and quality childcare center for Kiara, which enabled her to get a full-time job; this was essential for her to support a family with 3 other children.

UN Women thanks the Uruguayan National Care Secretariat and National Women's Institute for their input and comments.

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PROLOGUE

In the United Nations discussions on the global development framework — the Sustainable Development Goals and the 2030 Agenda — there was consensus that gender equality and women's empowerment should be key components of the new agenda. So much so, that care was enshrined as a specific target: 5.4 "Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate."

Taking care of children, the elderly, or people with disabilities, as well as indirect care activities such as cooking, washing, and cleaning, have been socially assigned to women. Therefore, historically many women have postponed or set aside professional aspirations to devote their lives to caring for others.

In recent decades, considerable progress has been made towards women's economic empowerment, with access to their own income, decent work and social protection as some of the most relevant achievements. The percentage of women without an income of their own in Latin America and the Caribbean fell from 42% in 2002 to less than 30% today. However, women continue to devote more than twice the amount of time their male peers do to homemaking and unpaid care work, hindering equal conditions, opportunities and rights.

Therefore, the first step to change this reality is to understand care as a basic right for all people, and that as such, it requires establishing public policies. The creation of the National Integrated Care System (NICS), the Care Act and the National Care Plan 2016-2020 in Uruguay opened a historic opportunity for the recognition, reduction and redistribution of care, as well as opportunities for the economic empowerment of women.

This study depicts the path adopted by Uruguay. Carrying out this analysis provides an opportunity not only to report the progress made, but also to point out the challenges that still lie ahead if we are to ensure the continuity and enhancement of a public policy of care.

In this sense, from UN Women we hope that this publication will contribute to the systematization of knowledge and encourage reflection on Uruguay's integrated policy of care. We also hope that the Uruguayan experience can be used as guidance by policy makers and experts currently working in the development of an integrated care system of their own in other countries in Latin America and the Caribbean.

María Noel VAEZA
Director of UN Women for Latin America and the Caribbean

INTRODUCTION

The objective of the Uruguayan National Integrated Care System (NICS)

> *"...is to generate a co-responsible model of care, shared by families, government, community and market; highlighting that it should be especially shared by men and women, so that Uruguayan men and women may share care responsibilities in an equitable manner as an attempt to do away with the unjust gender-based division of work that has historically characterized our society, and which still does. That is why — at the demand of civil society itself — caregivers, for the most part, women, are integrated from a gender perspective as an active subject of rights."* (Plan Nacional de Cuidados 2016-2020 p.5)

This is expressed by the National Care Plan 2016-2020 developed and adopted by the National Care Board in December 2015, after being approved by all political parties with parliamentary representation and following the enactment of the Care Act (# 19.353).

In paragraph G of Article 4, concerning the principles and guidelines of the NICS, the law already stated that:

> *"G) The inclusion of gender and generational perspectives, considering the different needs of women, men and the various age groups, promoting the cultural elimination of the sexual division of work and the distribution of care tasks among all the actors in society."*

Under this framework, the NICS develops and implements several actions to promote social and gender co-responsibility for care. This article is an early attempt to analyze the development of these actions considering the "three Rs" (Recognition, Reduction and Redistribution of Care) approach promoted by UN Women to analyze progress in overcoming gender restrictions for women's economic empowerment in Uruguay.

To this end, Chapter 1 presents an overview of gender restrictions based on the most recent studies on the matter; Chapter 2 provides a brief introduction about the Uruguayan Care System; Chapter 3 discusses each dimension of the "three Rs" approach; Chapter 4 provides an estimate of the costs of the system and Chapter 5 contains the final reflections.

1. GENDER RESTRICTIONS HINDERING THE ECONOMIC EMPOWERMENT OF WOMEN

By 2015 there were various research papers in Uruguay that showed the difficulties women experienced in addressing the care needs of the population, while trying to enter the labor market on an equal footing with men. Despite the significant progress in the insertion of women to the job market, women still had to adapt to an ideal worker model, "that of a worker with no family responsibilities," which did not fit their reality. This strengthened the case for the inevitability of a care system: without one, gender inequalities and economic injustice would be perpetuated.

A significant percentage of women have entered the labor market in Uruguay (the country has one of the highest activity rates in the region, ranging around 55%). This rate significantly increased in the 1990s, as a result of increased women's educational levels, the shift in cultural patterns and the increased demand for female employment. However, this trend reached a plateau in the second half of the 2000s, probably due to factors similar to those observed in other Latin American countries, i.e., the challenges women in lower socio-economic strata face as they try to meet their families' needs for care (Gasparini and Marchionni, 2015).

A research project[1] that covered eight countries in the region used quantitative and qualitative analysis tools to successfully demonstrate that, in general, women living with a partner (married or under common-law marriage), with young children who do not attend childcare facilities and do not have the assistance of domestic service, tend to see

1 The project called "Promoting the economic empowerment of women through better policies" was funded by the Canadian International Center for Development Research (IDRC), and coordinated by the Interdisciplinary Center for Development Studies-Uruguay (CIEDUR) and the Center for Labor and Social Distributional Studies (CEDLAS) University of La Plata, Argentina. The aim of the project was to improve the efficiency and effectiveness of public policies to promote gender equity in labor markets and to improve women's economic opportunities through research. The study was conducted in Argentina, Bolivia, Chile, Ecuador, El Salvador, Nicaragua, Mexico and Uruguay. http://www.ciedur.org.uy/genero/empoderamiento-economico-de-las-mujeres/empoderamiento-economico-de-las-mujeres-en-america-latina/

their chances of participation in the labor market curtailed. However, these factors have a positive impact on the employment of men. This shows that values and culture play an important part in the sexual division of labor, but it also reveals a gap in the provision of care services and co-responsibility actions to favor the distribution of care. The place of residence also plays a relevant role conditioning the activities of women, since those living in Montevideo are more likely to participate in the labor market. This is associated with more conventional labor patterns and a lower demand for workers in the interior of the country, together with the greater availability of jobs in the services and public sectors (which have greater female participation) in the capital, as well as a greater supply of care services to cover the working hours (Espino and Salvador, 2015, based in Espino, Galván and Salvador, 2014).

The study by Espino, Galván and Salvador (2014) also finds that the burden of care and lack of care provision services (for childcare and domestic services) affect the quality of women's employment, as they tend to take up informal jobs (either as freelancers or on a salary). Thus, the absence of co-responsibility policies increases inequality among women themselves.

Regarding the length of the working day, the study finds that women living with a partner tend to reduce it, while men increase it. The same holds true when they have children under the age of five: while men's working day is extended, women's working day is reduced, especially in the case of women who are self-employed or work in domestic service. Hourly income rates also depend on the length of the working day. Given that employers value workers' greater dedication to paid work, this adversely affects women's chances of being hired. But because women tend to have higher levels of educational attainment than men, their educational advantage partly offsets the hourly pay gap.

Therefore, all women face a gender-constrained framework that hinders their economic empowerment. This framework can be expressed in the various scenarios proposed by the UN Women report (2017):

- The *sticky floors* scenario refers to women who have not entered the labor market or whose incorporation is precarious; therefore, they require solutions to their care needs to enable them to receive training and enter the labor market.

- The *broken ladders* scenario refers to women who work intermittently because they lack social safety nets that would allow them to give empowering leaps or could prevent them from slipping towards sticky floors. They require policies that will help them keep their jobs when there is a high demand for care at home (because of childbirth, or other situations leading to dependency).

- The *glass ceilings* scenario applies to women with higher education and better access to care services; they may have professional backgrounds similar to those of men but find themselves in settings of recurrent inequality due to discrimination at work. In this case, the interventions they require have more to do with cultural change, transformation of gender stereotypes, demystification of the ideal worker model such as the worker with no family responsibilities, and corporate policies that promote co-responsibility of care (flexibility, reduced working hours, etc.).

2. BRIEF PRESENTATION OF THE NATIONAL INTEGRATED CARE SYSTEM IN URUGUAY

Uruguay's National Care System is based on the understanding that

> *"...care is both a right and a social function and involves the promotion of personal autonomy, care and assistance to people in dependency. It is the set of actions that society undertakes to ensure the comprehensive development and the daily well-being of those dependent on the help of others for their everyday activities."* (Sistema de Cuidados, 2018)

Therefore, this definition only considers the care provided directly to people, and leaves out the indirect care, which encompasses the most instrumental activities related to household chores such as cooking, washing, ironing, cleaning the house, etc. (Ministry for Social Development - MIDES, 2014).

The NICS consists of five components: services, training, regulation, information and knowledge management, and communication. The first component — the development of services — may imply the need to expand existing services, such as childcare, the creation of new services, such as the Personal Assistant Program or TeleCare; and the improvement of quality through regulation and oversight, such as the case of Long Stay Residential Facilities.

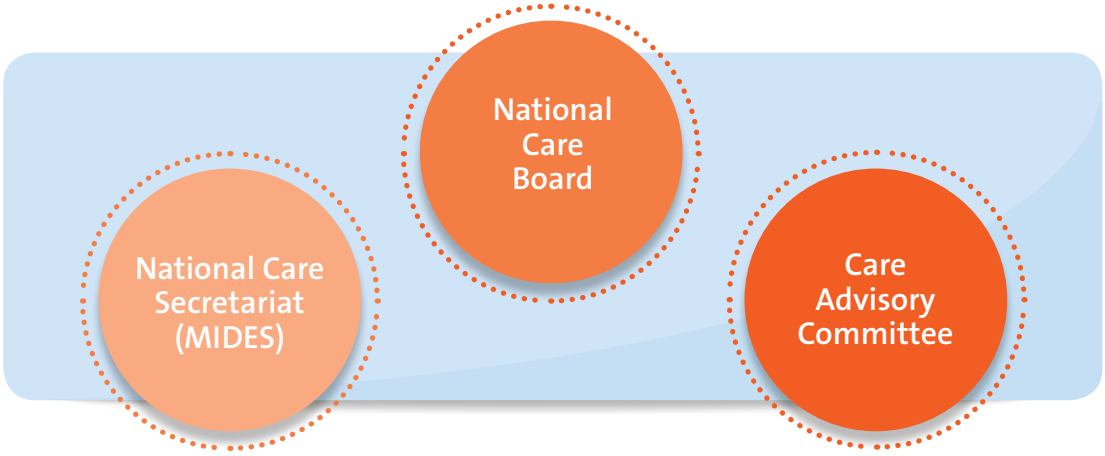
Regarding the training component, the NICS seeks to enhance and professionalize care by offering courses for new services, including training for personal assistants; and through regulation, promote the improvement of training of those already working in the Long Stay Residential Facilities.

The objective of the regulatory component is to create the conditions for the quality implementation of care policies guaranteeing the provision of comprehensive care, regardless of the legal nature of the provider. To this end, existing regulatory frameworks and the necessary tools have been revised and new ones developed to ensure the quality of all services.

Work on the information and knowledge management component is organized on the basis of the following axes: knowledge of target populations; development and adequacy of information systems for the management of the NICS; design the evaluation and monitoring (E&M) of the system and its performance; the National Care Registry and the Knowledge Agenda.

Finally, the communications component is conceived as the engine of the NICS's actions and a tool for the cultural transformation of Uruguayan society. During its inception, the communication strategy focused on people, being the male and female protagonists the ones that communicate services and changes in cultural practices (MIDES, 2018).

System Institutionality

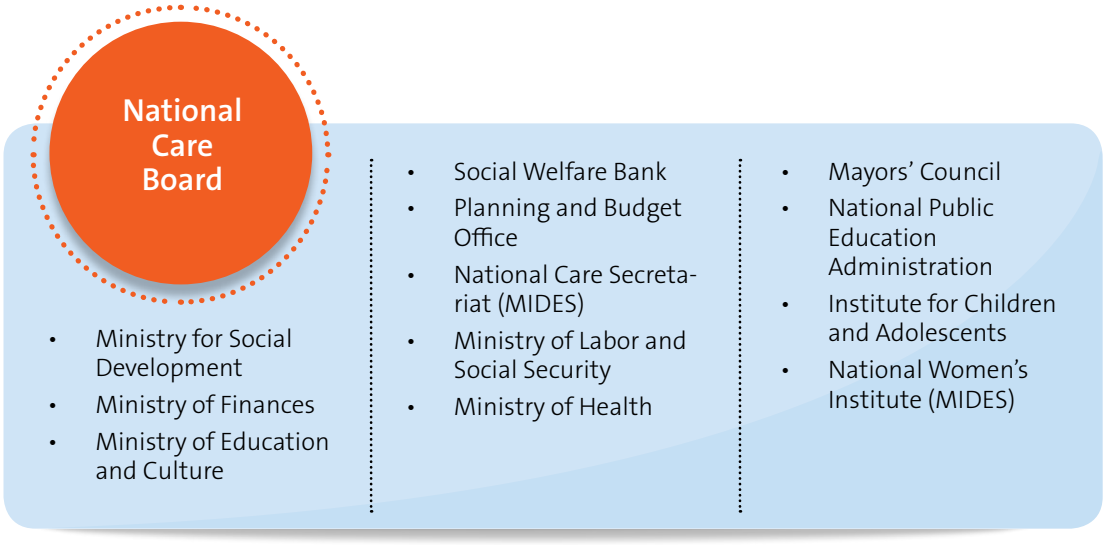


The institutional architecture of the NICS consists of a National Care Board that, among other things, defines guidelines, objectives and policies. It includes representatives of the Ministry of Social Development (chair), and the Ministries of Education and Culture, Labor and Social Security, Health, Economics and Finance, as well as the Office for Planning and Budget, the National Administration for Public Education, the Social Security Bank, the Uruguayan Institute for Children and Adolescents (INAU), the National Care Secretariat and the National Women's Institute (INMUJERES). The job of INMUJERES in the Board is to promote and monitor the integration of the gender perspective throughout the NICS; they have the right to speak but not to vote, just as the Secretariat.

In addition, they created the National Care Secretariat as the Board's executive body; it is responsible for the System's inter-agency linkages and coordination.

Through the Secretariat, the Board has an honorary Advisory Committee with representatives of civil society organizations, academia, workers and the private sector.

"The Advisory Committee (AC) was created as a result of the ongoing demand of civil society to have a formal space to discuss with the Government about care-related issues; this demand was considered in the law that created the NICS. The AC plays a key role overseeing compliance with the principles enacted in the law, as well as monitoring the incorporation



of the gender perspective into the implementation of the law." [2]

The creation of the AC was regulated by Decree 444/016, which states that it will consist of 16 members, four for each sector. The representatives of each sector should be nominated by each constituency, and if no agreement is reached within 60 days, the Secretariat will make the appointments. Its five-year tenure coincides with the term of government, and delegates can be re-elected only once. They hold monthly public sessions, and its secretariat is exercised by the National Care Secretariat.

On the other hand, the territorial deployment of the Care System is carried out based on the conception of territory as a space of production and re-significance of the policies that are planned at the central level. The territory is a privileged space for the construction of inter-sectoral actions and partnership management by the State and civil society, because the implementation process itself allows to overcome the limitations resulting from the fragmentation of initiatives, and it is possible to be more sensitive to the specific dynamics of each territory, improving outcomes. As an inter-agency and cross-sectoral policy, the NICS relies on the existing territorial deployment, and the coordination space at the territory level is reflected in the Inter-Agency Social Policy Boards. One of the principles that guide the deployment of the NICS is that of territorial equity, promoting similar opportunities to all the country's inhabitants, by acting on the conditions that limit equitable social development because of residential segregation (MIDES, 2018).

The Care Portal was developed to improve communication with the population; its aim is to unify and simplify access to the NICS, its information, and the enforceability of rights, by linking the services individuals may access and creating linkages with the social, health and education sectors. It originated as a channel to provide access to the new services, and now it also has the objective of facilitating the recognition of, access to, fulfillment, and enforceability of the right to take care and be taken care of. Hence, it operates as a platform of interaction between the NICS and all users, workers and public and private care services (MIDES, 2018).

All the above is geared to fulfilling the NICS's motto, i.e., to guide its actions based on people's logic, to render them effective, instead of asking people to adapt to the logic of services.

> ***Developing the Care System involves "moving from the logic of services to the logic of people."***
>
> ***Julio Bango (National Director of Care)***

2 http://www.sistemadecuidados.gub.uy/95711/comite-consultivo-de-cuidados

3.

THE CARE POLICY IN URUGUAY BASED ON THE "THREE Rs" APPROACH

The "three Rs" approach proposed by Diane Elson (2017) analyzes care policies based on changes recommended in one of three domains:

- **Recognition** of unpaid care work;
- **Reduction** of such work through the development of care services or provision of care (leaves and co-responsibility actions at companies); and
- **Re-distribution** of unpaid care work between males and females.

This approach applies a broad notion of care, incorporating indirect care (also called domestic work) into the concept of care. Clearly, domestic work (paid or unpaid) is very significant in Uruguay; therefore, where appropriate, reference will be made to advances in domestic labor policies.

UN Women's report (2018) presents a comprehensive analysis of the progress made in each dimension for Latin America and the Caribbean. This article specifically delves into the situation in Uruguay.

3.1. Recognition of unpaid care work

RECOGNIZE. Increase the visibility of care work and re-value the key role it plays for the well-being of societies and for a vibrant economy, both, as a service provided in households and as decent employment in a booming economic sector.

Recognition includes:

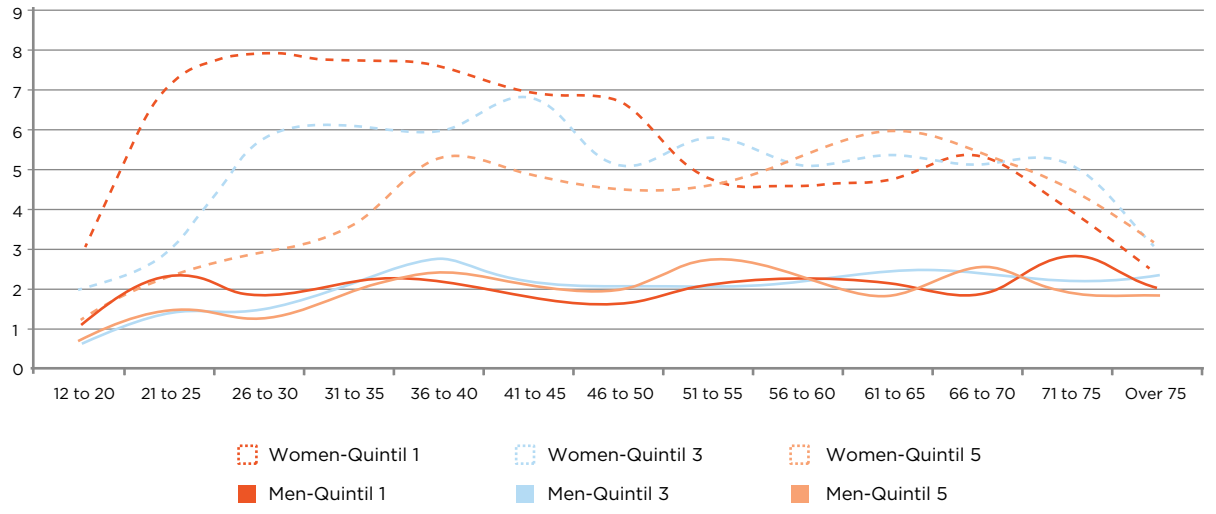
- measuring and accounting for unpaid work;
- revaluating housework and care work (regulation of both types of work, creation of an ambit for collective bargaining, training, oversight mechanisms);
- recognizing domestic work as a job that entails social security benefits;
- driving cultural change through communication.

3.1.1. Measuring and accounting for unpaid work

In 2007 and 2013, the National Institute of Statistics (INE) released information on the use of time and unpaid work from households (TUS or its Spanish acronym EUT)[3]. In each survey, the INE also valuated unpaid work, although it was not accounted for in the household satellite accounts (HAS) as recommended by ECLAC and as was done by INEGI (Mexico), DANE (Colombia) and some others countries in the region (including Ecuador and Guatemala).

The information from the TUS clearly shows the significance of the burden unpaid work poses on women at different stages of their lives. Women in the lowest strata must devote more time to this type of work, and they start earlier. Even women in higher-income tiers show two curves that refer to the care of small children and the elderly (Figure 1).

FIGURE 1. **AVERAGE DAILY HOURS DEVOTED TO UNPAID WORK BY SEX, AGE AND HOUSEHOLD PER CAPITA INCOME QUINTILE**

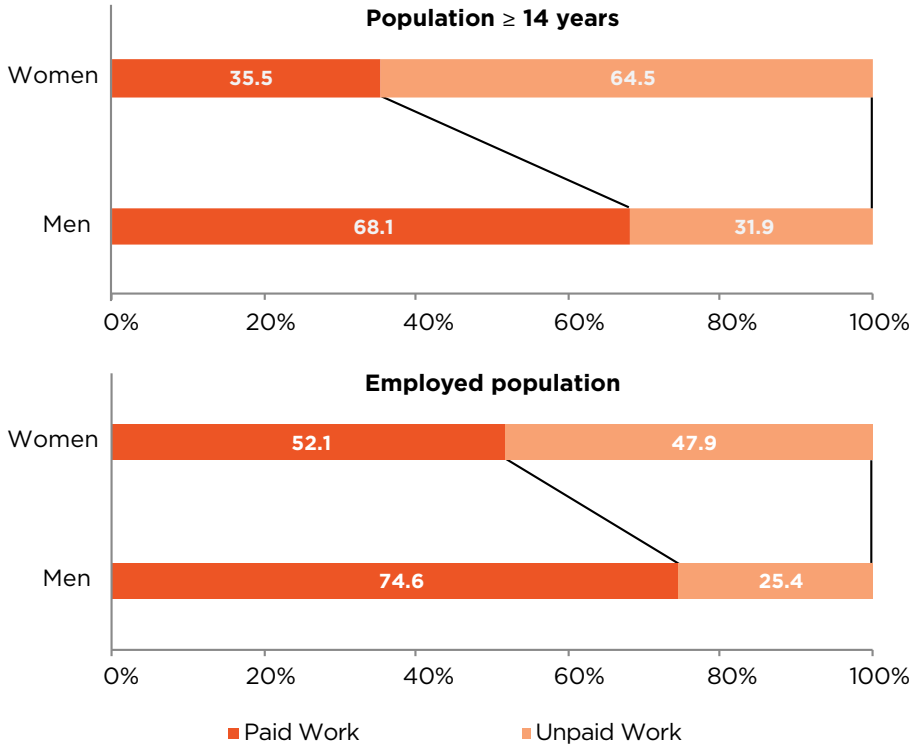


Source: Salvador (2011) based on the Module on Time Use and Unpaid Work – Continuous Household Survey (CHS) 2007.

3 http://www.ine.gub.uy/web/guest/encuesta-de-uso-del-tiempo-eut-

A In addition, it provides evidence of the sexual division of labor among the population over the age of 14 (considered working age), and between the males and females employed. In both cases it is very unequal, but among those who have a job, the double working day of women becomes clearly apparent (Figure 2).

FIGURE 2. DISTRIBUTION OF PAID AND UNPAID WORK BY SEX



Source: CIEDUR (2017) based on the CHS's Module for Time-Use and Unpaid Work - CHS 2013.

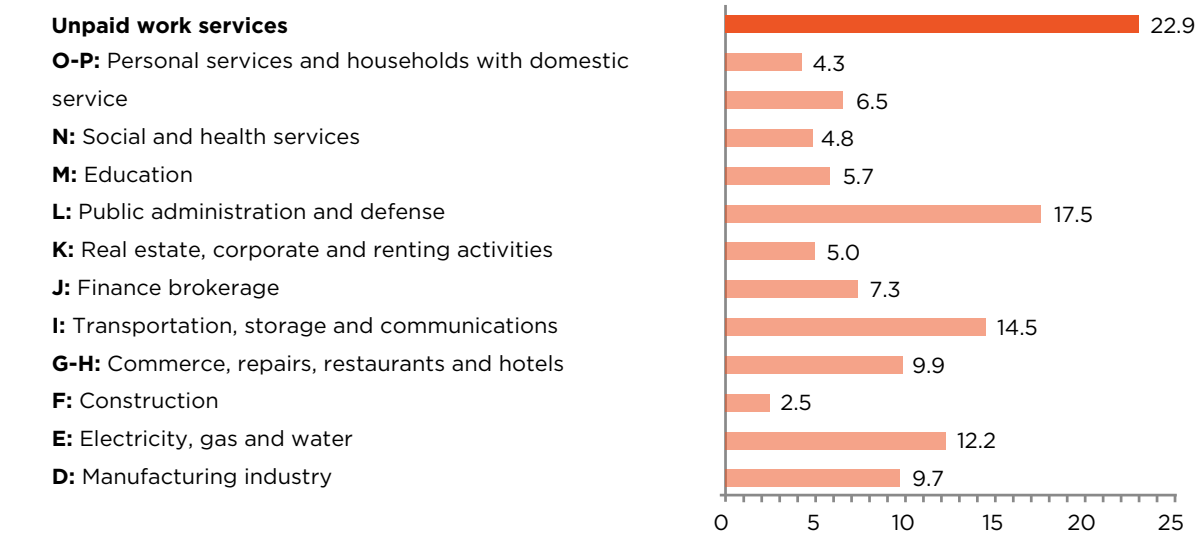
The estimated value of UW in 2013 amounted to USD 12,729 million, accounting for 22.9% of the GDP in 2013 (Table 1).

TABLE 1 Value of unpaid work and its share relative to GDP, by sex

	Million USD	% GDP
Women	9068	16,3
Men	3661	6,6
Total	12729	22,9

This means that what is produced by women alone (16.3% of the GDP) accounts for a percentage similar to the entire contribution of government institutions and the market in care-related services (personal services, social, health and education services together add up to 15.6%), and more than all the manufacturing industry (12.2%) and the commerce, repairs, restaurants and accommodations sectors (14.5%) (Figure 3).

FIGURE 3 **STRUCTURE OF THE GROSS DOMESTIC PRODUCT BY ECONOMIC ACTIVITY CLASS AND PERCENTUAL CONTRIBUTION OF UW TO THE GDP, 2013**



Source: Salvador (2015) based on data provided by the Uruguayan Central Bank (BCU).
Note: The classification of activities is based on the 3rd Review of the International Standard Industrial Classification (ISIC) (adapted to Uruguay).

As the most recent time-use survey is already five years old, a new survey is warranted. If possible, the methodology used for the economic revaluation of the UW should be agreed with the Uruguayan Central Bank (BCU).

3.1.2. Revaluating housework and care work

With the implementation of labor policies that promote the regulation, formalization and revaluation of housework, Uruguay has positioned itself as a pioneer in the region. In 2006, Parliament passed Law# 18.065, substantially changing the regulatory framework of domestic workers, not only by leveling their rights with the rest of workers', but also through the creation of Group 21 under the Wage Councils[4], to introduce collective bargaining in the sector. The law also established mechanisms for the inspection and oversight of working conditions. Thus, with the adoption of Law # 18.899 in 2012, Uruguay became the first country to ratify ILO Convention 189 on Decent Work for Domestic Workers.

Some care workers are still in disadvantage compared to the rest of workers. Informal workers that provide care in households receive the lowest wages and work under the most precarious conditions. On the one hand, the Care System is developing a personal assistant program,[5] where people receive training and are entitled to all the social security benefits. They do not have an area for collective bargaining yet, because it is difficult to find a counterpart representing the employers' sector. Still, they created the Personal Assistants' Union (SUAP), a PIT-CNT affiliate (Uruguay's workers' union), and they receive the support of FUECYS (the Uruguayan Federation of Trade and Services Employees).

4 https://www.mtss.gub.uy/web/mtss/servicio-domestico

5 http://www.sistemadecuidados.gub.uy/61052/asistentes-personales

However, there are many female caregivers (an estimated 60,000) who continue to receive low wages and work in precarious conditions, because they basically work in private homes and they are poorly educated (primarily women that provide care to adults). Half these workers are not registered in the social security system, and that percentage goes up to 70% among those working in private households, which account for 55% of the total number (Lodola and Etchemendy, 2018).

Therefore, formalizing and improving the remuneration of these pink-collar workers continues to be a challenge. The NICS is regulating the training of workers that provide care in long-stay residential facilities, but the mechanisms for monitoring and overseeing their working conditions fall under the responsibility of the Ministry of Labor and Social Security.

3.1.3. Recognizing care as a job in the social security system

Before installing the Care System, Uruguay explicitly recognized women's unpaid work in households by setting forth that women will be recognized one additional year for each liveborn or adopted child — up to a maximum of five years — when calculating their contributions for retirement or old-age pension (Article 14, Law # 18.395 2008). This benefit helps women to complete the years of service needed to achieve retirement rights or to enhance the woman's replacement rate if she has already completed the number of years required for retirement.

According to Lavalleja and Tenenbaum (2017), the new regulations have contributed to make up for and correct the gender inequalities in the labor market, by recognizing years of childcare that cause women to totally or partially suspend labor activities. In keeping with that, the number of children weighted more on the calculation of the retirement income than on the eligibility either for retirement or pensions.

On the other hand, although the retirement income has increased both for men and women, the variation has been differential: year after year women's retirement grew more than men's, leading to a steady reduction of the retirement income gap between both sexes. While in 2009 the average retirement income for men was 34% higher than for women, in 2015 the difference was 20%. Again, thanks to the flexibilization of the law, both counting the number of children and requiring fewer years of service to be eligible for retirement translated into an increase in the number of women that manage to retire, hence contributing to closing the gender gap.

3.1.4. The cultural change through communication

In its annual accountability report to Parliament, the National Care Secretariat, who drives policy on the matter, states that the challenge is to:

> *"publicly install an image of a System that provides social recognition of the right of all Uruguayans—male and female—to take care and be taken care of under equal and quality conditions; a System that generalizes notions of dependence and autonomy, that manages to integrate both the existing services and those to be created under a common logic, facilitates the joint work of the various institutional actors and promotes their commitment to a new model of social co-responsibility in the provision of care. That is why the System focuses its communication on people, having them—as protagonists—give an account of their experience with the services and show the changes in cultural practices."* (Care System 2018:75)

Several strategies have been developed, including publicity campaigns, workshops with care policy operators to discuss gender co-responsibility, and

support communication interventions proposed by the Inter-Agency Social Policy Boards (MIPS), who deploy the system across the different territories.

One of the campaigns developed as part of the publicity strategies was "A reality-changing reality."[6] Its objective was to make people aware of everybody's right to take care and be taken care of in conditions of quality and equality. The campaign focused on the testimony of people through a series of audiovisual spots that aired on open television, the television network in the interior of the country, digital media and street advertising screens in the capital, Montevideo. In addition, news clips were posted on the web and disseminated through the social media, telling more stories of the people involved in the Care System.

Under the premise "Together we provide better care," three animated spots[7] were made to promote co-responsibility in a broad sense, not only referring to the involvement of males in the provision of care, but also of other stakeholders that contribute to social co-responsibility in care, such as businesses and communities. Videos perform well in educational and community spaces; the tool has been adopted by the System's institutions and posted in social media of the MIDES.

The "Workshops for Raising Awareness on Social and Gender Co-Responsibility in the Provision of Care" were held in partnership with the National Women's Institute (INMUJERES). The project included a photographic exhibition[8] to help install the debate on care as a right, and to recognize the need for redistribution of tasks among the sexes, so as to contribute to social and gender equity. The workshops were held in six locations in the interior of the country, in the understanding that local opinion leaders would in turn continue to replicate the experience in other locations.

In April 2019, the Care Month was inaugurated with the campaign "*No se nace, se hace*"[9] (Nurture, rather than nature), with the purpose of promoting gender co-responsibility for care. The campaign picked common-place phrases that are often construed as positive, but that incorporate the notion that only women are responsible for taking caring of those in need of care. The campaign was geared to fostering cultural change promoting the idea of sharing care in a more egalitarian way. The aim was to provide girls and women with more opportunities to implement their projects, while providing boys and men with more opportunities to engage in tasks that allow everybody to have a more fulfilling life.

Gender co-responsibility initiatives[10] were also developed at a territory level, primarily aiming to promote engagement, ownership and expression of the responsibility shared by men and women in the communities. The initiatives were promoted by the Inter-Agency Social Policy Boards (MIPS) across the country. Specifically, they involve socio-cultural and communications proposals to raise awareness, including:

- **Urban interventions in public spaces:** festivals, murals, interventions at parties open to the general public and night interventions at parties and nightclubs.

- **Interventions in public schools:** CAIFs (Centers for the Care of Early Childhood and Families),

6 http://www.sistemadecuidados.gub.uy/75803/campana:-una-realidad-que-cambia-realidades

7 https://www.youtube.com/playlist?list=PL2iYaWHuQRQS0BVtOd3nT9wdBrEEHiMLv

8 https://enblancaynegrablog.wordpress.com/2017/05/31/compartiendo-los-cuidados/

9 http://www.nosenacesehace.uy/

10 http://www.sistemadecuidados.gub.uy/107558/iniciativas-de-corresponsabilidad-de-genero

Early Childhood, Primary and Secondary schools: playful-recreational proposals for girls and boys, mothers and fathers, communication campaigns at schools and production of teaching material.

- **Artistic proposals:** Development of a range of artistic proposals and performances, including theater, music, photography, dancing, *murga*, circus, publications, graphic and industrial design.

These initiatives are promoted and supported by the National Care Secretariat, the National Women's Institute (INMUJERES) and MIDES's National Territorial Management Directorate (DNGT).

For their part, UN Women, together with *Alcance*, a company that provides care services organized a contest calling for stories aimed at children and youngsters under the motto "We are a team," to promote the idea of gender co-responsibility in care and home chores.[11] Those stories were meant to contribute to the cultural change desired, tapping on fiction stories or stories related to the daily life of girls and boys. In this case, the story was used as a cultural tool to address gender equality and as a value-transmitting element. It also served as an opportunity for reflecting on the topic and exchanging ideas in homes. The competition was declared of cultural interest by the Ministry of Education and Culture (MEC), and was supported by the Directorate for Gender and Human Rights and MEC's National Reading Plan, the Human Rights Directorate of the National Education Administration (ANEP), the Ceibal Plan and the National Women's Institute (INMUJERES) of the Ministry of Social Development (MIDES).

3.2. Reducing unpaid care work

REDUCE. Support and cover the basic needs of care, reducing the burden of unpaid work disproportionately borne by women in households, based on a rights approach (the right to provide care as a key right for citizens), and on the principles of equality, universality and solidarity.

Reducing the burden of unpaid work in households calls for the development of services by government, companies, agencies or community arrangements.

During the NICS's first implementation phase in Uruguay, the system prioritized the creation of services for the care of children from zero to three years, as this was the sector with the worst shortage of services, and the home care of severely dependent people, because of lack of services for this population.

3.2.1 Childcare services

Regarding the provision of services for children under three years of age, the NICS set out to: a) achieve the universalization of the educational care offered to three-year-olds, particularly expanding the services provided by ANEP schools and nursery schools; and b) expanding the services (both in terms of coverage and modalities) for children under two. These objectives particularly emphasized a strict quality criterion, based not only on the structural aspects of services, but also on the expansion of the specific training provided and the development of quality criteria equally applicable to all sectors (ANEP, MEC and INAU).

11 http://lac.unwomen.org/es/noticias-y-eventos/articulos/2018/6/a-la-cancha-mi-familia

In particular, the increase in the number and range of services for children under two was achieved through the creation of new CAIF centers that are funded by the government but managed by non-governmental organizations. Under the NICS, CAIF centers began to provide daily care to one-year-olds (in the past, toddlers only attended the Timely Stimulation Program with their adult caregiver twice a week). To date, this intervention has led to the inauguration of 56 new CAIF centers, the expansion of the capacity of 96 existing centers; and the construction of 84 more (42 of them through PPP mode) is up for tender (Sistema de Cuidados, 2019).

In turn, INMUJERES has been working on the Caring with Equality Seal (SCI) a tool that certifies gender egalitarian practices at early childhood centers. This helps identify how a center is performing in certain dimensions that indicate equality (or that cause inequalities) and gradually incorporates the gender perspective into its institutional planning, by revisiting and altering its practices. It seeks to promote the incorporation of the gender equality approach into early childhood education and care centers. In 2019, this is being implemented in 18 public and private centers in Montevideo.[12]

Added to the above, other modalities of care installed included the Community Care Homes (CCH),[13] which seek to meet the care needs of mothers that work eight hours. The service is provided at the caregiver's or at a community facility made available for this purpose. To date there are five CCHs operating at caregivers' homes and four in community spaces; the plan is to reach a total of 22 by the end of 2019. (Sistema de Cuidados, 2019).

Another intervention currently underway is the Socio-Educational Inclusion Scholarships (BIS)[14] system; the aim is to enroll children up to the age of two (exceptionally three-year-old children) in private centers, in areas with no public facilities available. The beneficiaries of this program are families registered in the Family Support programmes run by MIDES and INAU, which serve an average of 1,200 families annually.

SIEMPRE Centers have been installed with the agreement of trade unions and companies. To date there are nine centers operating and three more are planned to open soon.[15] They provide care to children under 12 years of age while their parents are at work. The service is open for up to 12 hours a day (trying not to keep a child at the center for more than eight hours a day). The company or union provides the infrastructure, maintenance and initial equipment required to implement the service. The State pays the staff required to provide the services. So far, 720 children are attending the nine centers that have already been inaugurated (Sistema de Cuidados, 2019).

On the other hand, CODICEN, INAU and the National Care System developed a roadmap to assist mothers and fathers that attend high school. There are six childcare centers for those students' children, with the peculiarity that they are open in the evening.

In addition to those, other spaces are being opened for the care of children of middle school students.[16] They provide social and educational services close to ANEP schools (high schools and vocational schools-UTU) and they cover hours otherwise not contemplated by traditional childcare centers. Their purpose is

12 The NCS was created as an action by the National Women's Institute of the Ministry of Social Development, coordinated with the National Care Secretariat (NCS), Uruguay Crece Contigo (UCC), and the Uruguayan institute for Children and Adolescents (INAU), the Integrated System for the Protection of Children and Adolescents from Violence (SIPIAV) and the Ministry of Education and Culture (MEC).

13 http://www.sistemadecuidados.gub.uy/61063/casas-comunitarias-de-cuidados

14 http://www.sistemadecuidados.gub.uy/61063/casas-comunitarias-de-cuidados

15 http://www.sistemadecuidados.gub.uy/61063/casas-comunitarias-de-cuidados

16 http://www.sistemadecuidados.gub.uy/61063/casas-comunitarias-de-cuidados

to prevent dropouts and to maintain the educational continuity of those children's parents. So far, six have been inaugurated (Sistema de Cuidados, 2019).

With all these services, public coverage for children under three went from 33% in 2014 to 40% in 2017. However, the overall coverage has slowed down, because children that received care at private centers have shifted to the public sector. This is a major challenge for the system: to ensure that the expansion of public quotas fully translates into the advancement of global coverage for early childhood. In 2016, the overall coverage was 52%; the target proposed for 2020 is 65% of that universe of children, but so as to include 100% of three-year-olds. (Sistema de Cuidados, 2018).

3.2.2 Care services for the dependents

The Personal Assistants (PAs)[17] Programme stands out among the care services that address dependency. It seeks to facilitate access to the hiring of quality care and/or assistance for severely dependent people. The level of dependency is assessed by means of a scale, which so far has only considered the handicaps, the needs for aid and the frequency with which the person demands support. The ProCare Network and CIEDUR requested the Advisory Care Committee to consider that this scale fails to contemplate the gender perspective, because it focuses on the individual in need of care and does not address the support networks and the burden of care on female primary caregivers. Consequently, a study is underway and a survey is planned to define a measure that explores the burden of dependence on the caregiver in charge.

The program offers a subsidy to hire a NICS-enabled personal assistant (PA) 80 hours a month. A person can become a NICS-enabled PA in three ways: through training courses, validation of knowledge or certification of certain working competencies. The subsidy may be non-existent or cover 33%, 67% or 100%, depending on the household per capita income and the burden of care.

As the implementation of the programme is gradual, there are limits as to the age ranges of those requesting the service. Currently, the subsidy can only be requested for those under the age of 30 or over 80. It currently covers 4,763 people, 55% of which are women and half are under 30 (Sistema de Cuidados, 2019). Of the 3,852 people working as Personal Assistants, 2,850 have completed courses or validated their training.

TeleCare (TC) and Day Center services are being developed for mild or moderate dependency care.

Home TeleCare[18] is intended for people over 70 who require assistance because of incidents occurring at home. The benefit consists of a subsidy that may go from non-existent to 33%, 67% or 100% of the cost of a TC service by NICS-enabled companies. The service implies the need for a timely referral when a person needs help and is unable to get that assistance on his/her own, through the activation of the network of the person who uses it. This service was launched recently, and it already has 1,006 users and five companies have qualified to provide those services (Sistema de Cuidados, 2019).

Day Centers[19] target people over 65 years of age who are mildly to moderately dependent. These centers provide comprehensive care based on five programmatic axes: preventive social and health care and stimulation for everyday life activities, personal care and assistance, support for family members, caregivers and technical team of the center, integration to the community and support for the training of caregivers. Thus, they seek to support the families that

17 http://www.sistemadecuidados.gub.uy/61052/asistentes-personales

18 http://www.sistemadecuidados.gub.uy/77816/teleasistencia-en-casa

19 http://www.sistemadecuidados.gub.uy/61056/centros-de-dia

provide care and to contribute to the autonomy and permanence of the elderly in their usual surroundings. This service offers full subsidy and the person may attend the center two, three or five days per week. The centers are managed through agreements signed with municipalities, local governments and civil society organizations. So far, there are six Day Centers operating in the interior of the country and six more are expected to open between 2019 and 2020 (Sistema de Cuidados, 2019).

The Long Stay Centers[20] were incorporated under the Care System through Decree 356/016. The regulation specifies rights and obligations, defines the institutional competences of the Ministry of Social Development and the Ministry of Health, and fosters the progressive implementation of quality improvement plans in all centers. As they are enabled, the centers are incorporated into the National Care Registry, while it is up to the National Care Secretariat to authorize caregivers.

All centers should have a Center Project describing the strategic objectives for the promotion of autonomy, motor stimulation, participation, recreation, etc., as well as the actions provided for their attainment.

The system also sets the staff's curricular training requirements and the staff-to-user ratio; it also incorporated the figure of the Social Professional, who advocates for the residents' rights and supports the execution of the center's project.

Moreover, the residents were given the right to form a committee consisting of workers and resident relatives.

There are currently about 15,000 people living in long-stay establishments, 3% of Uruguay's elderly.

3.2.3 Local care initiatives and provisioning of care in small towns

Local care initiatives[21] are designed by civil society organizations and are part of the decentralization policy of the Care System as a tool intended to enable each territory to decide, design and implement solutions tailored to their own care needs. In 2017, 16 local care initiatives were developed and 19 were approved in ten departments in 2019. These initiatives have been promoted by the National Care Secretariat and MIDES's National Territorial Management Directorate (DNGT).

The selected proposals receive up to 600,000 pesos[22] for their implementation; they propose the creation of care alternatives, play & recreational spaces for school-age children and self-care strategies for caregivers who take care of dependent persons.

Some of the initiatives include childcare when parents attend training courses (e.g. at the National Institute for Employment and Vocational Training - INEFOP) or provide care solutions during holidays. Others propose the use of technology to provide care for young people with disabilities and to increase their autonomy.

Similarly, a project is being developed jointly with the Office of Planning and Budget (OPP) to find solutions to care needs in small locations.[23] The project seeks to identify those needs and to strengthen local capacities to generate solutions tailored to these people's realities. Work is currently underway in 13

20 http://www.sistemadecuidados.gub.uy/69583/centros-de-larga-estadia

21 http://www.sistemadecuidados.gub.uy/107561/iniciativas-locales-de-cuidados

22 Equivalent to approximately 17,000 US dollars at the July 2019 exchange rate

23 http://www.sistemadecuidados.gub.uy/105076/cuidados-en-pequenas-localidades

towns with less than 5,000 people in the interior of the country.

The project involves a participatory diagnosis involving the municipalities, local stakeholders, and civil society, to determine the care demands and potential solutions. Subsequently, spaces or care devices are developed to meet the demands detected.

An important aspect about local initiatives and those undertaken in small towns is that they adapt to the needs expressed by the population; they also seek to create alternative solutions, other than those defined for the country as a whole, because the insufficient demand and the scanty resources would render it impossible to solve the issue in the same way. The fact that a Gender Unit was created in the National Care Secretariat and INMUJERES participates in the body that regulates the policy (the National Care Board) ensures that these initiatives contemplate gender equality in their design and implementation.

3.3. La redistribución del trabajo de cuidados no remunerado entre varones y mujeres

REDISTRIBUTE. Implement fairer and more balanced ways to distribute unpaid care work and domestic responsibilities as well as the exercise of responsible parenthood between men and women.

The most far-reaching policy for the transformation of male-female care roles and responsibilities is set forth in Law # 19.161 on Leaves and Subsidies for the Care of Newborns. In addition, the inclusion of care co-responsibility clauses in collective bargaining is being promoted.

3.3.1 Maternity, paternity and parental leave

Prior to the installation of the Care System, in November 2013, Parliament passed Law # 19.161, which extended the duration of maternity leave to 14 weeks for private sector female workers, and expanded coverage to non-wage-earning women registered as social security contributors. It also extended paternity leave, which until then had been limited to three days at the employer's account for private employees and extended it to 10 uninterrupted days (additional for dependent workers) to be paid with social security funds. This benefit also reaches the non-dependent workers that contribute to social security.

In addition, a half-time allowance was incorporated for the care of newborns from the end of the maternity leave until the baby's sixth month. This benefit is for mothers and fathers but cannot be enjoyed simultaneously by both.

Central Administration female public workers reached a collective agreement[24] that extends their maternity leave to 14 weeks; these workers already work half their working hours if they are breastfeeding (up to the baby's sixth month or as prescribed by the physician). Fathers already enjoy a 10-working-day paternity leave.

In case of adoption, from the moment the foster parents have the legal custody of the child, both public and private (male and female) wage-earners are entitled to a maternity/paternity leave and equivalent subsidy for six weeks, after which they may enjoy a 50% reduction of their working hours, for a period of six months. When both parents benefit from the special leave, the mother shall be granted a special leave of 42 days in a row, while the father will be granted 10 working days off. In the private sector, this is paid by the social security system, and in the public sector, each government agency must pay for its own workers' benefits.

24 Según el convenio colectivo firmado por COFE el 28 de diciembre de 2016. https://saludlaboraldecofe.files.wordpress.com/2017/01/convenio-cofe.pdf

The law excludes the owners of companies (not classified as single-tax payers) with more than one employee, directors of companies with no remunerated tasks, collaborating spouses and business partners.

The study by Batthyány, Genta and Perrota (2018) shows that 97% of the potential beneficiaries use up their maternity allowance, and 83% of males use their paternity leave. Likewise, 70% of women request the half-time period to take care of their newborns, but very few men claim that benefit. According to the Social Security Bank (BPS) statistics, only 3% of the people applying for their half-time period are men. Therefore, more work needs to be done to promote the appropriation and exercise of this right. Batthyány, Genta and Perrota (2018) also conclude that paternity leave is increasingly popular among younger workers (18 to 29 years), and that the half-time allowance is more popular among more educated women with a higher socioeconomic status. Some of the reasons reported by men for not using their half-time allowance are related to gender roles; some claim that their leave would overlap with the exclusive breastfeeding period, and/or they believe women are the best caregivers. The reasons reported by women include the income-loss imposed by the labor market or the negative impact of their absence on their job dynamics.

In preparation of a campaign to encourage men's use of their half-time allowance, the National Care Secretariat commissioned a study that consisted of 15 interviews to find out why some parents had requested an allowance longer than 30 days. Based on this, they launched the campaign "Dads for longer hours,"[25] featuring men who took care of their babies and having them narrate their experiences and feedback.

It should be noted that in order for a man to be entitled to claim that benefit, certain requirements need to be met, including that his partner be employed, and that both be under the same labor regime; e.g., both must be working in the private sector. These limitations should also be amended; the National Care Secretariat is working on reforming the current legal regime to this end. The original proposal did not include any limitations in relation to the couples' employment status and it proposed that the half-time period could be enjoyed simultaneously by both parents, in the understanding that by taking turns they would be able to take care of their baby throughout the working day.

3.3.2 Actions to promote co-responsibility of care

Decree # 439 (Dec/2016) defines the catalogue of services, programmes and services to be provided by the National Integrated Care System (NICS) and proposes the co-responsibility actions below (Art. 29):

> *- Time allocation measures: these actions are intended to make it easier for the (male or female) worker to have time for care; they include:*
> *1. Parental leaves*
> *2. Leaves to care for dependent family members*
> *3. Working hours flexibility*
> *- Measures geared to providing access to services, i.e., actions that facilitate the workers' and/or students' access to care services, including, but not limited to material or economic support, benefits covered through agreements with service providers etc.*

Recommendation # 165 of ILO Convention # 156 sets out many of the actions that should be implemented to promote co-responsibility of care, targeting not only the employed, but also people that are being trained to integrate the labor market. These measures are:

- Parental leave for mothers and fathers;

25 https://www.youtube.com/playlist?list=PL2iYaWHuQRQSqWLFqnEgPrL1FTZ5vsxY8

- Leave in case of illness of son or daughter, or other direct family member;
- Developing or promoting childcare, family assistance and other community services, public or private, that meet people's needs;
- Duly regulated and supervised home aid and home care services, which—if necessary—can provide workers that have family responsibilities with qualified assistance at a reasonable cost, commensurate with their economic possibilities.

Likewise, regarding working conditions, Chapter IV of Recommendation # 165 proposes to:

- Progressively reduce the working hours and reduce overtime work.
- Introduce more flexibility in the organization of working hours, rest periods and holidays, considering the development and specific needs of the country and of various activity sectors.
- Wherever possible and appropriate, the special needs of workers, including those related to their family responsibilities, should be taken into account when organizing shifts and assigning night work.
- When transferring workers from one site to another, the workers' family responsibilities and factors such as spouse's working place and the educational possibilities of the children should be considered.

Since 2005, three-party negotiations (that engage Government, employers and workers) on wages and working conditions have resumed, under the Wage Councils.[26] For the National Care Secretariat, this is the natural ambit where these co-responsibility measures should be pushed. Experience so far shows that progress has been slow. To encourage the inclusion of these clauses, in May 2018, prior to the start of the new bargaining round, PIT-CNT presented their recommendations on the type of clauses that could be agreed upon.

CARE CO-RESPONSIBILITY CLAUSES PROMOTED BY PIT-CNT FOR THE SEVENTH COLLECTIVE BARGAINING ROUND (2018-2019)

Family co-responsibility:

Model 1 clause: Workers in charge of direct family members (mother, father, minors or disabled people, spouses and/or common-law marriage spouses) with disabilities or cancer or chronic/terminal diseases may request the following leaves:

1. They will be entitled to 20 hours a month of paid leave, which may be requested in fractions for visits to the doctor's office in general, any kind of tests, any therapy related with the condition, psychological or physical therapies, etc.

26 https://www.mtss.gub.uy/web/mtss/consejos-de-salarios

This leave cannot be accumulated and rolled over for subsequent months; it must be requested at least 72 hours in advance and the worker requesting it needs to bring a certificate issued by the treating specialist, stating that the worker took the family member to the visit.

In addition to the above certification, the worker must prove just once to the company that he/she has a direct family member with a disability, a chronic condition or cancer. The company undertakes not to disclose any information provided by the worker that requests this leave.

2. In the event of the hospitalization of the direct family member, the worker shall be entitled to a paid leave of up to 10 days per year, counting the day of admission; this leave may be requested fractioned and shall not accumulate from one year to the next.

Without prejudice to such leave, if the severity of the intervention requires it, the worker may request up to 15 days of leave but will receive no pay for the last 5 days.

A Model 2 clause: Workers in charge of direct family members (mother, father, minors or disabled people, spouses and/or common-law marriage spouses) with disabilities or cancer, chronic or terminal conditions, will not be penalized if they are absent without previous notice because of the family member's admission to hospital or medical activity related to one of the ailments above. Such circumstances must be accredited.

Workers responsible for minors:

Modelo 1 de cláusula: Todo Model 1 clause: Any (male or female) worker, who is a father, mother or guardian responsible for minors, shall be entitled to the following special paid leaves:

A) Parents or guardians of children under 14 years of age without any prior condition will have the leave days established by the National Childhood Programme for medical checks (pediatricians, specialist doctors, ophthalmologists and dentists), that is:

a. children under 6 months: one day per month.

b. children between 6 to 12 months: one day every two months.

c. children between 1 to 2 years, one day every three months.

d. children between 2 to 3 years, one day every four months.

e. children under the age of 4, one day every six months.

f. children between 5 to 14 years, one day per year for each child in this age range, with a maximum of three days a year.

The worker that obtains such leave must request it at least 72 hours in advance and on returning to the company must show a certificate issued by the treating physician, stating that the worker indeed took the child to the medical visit.

Model 2 clause: workers with children under the age of 15 and older children with a disability will be entitled to a special paid leave of XX days per year, so they may take care of their children when they are sick, or take their children to medical checks at medical facilities or attend their children's school activities. Workers must provide a certificate from the doctor or school. In order to qualify for this benefit, the worker must have worked at the company for at least six months. The workers' absences exceeding the above days will be considered justified (and therefore will not be subject to disciplinary punishment, although appropriate discounts may apply). The use of this benefit does not affect the entitlement to good attendance incentives or any other benefit related to attendance.

Source: PIT-CNT (2018) "Cláusulas no salariales de los convenios colectivos". Instituto Cuesta Duarte. Montevideo: PIT-CNT.

Two studies have been conducted, one on the Fifth (Alles, 2017) and the other on the Sixth (Villegas, 2017) Collective Bargaining Rounds (the rounds where more significant care co-responsibility clauses were at stake) to analyze whether they contemplated a gender perspective and to what extent they promoted equality. In general, the authors conclude that although progress has been slow, the experience of companies or sectors that have agreed to grant days or hours of leave for the care of dependent children or family members, or other measures of flexibility in the working day has been positive. A recent paper (Salvador and Alles, 2018) on the Uruguayan case shows that such measures contribute to reducing the stress posed by such care on workers when it overlaps with work responsibilities. These circumstances are school vacations or adjustment periods at the initial stage of schooling, and therapy sessions for children with disabilities. Being open and frank about the situation and obtaining a permit to reconcile both responsibilities improves the productivity of the worker, as well as the working atmosphere in the company. In line with that, and rather counterintuitively, significant progress was found in highly masculinized sectors (such as metallurgical, beverages and rice).

In these areas, progress has also been observed in the initiative to install care services for children to cover off-school hours or to care for young children (the so-called SIEMPRE centers described in section 2.2.1). This initiative has facilitated the inclusion of this issue, which, until now, had been heavily resisted by companies, on account of its relatively significant cost.

Work is also ongoing at the corporate level to promote co-responsibility in care, both within the framework of the Quality with Equity Model[27] of the National Women's Institute and the Co-Responsibility Boards developed by the UNDP office in Uruguay with some private sector companies.[28] This has helped some companies and unions to begin to understand these issues and to seek solutions for care.

27 http://www.inmujeres.gub.uy/75652/modelo-de-calidad-con-equidad-de-genero

28 The following guideline was developed for work with companies: http://www.undp.org/content/dam/uruguay/docs/Pob/undp-uy-guia-conciliacion-2013.pdf

The Ministry of Labor and Social Security (MTSS) has held some workshops with negotiators from the corporate sector, trade unions and government to contribute to the inclusion of these measures in the bargaining rounds.

The study by Salvador and Alles (2018) is one of the first to assess the potential impact of co-responsibility actions on the lives of male and female workers and on companies. Further work is required to analyze their impact on sectors that have already agreed on the implementation of such clauses and on identifying co-responsibility needs in different activity sectors.[29]

29 A first approach was done by Fernández (2017).

4. SYSTEM FINANCING COSTS

In article 4, paragraph H ("System Principles and Guidelines"), the law that created the NICS sets forth the "solidarity in financing, ensuring sustainability in the allocation of resources for the provision of comprehensive care."

The incremental budget of the National Care System between 2015 and 2020 amounts to 3,084.8 million Uruguayan pesos, accounting for 0.2% of the current Gross Domestic Product. This was the cost of expanding existing services, developing new benefits and training courses.

Analyzed by components, 62% of the cost corresponds to Early Childhood, 35% to Dependency Care and 3% to Training. (Table 1)

TABLE 2. THE NICS'S INCREMENTAL BUDGET PER COMPONENT AND POPULATIONS

In million Uruguayan pesos

	2016	2017	2018	2019	2020
Extension of coverage for 3-year-old children	97,4	306,7	99,3	99,3	99,3
Extension of coverage for children under 2	461,4	721,4	820,6	1.089,6	1.567,60
Extension of coverage with innovative services	92,1	182,2	182,2	223,2	224,2
Strengthening of Management and Oversight (Early Childhood Secretariat - INAU)	25,4	26,2	26,2	26,2	26,2
Sub Total Early Childhood	676,4	1.236,50	1.128,3	1.438,30	1.917,30

	2016	2017	2018	2019	2020
Vouchers for Long Stay Residentials	15,5	39,8	39,8	39,8	39,8
Day Centers	-	57,6	42,9	42,9	42,9
Tele-assistance	24,7	40,8	40,8	40,8	40,8
Personal Assistants	146,1	542,9	632,9	802,9	802,9
NCS operations	128,8	130,2	152,4	152,4	152,4
Sub Total Dependency	315,1	811,3	908,8	1.078,8	1.078,80
Training of Early Childhood Educators	11,3	16,3	16,3	16,3	16,3
Training for the Care of Dependency (INEFOP funds)	15	30	60	72,3	72,3
Sub Total Training	26,3	46,3	76,3	88,6	88,6
TOTAL of the National Care System	1.017,7	2.094,2	2.113,5	2.605,8	3.084,8
GDP (million pesos)	1.589.195	1.707.109	1.831.132	s/d	s/d

Source: National Care Secretariat &Economic Statistics Division of the Uruguayan Central Bank

5. FINAL CONSIDERATIONS

One of the strengths of Uruguay's commitment to a care system is to ensure that the policies implemented consider the comprehensive actions that households undertake to meet the care needs of their members. Although the definition is restricted to the direct care of children and dependent people, this position is warranted because of the deficit of policy to serve these populations.

Some challenges remain regarding the effective inclusion of the gender perspective and the development of monitoring and evaluation tools to account for the progress made in terms of equality.

In relation to recognition, there is still a need to ensure a periodic survey of time-use surveys and other surveys that are considered essential for the design, implementation and evaluation of policies. An agreement is still to be reached as to the criteria and methods of time valuation allocated to unpaid work to add it as a component of the national accounting system. More information is needed to characterize the care required by dependent people due to ageing or disability. Some studies have been launched to include the caregivers' burden of care in the dependency scale. This is a major step forward to include gender in the assessment of dependency and will be an innovative input for other countries.

As for the training of paid caregivers, there is still work to do in the design of tiered programs, where people specialize and acquire their professional profiles depending on the types of care they are interested in. Such training should be designed based on the professional characteristics required by the system, depending on the services provided and the emerging demands.

As this activity is considered a booming sector, it is essential to guarantee labor rights to all care workers, and to include them in collective bargaining, preferably through a specific group that contemplates their specificities.

With regard to strategies for cultural change, work with the private sector must be deepened to demystify the figure of the ideal worker as a worker with no family responsibilities. The aim should be to strive for the construction of a "care-minded society." More in-depth work is also needed to raise awareness about social and gender co-responsibility in caregiving with the policy operators in the capital and, more still so, in the rest of the country.

The gender and human rights approach to the implementation of policies needs further strengthening, both in terms of the provisioning of services and the training of people that implement, execute and monitor services. Also, if universal access to the system is to be ensured, the design of policies should be further promoted locally, engaging all the stakeholders.

Regarding the challenges observed in the gender redistribution of unpaid care work, the strategy should be revisited to increase the use of part-time allowance by men in general, and by women in the medium and low socio-economic strata.

In turn, strategies should be developed in partnership with trade unions and businesses to speed up the inclusion of co-responsibility clauses on care in collective bargaining. It is to be noted that the most masculinized delegations in the collective bargaining rounds are those of employers and trade unions. In the latest rounds, none of those delegations reached a participation of women surpassing 20%. This means that we must also work on sensitizing and raising awareness on the issue. On the other hand, it is essential to identify the conciliation challenges that may arise in the different sectors of activity, depending on the forms of organization of work and the extension of the working day.

All in all, although progress has been very significant, several challenges still need to be addressed, including commitment to ensure stable funding, as the care policy cannot be left to fluctuate with the economic situation; being a right, it must be guaranteed just as education and health.

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