Reconfiguration of Child Care Strategies: Challenges from a Gender Perspective

Abstract

This article aims to discuss the child care strategies of families in Uruguay. It focuses on the differences experienced by three generations of men and women with regard to gender-related practices and representations. In Uruguay, various quantitative studies shed light on the institutional and family coverage of child care, while others address the division of child care between men and women within the home. However, only a few focus on the root causes that lead to the development of child care strategies and on the role played by evaluative elements, living conditions and gender mandates in the adoption of such strategies.

The empirical information analysed was obtained by interviewing three generations of male and female members of the same families. The methodological strategy falls within the framework of longitudinal qualitative research focused on identifying those attitudes and values that distinguish one generation from the other. The current generation consisted of parents of young children (under 6 years of age). These couples' experience regarding care goes from 2010 to date. The "grandmothers'" generation was made up of the children's current grandparents. These couples had taken care of their young children during the 1975-1990 period. Finally, the oldest generation consisted of the children's maternal great grandmothers. These great grandparents had cared for their own children between 1955 and 1965. Previous research work suggested the need to include the families' socioeconomic status as a relevant variable for understanding the representations and practices associated with

care and gender mandates. Three relevant tiers were identified: high, middle and low socioeconomic-level families. In order to identify each tier, the following variables were defined: the female member's remunerated job and characteristics (occupation, profession, whether full- or part-time, area of activity).

This article unveils changes and continuities in child care strategies across generations, evidencing progress and setbacks in the evolution of gender systems. The new care policies, the multiple work places currently occupied by women and the new cohabitation arrangements represent significant changes over the past 6 decades, generating a favourable scenario for more equitable gender relations. However, the findings show a replication of the traditional gender system, which has been capable of reinventing itself. Despite women's educational and career achievements, growing maternalism among high-tier university graduates evidences new and innovative mechanisms for reproducing the ideology of intensive mothering and a gender system that perpetuates its natural association with quality care. This context further challenges gender relations, especially in the middle-class sectors which represent the greatest breakaway from the past. Firstly, when it comes to taking a decision with regard to care strategies, many families openly discuss possible options rather follow custom mandates. Secondly, women in the middle-class sectors who are integrated in the labour market are beginning to challenge men's role in care. Thirdly, men are more involved than in the past and are starting to actively participate in such care strategy. Though within a certain context and for certain social profiles, the above three phenomena evidence progress on the road to more equitable gender relations.

1. Introduction

This article aims to discuss the child care strategies deployed by three generations of women and men, by gaining an insight into their root causes and the economic, social, cultural and gender-related elements that have an impact on them.

In Uruguay, various quantitative studies shed light on the institutional and family coverage of child care, while others address the division of child care between men and women within the home.

However, only a few focus on the root causes that lead to the development of child care strategies and on the role played by evaluative elements, living conditions and gender mandates in the adoption of such strategies.

2. Methodology

The empirical information analysed in this paper was obtained by interviewing three generations of male and female members of the same families during 2016.

The methodological strategy falls within the framework of longitudinal qualitative research, which sheds light on current changes, as well as on how and why such changes are taking place by analyzing how individuals generate, go through and experience change.

Within the generational analysis, we developed a horizontal methodological approach focused on identifying those attitudes and values that distinguish one generation from the other (Cais et al, 2014). The population sample was made up of families with three generations of female members, the current-generation member being the mother of

a child under 6 years of age. Thus, the "mothers'" generation consisted of parents of young children. These couples' experience regarding care goes from 2010 to date, a period marked by the introduction of this theme into the public agenda through the initial debate on the National Integrated Care System[1].

The "grandmothers'" generation was made up of the children's current grandparents. These couples had taken care of their young children during the 1975-1990 period.

Finally, the oldest generation consisted of the children's maternal great grandmothers. These great grandparents had cared for their own children between 1955 and 1965.

Previous research work (Batthyány, Genta, Perrotta, 2013, 2015) suggested the need to include the families' socioeconomic status as a relevant variable for understanding the representations and practices associated with care and gender mandates. The socioeconomic status was defined theoretically based on the mothers' generation. Three relevant tiers were identified: high, middle and low socioeconomic-level families. In order to identify each tier, the following variables were defined: for the high tier, belonging to wealthy, prestigious families in Uruguayan society. For the other two tiers, basically the female member's remunerated job and characteristics (occupation, profession, whether full- or part-time, area of activity).

A total of 12 families were interviewed (2 of high, 3 of low and 7 of middle socioeconomic level), adding up to a total of 49 individual interviews. The decision to

[1] The National Integrated Care System is a public policy on dependants' care which began to be implemented in Uruguay in 2015. By providing or regulating dependant care services, the System seeks to acknowledge and duly recognize care-related labour, and to promote shared responsibility between the families and the State, as well as between women and men within the household. It further aims to have a positive impact on the equitable distribution of income, and also on equity from a gender, generational and ethnic-racial perspective.

interview a larger number of middle-class families was taken considering the diversity of discourses and living conditions within this tier.

3. Theoretical Framework

Women's sustained integration in the labour market since the 1970s has had an impact on care strategies. While traditionally care relied upon the women in the family, the new roles played by them in public spheres challenge the female-based care strategy.

From the moment women entered the labour market, child care began to be problematic. For the first time, families had to address how to deal with housework and child care. The manner in which such care-related problems are solved through the intervention of different agents is known as "care strategy" (Wallace, 2002 in Batthyány, Genta, Scavino, 2017) underscores the importance of analyzing strategies by highlighting a theoretical resurgence associated with the pondering and awareness that characterize present-day societies, which render of remarkable analytical value how time and money resources are allocated by households.

Care strategies will be considered as choices made by household members based on a combination of factors of structural nature (sexual division of labour within the home, class status, sex segregation in the labour market, availability of material access to private and State care services, etc.) and socio-cultural factors (gender mandates, opinions as to the ideal care and the ideal caregivers). (Wallace, 2002 in Batthyány, Genta, Scavino, 2017)

A remarkable study on child care strategies is the research conducted by Kröger et al (2013), who compared five European countries in different socio-cultural and economic contexts (Finland, France, UK, Italy, Portugal). The study focused on the connection between public policies and family decisions regarding care and its articulation with remunerated work. (Kröger et al, 2013)

One of the conclusions of this research regarding dual-earner families is that they develop different strategies in countries with similar institutional conditions (care services/benefits) with no evidence of one mainstream strategy. According to this study, such strategies are adopted considering, *inter alia*, the services and benefits provided by the State, available alternatives in each household, the time constraints imposed by remunerated jobs, family members' educational level, attitudes, perceptions and values, career/care preferences, the children's and parents' ages, the extent to which traditional gender roles prevail, income levels, and degree of dependence of those in need of care. (Kröger et al, 2003)

In Uruguay, past research demonstrates that care strategies are strongly influenced by socio-cultural factors, gender mandates and the reluctance to use child care centres for children in the early years. According to the National Survey of Social Care Representations (ENRSC), people are reluctant to use institutional care services for young children and expressly state that, ideally, child care should rely on families, in particular mothers. A key finding was that social representations of care are influenced by socioeconomic conditions. Indeed, lower-income homes tended to adopt a more 'familist' approach. (Batthyány, Genta & Perrotta, 2013)

As regards care practices, evidence shows scarce use of institutional care services for young children, whose care largely relies on their mothers and other female family members. The household's economic situation and women's integration into the workforce have an impact on the strategy adopted, as there is a direct relation between the use/hiring of external care services and/or caregivers at home, and the family's income level and women's remunerated jobs. (Batthyány, Genta, Scavino, 2017)

4. Institutional Care-Related Context of the Three Generations Studied

During the 1950-2010 period covered by the three generations surveyed, the country saw significant changes, among which we would like to highlight family structure, women's status in the labour market and care-related public policies.

Regarding family structure, changes began in the 1970s and consolidated in the 1980s and 1990s. Their root causes include: increasing number of cohabiting unions and separations, and a declining fertility rate. This resulted in more single-person households (from 11.4% in 1963 to 23.4% in 2011) and single-parent families headed by women (from 7.3% to 11.1%), and fewer extended families (from 21.2% down to 14.9%). (Cabella et al, 2015)

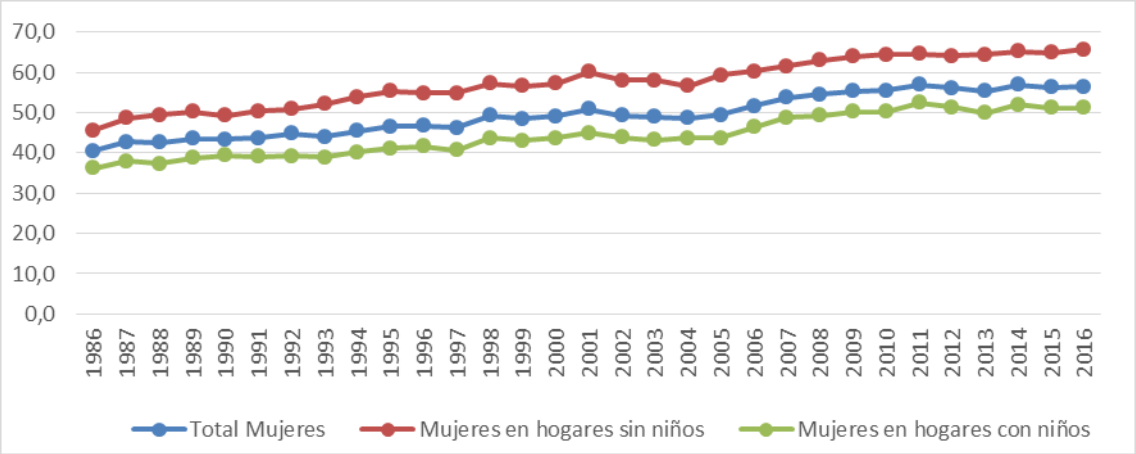
Household structure changes evidence a reduction in traditional cohabitation arrangements, i.e. a couple with children, lifelong marriages. The new cohabitation patterns may challenge the traditionally rigid sexual division of labour. To a certain extent, the growing number of single-parent homes headed by women reflects women's entry into the workforce and an increasing divorce rate. The reduction in the

number of household members and of extended families evidences a gradual breakaway from the traditional three-generation cohabitation arrangements where grandparents and grandchildren used to live together.

The care strategy in those homes where grandparents would care for their grandchildren (and vice versa) is being gradually abandoned nowadays. On the other hand, more and more elderly people live by themselves in single-person homes. For Uruguay, these changes should be understood within the context of socioeconomic variables. Indeed, certain types of households, such as single-parent and single-person homes, are more likely to be found in the top quintiles, whereas extended families are more often seen in the bottom quintiles. Thus, in the poorer sectors of the population, extended families continue to resort to cohabitation as an income-earning and care strategy.

Regarding the changes in the status of women in the labour market, their participation, even in the case of mothers, has steadily increased. While in the 1980s it was approximately 40%, it is as high as 55% at present.

Chart 1. Evolution of the rate of activity of female family members with and without children under 12 years of age. Towns of +5,000-inhabitants in Uruguay. 1986-2016



Total of women Total of women (homes with no children) Total of women (homes with children)

Source: Socio-Demographic Area, Databank, School of Social Science (FCS), University of the Republic of Uruguay (UdelaR), based on the National Statistics Institute's Continuous Household Survey (ECH 1985-2015-INE).

Since the 1980s, the entry of women in the workforce has had a great impact on the traditional male breadwinner/female homemaker pattern, leading to the proliferation of dual-earner households.

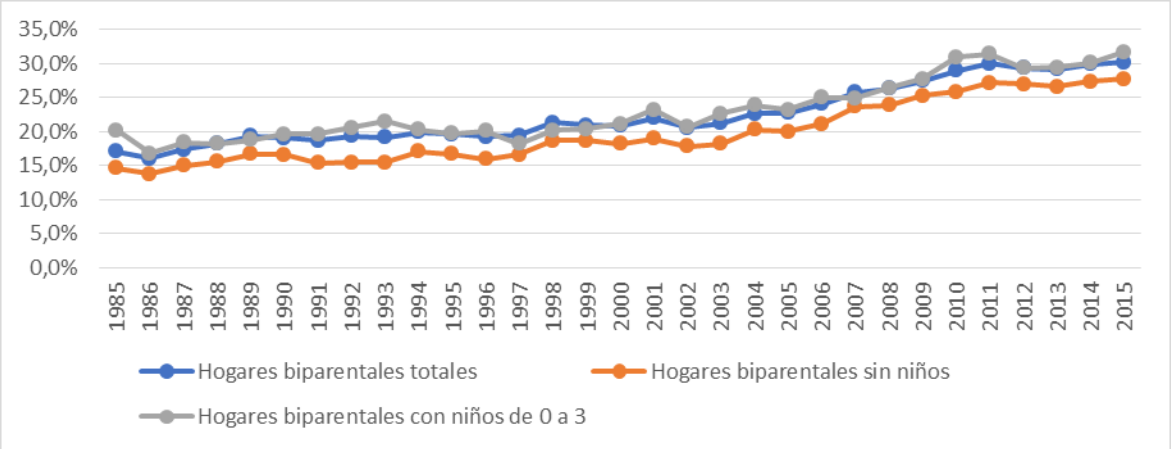
The same applies to families with young children (0 to 3 years of age), though the changes are not as significant in terms of the traditional couple reduction and dual earner couple increase rates.

The traditional male breadwinner model has declined, yet it still tends to prevail in couples without children. While in 1985 50% of families with young children followed the traditional male breadwinner pattern, only 34.2% do so at present (ECH 2015). The modified male breadwinner model (where men are the primary breadwinners and

women work part time) stayed at about the same level throughout the period, and even rose slightly toward the end (from 19.3% in 1985 to 24.2% in 2015).

A third model nowadays is the dual-earner couple, which accounted for 20% of households with young children in 1985 and now stands at 31%.

Chart 2. Distribution of two-parent dual-career families. Towns of +5,000 inhabitants in Uruguay. 1986-2015



Total of two-parent homes Total of two-parent homes with no children Total of two-parent homes with children aged 0 to 3

Source: Socio-Demographic Area, Databank, School of Social Science (FCS), University of the Republic of Uruguay (UdelaR), based on the National Statistics Institute's Continuous Household Survey (ECH 1985-2015-INE).

Regarding the evolution of public child care policies, which go in line with the changes described above, we would like to highlight the following three stages based on the research conducted by Ferrari (2017).

The first stage, from 1955 to 1980, in which services and benefits provided by the State were scarce. For the first time in Uruguay, women were granted maternity leave as

they began to enter the workforce, and the first kindergartens were established for children aged 3 to 5, though only covering 17.9% of this population in 1975. These kindergartens were basically intended to reinforce primary education rather than to help harmonize work and family duties. There were no public kindergartens for children under 2, nor is there any information available about private kindergartens.

In the second stage, from 1980 to 2000, a number of actions were taken, which evidence greater State's involvement in the provision of care.

The first 3-day paternity leave was granted, but only to public servants, and maternity leave was extended. Kindergarten coverage was widened for 4- and 5-year-old children. While in 1990 pre-school coverage for children aged 3 to 5 was 52.8%, by 2000 it had reached 91.4%. These figures primarily reflect the increase in kindergarten coverage for 4- and 5-, rather than for 3- year old children.

In this second stage, public care coverage for babies and toddlers aged 0 to 2 was inexistent (only 4.4% were enrolled in nurseries in 1990). Given the need arising from women's sustained participation in the labour market and the unavailability of men as caregivers, a proliferation of private services allowed those who could afford them to manage work and child care (10% of children under 2 attended nurseries in 1990).

Dedicated care and development centres for babies and toddlers - the *Centros de Atención a la Infancia y a la Familia* (CAIF) - were established for the purpose of alleviating child poverty in at-risk populations.

In this period, the policies addressed to children were primarily aimed at reinforcing education, and also at improving health indicators and promoting social integration, especially among the most socially vulnerable. The phenomenon known as

“juvenilization of poverty” in the country was the central concern during this period, leading to the development of programmes and to the establishment of institutions.

Finally, the third period goes from 2000 to date. This was a turning point as care became one of the objectives of child-related policies. For the first time in history, the need to care for children during parents’ working hours was introduced as one of the reasons for creating a service or benefit. Greater male participation in child care was further included as an objective of these policies. However, such objectives went hand in hand with poverty reduction and other goals related to early childhood education and health. Public services and benefits continued to be primarily addressed to at-risk populations. This trend started in the 1980-2000 period and has prevailed throughout the subsequent stage, though with subtle differences.

The groundbreaking development in this third period is the creation of the National Integrated Care System (SNIC). Parental leave legislation has changed. Fathers have been granted a reduction in working hours, so that they can take turns with mothers to care for their babies during their first months of life. Public coverage for 3-year-old children has been widened. More CAIF centres have been established, though access to the services they provide continues to be restricted to children in vulnerable populations.

On account of the changes described above, the context in the 1950-2016 period favours a more equitable gender balance: greater male involvement, shared responsibility with public and private institutions regarding child care, and women’s greater economic and decision-making autonomy.

5. Child Care Strategies: Progress and Setbacks on the Road to Gender Equity

We will now proceed to analyze the care strategies for each socio-economic tier identified in our field work. Both the above empirical precedents for Uruguay and international precedents (Crompton, 2006; Castello, 2012; Palomo, 2010) demonstrate that one of the key factors in the adoption of care strategies is the household's socioeconomic status.

As suggested by Castello (2012), it is important to consider the different approaches to the provision and management of care among women and their social status as a key element for designing work-family harmonisation strategies. Along the same line, Crompton (2006) stresses the importance of social structure when it comes to establishing a link between production and reproduction. He states middle-class women adhere to a male working pattern, as they outsource housework and care in pursuit of career goals. On the other hand, the "working classes" rely on their family networks. Yet in these cases, care strategy still adversely affects women's working conditions, which are characteristic of precarious jobs. These women's primary motivation to enter the workforce is the need to supplement household income, not the pursuit of career goals as is the case with their middle-class peers.

Within each socioeconomic tier, this article will discuss the different generations. Generational analysis is extremely important as it sheds light on the impact of the varying historical, political-institutional and cultural contexts on the strategies adopted, which often entail significant changes.

5.1 High Tiers: The Ideology of Intensive Mothering is Present, though from a Different Perspective

The perception of care, what it entails and how it is experienced varies across socioeconomic tiers and generations - in particular, the content of care and how parents convey their sense of duty. Care can entail companionship, availability or the execution of all tasks, including care support or housework. (Castello, 2012)

For women in high tiers, the content of care is partially related to what is known in literature (Tobío, 2010) as indirect care, that is, the management of care rather than the execution of the tasks themselves. While indirect care represents a significant share, this does not mean high-class women only manage these duties. They also undertake direct care, though under certain conditions described below.

Hiring in-home help to care for toddlers and young children is the first choice in high-class tiers across all three generations. The main purpose is to support child care at home, but not necessarily to harmonize women's or families' paid work with child care.

The election of this strategy is not perceived by families as a decision adopted rationally, considering the advantages and disadvantages, but rather out of habit.

> *The family I come from had the same system of care. A person worked at our home for many years and cared for us since we were toddlers, so this decision was only natural. As soon as I became pregnant, already knowing we would have an in-home made, we did not even hesitate to choose that option. (Woman 1, G3, High Tier)*

The in-home help hired does both housework and care-related tasks. Even when children start going to school (not before 2 or 3 in the case of mothers, and up to 6 or

7 for grandmothers and great grandmothers), families still hire in-home help, especially for housework.

Child care and domestic work is divided between mothers and maids, with the latter doing the routine cleaning chores and less pleasant tasks. The so-called dirty work is done by the most disadvantages members of society in terms of gender, race and class, i.e. non-white, low-class women. (Tronto, 1993) According to this author, it is difficult to tell whether these social groups are more disadvantaged because they provide care and care in itself is devaluated, or because it is the more disadvantaged groups who are assigned this task. The fact is, this is actually a vicious circle of interconnected phenomena where care is devalued and so are those who provide it. The devaluation of these groups does not only stem from the position they hold in terms of low pay or social prestige, but also from its association with the human body. This is evidenced by the fact that women are considered more natural, more instinctive, more animal. The descriptions of women, and in particular of poor women, often highlight their association with natural instincts deployed in care. (Tronto, 1993)

On the other hand, there are privileged groups who can afford to pay for care. At this point, it might be useful to remember the phases of care described by Tronto (1993, 2011): 1) “Caring about”: Identifying others’ needs, which entails recognising there is a need that has to be addressed. 2) “Taking care of”: This is the second step in the process of care. It involves taking responsibility for the need identified and determining how to respond to such need. 3)”Care-giving”: Direct execution of the tasks required to satisfy such need. It involves physical work and practically always demands being in contact with those who receive care.

To Tronto (1993), it is possible to conceive paying money as a way to provide care, as long as it entails contacting someone for the provision of care. While money does not in itself satisfy human needs, it provides a means for satisfying such needs. 4) "Care-receiving": This phase recognizes that the person who receives care will respond to it. Only by including care-receiving as a component of the process is it possible to know whether the care needs are actually being met.

According to this author, those in a privileged position develop some elements of care, but not all. Thus, they identify the care needs (caring-about), take responsibility for care (taking care of), but do not directly execute these tasks (care-giving).

In the high tiers, women are a 'bivalent' group[2] as they are relatively privileged as compared with other women, but are at a disadvantage in comparison with men. On the one hand, this group of women are privileged in that they can pay others (lower-class women) for the "dirty work". These women can set the terms and schedule of care. Thus, they can choose to perform activities that help develop bonds of affection (play, talk), and leave the more routine, exhausting tasks in the hands of paid help, or even perform these tasks themselves, but not systematically.

However, these women are at a disadvantage vis-à-vis their male counterparts, who enjoy "privileged irresponsibility". (Tronto, 1993, 2011) This term helps understand why men merely pay for care tasks, and do not see the need to monitor the interactions between caregivers (hired help and even mothers) and those cared for

[2] Nancy Fraser (1997) uses the term "bivalent communities" for women, as she believes this group suffers two kinds of injustice: material (unevenly distributed material resources) and cultural (related to social worth or recognition).

(children). Such “privileged irresponsibility” allows men to neglect anything related to the management of care, which is in the hands of the women in their social tier.

As a result, care is divided between mothers and maids, though such division has changed through the generations. Mothers’ discourses evidence they now tend to devote more time to direct care, particularly as it relates to creating bonds of affection. In the past, on the other hand, mothers would focus on managing care, while hired help would execute all the components of direct care.

Accordingly, those people hired for child care in the past used to be more specialized. Families would hire nannies rather than domestic workers. Not only caregivers were specialized, but also the rest of the service: one for ironing, another for cleaning a specific area in the home, and so on. This does not mean previous training or expertise was required, but rather that tasks were distributed after hiring the in-home staff.

The grandmothers and great grandmothers quoted below hired help as a care strategy, but in this case specifically for child care. The grandmother had a paid job and was also actively involved in politics. The great grandmother did not work and was mainly engaged in managing the household. Though each of them had a different public status, both adopted the same strategy.

> *“I used to have a very good in-home maid. At the time, I had more important things to do than bring up children. She would be here all day, care for my daughters, cook and take care of everything that had to do with meals. I simply forgot about home, where things worked fine. There were always more important things to do then. At times I would not see the girls; I would leave at eight o’clock in the morning, go to work, study and return in the evening, but things worked at home.” I never helped them with their homework as I thought it was only natural for them to do those things by themselves... (Woman 2, G2, High)*

> *"I would say I did only a reasonable share of tasks, not more than that, because I was lucky to have an extremely kind Spanish maid who always worked in-house and helped me care for them (...) My children did not have lunch at the dining-room table. They were served lunch before us at a small table in the kitchen. And at night, they had dinner early because they took a shower before going to bed, while I had dinner later or not have dinner at home, I'd go out." (Woman 1, G1, High)*

In contrast with these discourses, the mothers noted the role they played in the direct care of their children as opposed to that of grandmothers and great grandmothers. They suggested that, in the past, women used to be less available for care. They remarked quality care is associated with the development of bonds of affection.

> *"In those days, mom would not get up at the same time as we did. I'd say she was slightly awake, but would not have breakfast with us. She just sat there, half awake. Perhaps it was just me, as I used to rush every morning. There was not much chance of doing anything together." (Woman 1, G3, High)*

The current division of care between mothers and hired help most probably explains why the latter's skills are not a matter of serious consideration, as is the case with middle-tier families. Nor do they mention explicit mechanisms for monitoring care, which middle-tier families do have in place. Clearly, the family plays a key role in care and the person hired does not "replace" family care. "We don't just forget about it and tell the maid to go take care of the kids." (Man 1, G3, High tier).

The analysis of different generations of high-tier women reveals continuities in the strategy adopted, and even a trend toward strengthening the traditional role of mothers as the family member primarily responsible for care. According to Palomo (2010), there have been hardly any changes in women's responsibility regarding care

and ideal care as a result of their entering the labour market or their increased autonomy. These changes "entail only a slight variation; by no means do they invalidate the findings on care in and for the family home, the person hired as main caregiver and to how she must perform this task.

Now high-tier women's role in paid work has undergone changes. In the great grandmothers' generation, women had various skills learnt informally at home, yet only a few participated in the labour market, and when they did, it was within the framework of their own family's business. Whether or not they had ever worked outside their home, marriage meant they would potentially or actually no longer have access to the labour market.

> *"I got married at twenty-one, which was usual in those days. I had studied and had planned to go somewhere else, but one day I fell in love, decided to get married and moved with my husband to the country. I didn't mind, though. I did have to give up things I really liked, but that's not unusual either." (Woman 2, G1, High)*

In the case of the grandmothers, while in Uruguay women had already started to have paid jobs, high-tier married women displayed a wide range of attitudes.

The mothers, on the other hand, create new mechanisms for harmonizing their traditional duty of care with their participation in the labour market. The women in the high tier changed their relationship with paid work once they had children. They started their own undertakings, so as to have a more flexible schedule that would allow them to fulfil their duties as mothers while maintaining a certain degree of participation in the public sphere. In contrast with great grandmothers, these women have had access to formal education and have gone to university. Therefore, their

participation in public life has to do with the needs arising from such academic pursuits.

Interestingly, it was these women who had had access to tertiary education and had achieved remunerated positions before becoming mothers who later chose to give up conventional jobs.

> *...To practice my profession, I had to leave home early, never knowing at what time I would be back. I felt it was important for me to stay at home rather than go to work, earn a little more and pay someone so that she would care for my child all day long (...). I did not work out of home. I made EVA foam shapes for birthday parties and so on. I came up with this idea (...) just in order not to have to leave home." (Woman 2, G3, High)*

In the absence of economic factors restricting choice, women tend to adhere to socio-cultural mandates when it comes to adopting a care strategy.

In the case of grandmothers and great grandmothers, the traditional pattern of staying at home and managing the household was only natural. They didn't need to go out to work because men were the breadwinners.

> *"I thought that was what a housewife was supposed to do. I mean, I didn't have a job. If I hadn't done that, what would I have done? Of course I thought that was what a mother was supposed to do. I had free time. I lived in the country. I had plenty of free hours. I prepared the meals or else had them prepared." (Woman 1, G2, High).*

In contrast with grandmothers and great grandmothers, current care strategy based on mothers' withdrawal from the labour market is considered a personal choice where women rationally consider, adopt and take full responsibility for this decision. In these cases, it is women themselves who choose to change their labour status.

> *"The importance of the mother in bringing up a child not only lies in her physical presence, but in her holistic approach to her child (...). This was a deeply-thought decision on my part. I did not doubt. I didn't want someone else to bring up my son, (...) I am here because I want to be here. I have a profession, I can work, but I choose this because I feel it is important... I think this is one of the roles we have arranged, it is part of what we share, you see." (Woman 2, G3, High)*

Unlike the new mothers who are successful career-women (Sole & Parella, 2004; Imaz, 2016), the high-tier mothers in this generation tend to reproduce what, according to Hays (1998), is the "ideology of intensive mothering". This ideology represents something akin to a Decalogue of proper behaviour for mothers. Such mothering appears to be based upon three principles. First, that mothers should devote a huge amount of time, personally engage in, and spend a lot of money on their children's care. Secondly, the idea that male care is not necessary because only women have the natural skills needed for this task. Thirdly, the mother-child relationship symbolizes the importance of bonds of affection, the opposite of a mercantilist society where people seek individual benefits.

Based on how the social implications of care at both family and community levels inter-relate, women's decision to stay at home are attributed to the prevailing ideology of intensive mothering. According to Palomo (2010), the moral dimension of care refers to the standards on who should feel responsible for it. These moral principles based on what is considered fair underpin behaviour. As we select a course of action, we need to justify our choice. The decisions taken as to the role each person will play in child care entail a moral dimension that calls for justification. While mothers' justifications actually relate to their sense of duty with regard to care, they are outwardly voiced as an arrangement and a personal decision.

Though women have had more access to paid jobs, economic resources and education than ever before, the gender system still prevails and manifests itself through new mechanisms. Moreover, traditions are stronger than ever, yet they are rendered invisible because they are disguised as “individual decisions” or “arrangements”.

As stated by Zicavo (2013), at present the ideology of intensive mothering coexists with other social projects involving women’s professional and economic success in the labour market and the academic spheres. This translates into clashing mandates for women. Those who express their desire to stay at home to care for their children and depend on the economic resources provided by their husbands find this model does not have the prestige and worth it used to have in the old days.

The changes in women’s integration into the public sphere and the fact that women’s traditional role is being challenged call for new legitimizing arguments in the current scenario. Thus, the gender system is replicated through new mechanisms.

5.2 Low Tiers: Reproducing the Traditional Model at Higher Costs

In the low tiers and across the three generations surveyed, the standard strategy is based upon the traditional sexual division of labour where mothers care for their young children.

Regarding the labour market, we have found some specific trends in the different generations. Great grandmothers are absent from the labour market. Grandmothers are integrated, though with temporary absences during the early years of their children. Mothers appear to withdraw from the labour market and encounter difficulties to re-enter the workforce once their children have reached a certain age.

In some cases, both at present and in the past, rather than abandon the labour market altogether, they take precarious jobs that allow them to continue to care for their children, as described by Crompton (2006). They work a few hours a day with flexible schedules that will not overlap with their regular paid job. Domestic work "by the hour" allows these women of low educational level to harmonize work with child care. They also work freelance, usually in traditionally female jobs, such as seamstresses or cooks, though these activities entail low pay, lack of stable, formal working conditions, and hardly any training and development opportunities.

> *In their early years - from zero to four - I stayed at home and cared for my girls. I didn't want anyone else to take care of them. I preferred to do this myself. Of course, when they began to go to school and I had time, why would I stay home? I went to work. I would always get jobs near their school, so that I could go pick them up and then go back to finish my work. Since I was paid by the hour, there was no problem. (Woman 1, G2, Low)*

Across all three generations, women are primarily responsible for providing care and doing housework. They do not share these tasks with men or hired help, except occasionally with female family members, such as grandmothers or sisters. Care in this case consists of managing and executing all those care-related and domestic tasks involved in child care.

This tier displays the highest level of continuity in the rigid sexual division of labour and the care strategies adopted. As observed by Palomo (2010), these people more naturally and readily accept the traditional pattern of rigid distribution of roles by sex. Women naturally undertake mothering and also naturally assume unilateral, exclusive responsibility for the tasks associated with it.

I've seen many workmates work to buy things for their children instead of enjoying time with them, and that's something I don't want for myself... Even if you have a reliable person who can help you care for them, no-one can actually replace parents. Parents have to be present at all times, whether or not they are working. If they call them and tell them 'something happened to your child', they have to come and be there. And I don't like the idea of giving up the time you can enjoy with your children just because you want to go to work. (Woman 1, G3, Low)

Women's role in care is not questioned, and access to paid work is only attributed to economic necessity. With not great economic aspirations - just enough to make ends meet - access to the labour market is unstable, and women frequently enter and withdraw from the workforce. Women's entry is driven by economic necessity, while their absences are associated with those periods when their children are young or their husbands manage to earn more.

"I have always been a maid (...) I would quit whenever my husband would get a stable job, see? Then I'd take it easier and stay home to take care of the kids (...). Later on, when they were a little older, (grandma) took over and I went back to work (...)." (Woman 1, G1, Low)

In those periods when women work, they rely on their family networks for child care. Elder sisters play a key role in their young siblings' care, often at the expense of their own education and future career opportunities.

"*The first four months were just wonderful because I stayed with my baby girl, as I had maternity leave and also annual leave (...), but after that things got really difficult for me. I would bring her to my sister's home, to my mother's home, to my other sister's home, I would call them up to ask them if they could take care of her... You see, I started work at 2 a.m. and had no fixed work schedule (...) My sister used to take care of my baby a lot for me... but then, when my sister was not available, I had to leave her with my mother or my other sister (...)" (Woman 2, G2, Low)*

In line with the findings of Palomo (2010) across all three generations - mothers, grandmothers and great grandmothers - this radical division of roles has to do with the fact that men were mainly engaged in paid work. As primary breadwinners, they were released from domestic duties. Given the scarce economic resources and low wages on the market, a care strategy outside the family network was simply not affordable.

> *"You see, with the jobs you got those days, you just exchanged the money you earned for hired help. I had to hire someone to care for my baby, because mom had moved in with my sister. And she took care of my sister's baby. So I had to hire someone and go to work in order to pay her wage. It was simply not worth the hassle." (Woman 3, G2, Low)*

Unlike their peers in the high tiers, these women have precarious jobs and scarce sources of personal income, if any. Their educational level reduces their opportunities to find a job, let alone one that may allow them to harmonize work and child care.

> "*I take care of my son… Yes, he goes to school from 8 in the morning to 12. Then he comes home and we have lunch together. I am not working at the moment. I don't have anyone in my family or any other person I can rely on to care for him for eight hours… I stay with him all day (...) He started going to school at 4. You see, the private kindergartens available were expensive. You were charged as if you earned a big salary.*" (Woman 3, G3, Low)

The salaries earned by low-tier women (of low educational level) are not sufficient, or if they are, they merely cover the cost of private child care. The free public care services available in the country for low-tier families have limitations in terms of both the number of children who can enrol and the number of hours of care offered (in most cases, not more than 20 per week).

Therefore, considering the possibility of going out to work and earn only enough to cover the cost of private care, socio-cultural factors prevail and mothers care for their children themselves.

> *"Why keep working to pay the nanny, buy nappies and have nothing left? Not worth the effort. She used to commute to Montevideo to do these dress fittings. What she was paid, she had to pay my mother-in-law, plus the bus fares, and she hardly had any money left. (...) At the end of the day, working was just as not working, 'cause all she earned went to the granny and the bus fares." (Man 1, G3, Low).*

The fact that families in these tiers are extremely reluctant to rely on institutions and idealize maternal care in the early years of their children, added to the low pay which prompts women to withdraw from the labour market, seriously affects their current and future autonomy.

5.3 Middle Tiers: New Conflicts and Continuities in the Sexual Division of Labour

The middle tiers display the greatest breakaway from previous generations regarding care strategies and the sexual division of labour, as will be discussed below.

5.3.1 Negotiations and Tensions in the Division of Household Chores

Unlike what used to be the case with grandmothers and great grandmothers, care strategy in current generations often include the male members of the family. While their participation does not reach the point of equitable distribution with women, men are more involved than their peers in the high and low tiers, and also than men in previous generations. This is not apparent in the data obtained through Time Use Surveys (TUS), perhaps because they only refer to certain male profiles. Even though

this trend manifests itself in what people express, it is still not possible to detect through quantitative methods such as TUS, most probably due to the small number of cases surveyed.

> *"It's not that I don't care whether he is here or not. Though I always do the housework, you can tell he does participate a lot in the family dynamics because, you see, everything is much easier when both of us are at home." (Woman 2, G 3, Middle)*

Adopting care planning, implementation and management strategies involves tensions, negotiations between husband and wife, and the need to compromise. Men's changing role in care often leads to tensions in couple relations nowadays, and this has to do with women's greater demands (Castello, 2012).

Hochshild (1995) describes current tensions and negotiations in dual-career couples, based on each member's contribution in terms of paid work and care. In the absence of wider changes in the culture of manhood and the workplace, two-job couples often suffer a micro version of the care deficit.

The author suggests that care at home is a stressor in contemporary couples. Men who share household chores wish their wives would be more thankful for their being so unusually cooperative, especially when they get no recognition in this regard outside their homes. Wives who decide to work fewer hours a day in order to be home wish their husbands would appreciate their giving up paid work. On both sides, there are these painful feelings of lack of gratitude. (Hochschild, 1995)

> "*It was not easy; we had arguments, comings and goings, and now we've reached a slightly more harmonious stage. We have our days. There are days when I am more stressed out, and there are days when he just sits there and relaxes a bit too much, but well... We manage somehow. Still, life together is much better now. You know, for instance, now he brings in the*

clothes and folds them. In the past, he would just bring in the clothes and dump them on the bed. Do you think clothes fold and go to the shelves by themselves? Go do the whole task – I would tell him. I don't bring in your clothes and dump them on the bed so that they fold by themselves, do I? I fold them, I put them away. In things like that, we negotiated and eventually reached a compromise. I would say it was like a process, you know. (Woman 1, G 3, Middle)

Women tend to challenge men's traditional role much more than in the past. Their access to paid work generates a scenario where they can discuss who should provide care and to what extent, putting into question the tasks performed by men.

On the other hand, the discourses of grandmothers and great grandmothers evidence their rigid approach to gender roles. The fact that they repeatedly stated "it was just that way", "that's the way things happened" shows they did not put into question that division of tasks when their children were young. However, in light of the changes that have taken place over the past 30 to 40 years, such division in hindsight is not considered fair.

"Did the father ever...? No... no... he belonged to the macho era when the mother used to take care of all of that, ... He was not a bad man or anything, things were simply that way, and in those days I thought it was ok (laugh). If you asked me that question today, I would say that's not right... but in those days it was only normal, I didn't even put it into question, that is, if the kids were ill, I would take them to the doctor; I would take them to the dentist, ... I didn't even stop to think whether it was fair or not. You see, that's the way things worked in the old days..." (Woman 2, G 2, Middle)

Grandmothers and great grandmothers show a tendency to take maternal care as far more natural. Regardless of whether or not women had paid jobs, they tend to clearly prefer maternal care. They refer to a certain "instinct" present in women which distinguishes them from men and places them in a natural position as better

caregivers. This "instinct" allows them to know what's wrong with their children, and thus better understand and fulfil child care needs.

> *"To me, the mother is the mother. It's not the same to leave the kids with someone else you don't know. I think mothers have this natural instinct of understanding children and telling when something is wrong with them." (Woman 3, G1, Middle)*

Being a woman in the great grandmothers' generation was often experienced as inextricably linked to child care. One thing led to the other. The mere fact that they can give birth renders them "naturally" capable of caring for their children and fulfilling their needs, because they are "programmed" to know them better than anyone else. The mother-wife role associated with the management of, and responsibility for, household tasks is also mentioned:

> *"'Cause when our baby was born, I stayed at home with the baby and we arranged it this way: I would care for the baby and my husband would go to work. He never even suggested I should go to work - let alone my father. As a mother, I thought it was my duty to care for my children and manage our home - as I did. I knew I had to care for them, because they were my children. I feel they are safer with their mom. And this was a decision I took as a mother." (Woman 3, G1, Middle)*

While great grandmothers were beginning to identify in their own circles the phenomenon of women's entry in the labour market, to some of them the possibility of going to work was out of the question as there were no care services available, nor could they hire help that would allow them to harmonize family life with work.

As a result, child care was women's main and only duty, and only economic necessity would justify their joining the workforce. This is what had led great grandmothers in the low tiers to go to work, though in unstable, precarious jobs. However, middle-tier

women did not have a valid justification for getting paid jobs. Personal development, economic autonomy or the possibility to take decision on their own were not considered legitimate arguments in those days.

Not being allowed to work by fathers or husbands was usual 60 years ago. As difficult to believe as it may seem today, those were the mechanisms in place to deprive women from their right to work. At present, such rights continue to be challenged, though through other more indirect mechanisms related to the unavailability of institutional services for dependant care.

> *Once I told my dad I wanted to go to work. He almost killed me! "You talk as if you weren't getting enough to eat", he would say. "What's wrong with you? Aren't you getting enough to eat?" My parents wouldn't let me go to work. (Woman 1, G1, Middle)*

Grandmothers break away from great grandmothers in that they have joined the labour market and that child care is not their only duty. This generation can be defined as "transitional", as described by Palomo and Muñoz. Women's integration in the workforce has widened, though their role within the household is not put into question. This is the "dual-presence" generation (Balbo, 1994), since these women are integrated in the labour market, yet at the same time keep fulfilling their duties and devoting time to domestic tasks at home.

Interestingly, while the integration into the labour market is a reality, they are not critic of men when they had young children, but only of the situation in the old times.

> *"In my case, if I didn't feel like cooking, I had to cook anyway, see? (...) To me, how young people manage today is just perfect. Fathers' getting involved, that's just great!"* Woman 1, G2, Middle)

While women's entry into the workforce and their increasingly high educational level are key developments (24% had gone to university in 2015 as compared with 9.4% in 1985), they do not result in a fast change, but rather in a longer-term process. In the case of grandmothers, women in the middle tiers (though not all) had already entered the labour market, leading to the emergence of dual-career families. However, a rigid sexual division of household labour prevailed and their discourse does not put such division into question.

At present, while the actual division of tasks between men and women continues to be uneven, gender roles are being challenged in middle-tier sectors.

5.3.2 "Hyper-planning" of the Care Strategy

A remarkable trend in the current generation is families' careful consideration of the advantages and disadvantages of each possible care option. This most probably stems from the fact that most women are integrated into the labour market and therefore families need to plan a care strategy.

Considerations refer to the best possible quality, the conditions, and a daily monitoring system to supervise and ensure quality care.

Parents' reflections on care strategies are associated with what Beck Gersheim (2000) calls "planned parenthood" and "responsible parenthood". The author states that, while in the past motherhood and fatherhood were experienced as a natural event, nowadays they are a planned decision.

Planning comprises choosing the right moment in life to have a child and assessing such factors as the stability of the couple's relationship, assets, income, career stage,

housing, etc. Nowadays, the ideal regarding parenthood is that procreation comes from a planned decision. The opposite, that is, having children without contraceptive planning, is considered morally wrong.

Within the framework of such new planning of parenthood, parents' responsibilities also change and increase. According to Beck Gersheim (2000), at present parents face new responsibilities which could be summarized in the idea of "maximizing opportunities for their children". Because parents have fewer children than in the past, and therefore a child becomes a scarce resource, they invest in health, education and everything that may help guarantee their training and well-being. The child becomes a goal in itself. All efforts go to correcting their children's imperfections and developing their talents as much as possible.

Over the past few years, several factors have contributed to an understanding of children's place in the social imaginary. Firstly, the scientific discourse from neurosciences has emphasized the important mental processes that take place in the brain during the first years of life (Echebehere, 2011). Secondly, the evolution in the field of children's rights, and therefore the need for policies addressed to them (Ferrari, 2017).

This relates to the changes in the social representations of childhood. As suggested by Carli (2010), in contrast with traditional society, where the child could not be represented and a brief childhood prevailed, modern societies see the emergence of a new space occupied by the child and the family, which generates the idea of a long childhood and the need to provide special skills and education to the child. The social

construct of childhood relates not only to the transformations the family has gone through, but also to the emergence of educational institutions.

According to Carli (2010), who describes Argentina's historical evolution during the 19th and 20th centuries, pedagogical programmes were designed to discipline children and standardize their distinct identities within the framework of public education. Starting from the 1970s, increasing social inequality resulted in a deeper gap between children's different living conditions. Educational institutions began to undergo a process of segmentation in line with the divisions in the social tissue, giving rise to an emerging move in favour of private education. This in turn generates a process of individualisation of childhood associated with greater parental protagonism which tends to weaken the State's responsibility for children's well-being (Carli, 2010).

Along with the growing number of policies addressed to children and the symbolic status given to childhood, families - and particularly mothers - are assigned an increasingly important role in building upon such development.

Parents' new duties are related to what can be modified through human intervention. While this gives them the opportunity to choose, it also generates a burden of responsibility and stress.

> *Our children were planned, wanted and sought. When you take such a life-changing decision, that is, 'I want to have a child', then you have to make sure you can afford to pay all the costs it entails, from nappies to food to education." (Woman 2, G3, Middle)*

Undertaking such responsibilities prompts parents to ponder and carefully consider the best possible care strategy for their children rather than follow custom mandates.

This partly explains why care centres are the privileged option amongst middle-class families.

> *"As an alternative to a nanny, a private nursery would ensure safe standards of hygiene, cleanliness, good habits, ... As compared with having someone come to our home with the concerns this would involve, we thought it would be better for our child to be with 5, 10, 15 peers. Moreover, the adult in an institution would have academic training. It would not be just a nanny who would come over and take care of my child, but a specialized teacher. At that stage, I would enquire about the qualifications of the teachers in charge and the activities they would have. At the school they finally attended, there was a dance teacher, and they also hired a specialist in psycho-motor skills. You cannot get those things with a nanny who takes care of your child at your home." (Woman 2, G3, Middle)*

Regardless of the type of child care centre, what is offered to families appears to be more attractive than what a domestic worker could possibly offer. Centres foster children's development and have duly qualified, trained staff. They are supervised and controlled by public regulatory authorities. All of these are key elements considered by these modern-day parents who reflect upon the best strategy for their children and are attracted by options that allow them to "maximize their children's resources".

The ideas set out by Lareau (2003) help understand the different meanings given to child care in each social class. Based on her research on American society, she states that in the middle class, the cultural logic regarding child rearing focuses on developing children's potential. To that end, parents invest time and energy so that their children can take part in multiple structured activities organized by institutions. Parents believe such activities will equip their children with important skills. They become part of families' daily lives and demand time, especially from women, who are mainly responsible for taking their children to, and picking them up from, piano or music

lessons and/or sport coaching; attending open classes; interacting with teachers and coaches; purchasing and organising the materials required for each activity - to name just a few of their many duties.

Among poor, working-class families, on the other hand, child rearing strategies focus on "accompanying natural growth." (Laureau, 2003) In this upbringing model, parents consider that, by providing love, food and safety, their children will grow and thrive. They do not focus on fostering special talents in them individually. These children have more free time, and also deeper and richer bonds of affection within the extended family than those in the middle class.

In contrast with the low, working classes, middle classes understand parents are responsible for eliciting opinions and fostering their children's talents and skills. As a result, their care strategy choice is based on how to best fulfil such goals.

However, in the grandmothers' generation, choosing the care strategy does not entail as much reflection or stress. On the contrary, they describe having been able to enrol their children in a good educational centre near the home or the mother's workplace as a great achievement. In the grandmothers' generation, rather than a series of factors to be considered, the proximity to the home is essential, because it facilitates the process of taking and picking up the children. The strategy choice was primarily based on practical considerations.

> *"I managed to find a nursery (…) from twelve to five. I took all my children to that nursery for about five hours a day, because I always started work at noon, and so, as they grew up, they would go to that nursery (...) It was near home. I would take them to the nursery on foot if the weather was good, or otherwise by bus, and my husband would pick them up and only had to walk three streets to get home (Woman 7, G2, Middle)*

In the great grandmothers' generation, care outside the family does not appear to be an option. They do not reflect upon "the best option", but follow the custom mandate. Practically all the women interviewed did not have a paid job and devoted entirely to caring for their children. Nor were there care services available for toddlers and young children.

6. Conclusions

This article unveils changes and continuities in child care strategies across generations, evidencing progress and setbacks in the evolution of gender systems.

The new care policies, the multiple work spaces currently occupied by women and the new cohabitation arrangements represent significant changes in the Uruguayan society over the past 5 to 6 decades, generating a favourable scenario for more equitable gender relations.

However, the findings show a replication of the traditional gender system, which has been capable of reinventing itself. Despite women's educational and career achievements, growing maternalism among high-tier university graduates evidences new and innovative mechanisms for reproducing the ideology of intensive mothering and a gender system that perpetuates its natural association with quality care.

This context further challenges gender relations, especially in the middle-class sectors which represent the greatest breakaway from the past. Firstly, when it comes to taking a decision with regard to care strategies, many families openly ponder and discuss possible options rather follow custom mandates. Secondly, women in the middle-class sectors who are integrated in the labour market are beginning to challenge men's role

in care. Thirdly, men are more involved than in the past and are starting to actively participate in such care strategy. Though within a certain context and for certain social profiles, the above three phenomena evidence progress on the road to more equitable gender relations.

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