

**Women's Unpaid Care Work Programme: National Policy Scoping
Study**

A Final Report Submitted to

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Henry Manyire
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Section One: Introduction

1.1 Introduction

Unpaid care work refers to work that involves human contact and is not remunerated. It is work carried out in households and communities and includes taking care of the vulnerable particularly children, the ill and the elderly. It further includes preparing food, collecting firewood and water, maintaining household cleanliness and hygiene. Socialisation of children is also part of the unpaid care work. Unpaid care work is propagated, legitimized and justified by gendered social and cultural norms, beliefs and values associated with gender identity including the roles of boys and girls and men and women in society and subsequently, attitudes towards paid/unpaid work and working within and outside the home.

Gender is defined as the social construction of the masculine and feminine identities. Gender identity refers to the internalisation of the norms and beliefs associated with masculinity and femininity and the resultant formation of gender "appropriate" attitudes which later influence social and economic behaviour. For example, femininity in many a Ugandan society is culturally associated with reproductive achievements (marriage, child bearing and rearing, and household management). Most reproductive achievements are attained within the private sphere of the household and are considered as females' responsibilities and are not remunerated. Alternately, masculinity is associated with productive achievements, which in rural areas include skills in cultivation, animal rearing and trading. Increasingly, cultivation and animal rearing are losing appeal to males, majority of whom opt for the public sphere to earn income. However, even when males are not outside the private sphere, their participation in the unpaid care work is very minimal, restricted to the disciplining children during the socialization process. Thus, unpaid care work is overwhelmingly women and girls' obligation.

Unpaid care work has lot of opportunity costs. It competes with agricultural labour for ploughing, planting, weeding, harvesting and processing and time for participation in off farm income generation especially trading, marketing agricultural produce and sometimes selling labour. Unpaid care work perpetuates women's time poverty due to their inordinate labour overloads. For girls of school going age, unpaid care work competes with time for going to school and attending regularly. This is because girls are better substitutes for their mothers than boys are for their fathers. Hence, because of unpaid care work responsibilities within households, girls' education has more opportunity costs than boys'. Opportunity costs of girls' education arising from unpaid care work within households are higher in homes of lower socio-economic status, where one or both parents are deceased or physically weak and amongst older compared to younger children. Thus, women and girls living in poverty often have to forego their basic human rights to an education, healthcare, decent work and leisure time in order to fulfill their unpaid care work responsibilities. This perpetuates gender inequality, reinforces inequitable gender norms and keeps women and girls in poverty.

Unfortunately, the gender determined women's obligations in unpaid care work are so institutionalized and regarded as a given or 'natural' that the existing development model places little value on unpaid care work. The monetary value of unpaid care work is not included in

national income statistics while there are little efforts at governmental level to alleviate the time poverty females face on account of the unpaid care work. For example, mainstream economic policies intensify women's work by cutting back public services, such as healthcare centres, that provide care, particularly in countries heavily affected by the HIV/AIDS pandemic where the demand for care services drastically increases; or by implementing lax labour standards that result in women working longer hours while still earning low wages. This increases women's workloads as they are still expected to provide the care within the household as well as working outside the home.

ActionAid is seeking to challenge the existing development model that places little value on care work. It is seeking to propose an alternative model that recognizes and supports men, women, business, civil society organisations and the state to provide care in a way that does not unduly burden particular actors. ActionAid intends to implement a women's unpaid care work program aiming at making women's unpaid care work visible so that it is valued by women, their communities and governments. ActionAid hopes that this pilot program will provide the evidence base needed to define its programming, research and advocacy on unpaid care work, and to define concretely the change it wants to see over the next 5 years and how it will achieve it. The program will not only target a more equitable division of labour between women and men within households, but also a more equal sharing of these responsibilities with government as the primary duty-bearer. ActionAid will be calling on states to provide basic services such as primary healthcare centres, early childhood education (ECD) centers and social protection transfers.

It is in this regard that ActionAid sought to undertake a policy scoping study to identify the number of national policies that can help reduce women's unpaid care work. This will inform ActionAid's advocacy strategy both locally and nationally and complement the community organizing that is taking place in Pallisa District and Bwaise in Kampala City. This report presents the findings of the policy scoping study.

1.2 Terms of Reference for the Assignment

1. To provide a detailed inception write up on how the policy information will be collected detailing the methodology and financial implication of the task.
2. Develop data collection instruments that will be shared with AAU before administering.
3. Collect data from review of existing policies, laws and regulations from the various ministries/sectors/international bodies (UN, USAID, DFID, embassies and CSOs)
4. Analyze the data into usable information that will guide the design of indicators of the project and project anticipated impact areas.
5. Produce a policy scoping report that will be validated by the stakeholders interviewed and AAU staff before dissemination to wider stakeholders

1.3 Overall Research Question

The main question asked in this policy scoping study is: What policy interventions are needed to **R**ecognise, **R**educe and **R**edistribute unpaid care work?

1.4 Specific Objectives

1. To establish whether programs, policies or interventions exist on:
 - a. Early childhood education
 - b. Primary community healthcare including HIV, family planning, etc
 - c. Cash transfer schemes to poor families and vulnerable groups
 - d. Energy, water and sanitation infrastructure in rural and urban areas
 - e. Any other policies that may have an impact on unpaid care work
2. Where these policies exist, to what extent are they implemented throughout the country?
 - a. Are there areas where these policies are less implemented than others?
 - b. Policies implemented in a specific type of geographical area - i.e. urban or rural areas?
3. To provide a short description of each policy describing the following:
 - a. Which level of government (e.g. district or ministry) is responsible for making the policy, for funding the policy, and for implementing the policy?
 - b. What is the rationale behind the policy or program?
 - c. Who is this policy or program primarily intended for?
 - d. What impact, positive or negative, can it have on women's unpaid care work?
4. Which civil society organisations at the national level can Action Aid work with on unpaid care work related to the different policy areas discussed?

1.5 Approach to the Specific Objectives (SO)

1.5.1 Specific Objectives

SO 1: To establish whether programs, policies or interventions exist on:

- a. Early childhood education (ECE)
 - b. Primary community healthcare provision including HIV/AIDS, family planning, etc
 - c. Cash transfer schemes to poor families and vulnerable groups
 - d. Energy, water and sanitation infrastructure in rural and urban areas
 - e. Any other policies that may have an impact on unpaid care work
1. This required identifying existing programs, policies and/or interventions for each of the above mentioned 5 areas at the following levels:
 - (i) Government Ministries, e.g. the Ministry of Education and Sports, the Ministry of Health and the Ministry of Gender, Labour and Social Development, Ministry of

Lands, Water and Environment.

- (ii) NGOs/CSOs
- (iii) Community Based Organisations
- (iv) The private sector

SO 2: Geographical Coverage of Implementation of the Policies

This required:

1. Determining the geographical coverage of the policies (whether national, regional, district and/or community levels).
2. Ascertaining the geographical areas where these policies are more or less implemented.
3. Determining the localities (urban or rural) where the policies are implemented.

SO 3: To provide a short description of each policy describing the following:

- a. Which level of government (e.g. district or ministry) is responsible for making the policy, for funding the policy, and for implementing the policy?
- b. What is the rationale behind the policy or program?
- c. Who is this policy or program primarily intended for?
- d. What impact, positive or negative, can it have on women's unpaid care work?
- e. Which civil society organisations at the national level can Action Aid work with on unpaid care work related to the different policy areas discussed?

This necessitated:

1. Identifying particular Ministries, Departments and Agencies responsible for particular ECD policies, their funding and implementation, e.g., the Ministry of Education and Sports, the Ministry of Health, the Ministry of Labour Gender and Social Development, Ministry of Lands, Water and Environment, District and Sub County Sectoral Offices etc
2. Determining each policy's or program's vision, philosophy, focus (objectives), approaches (implementation strategies), management and regulation with respect to facilitating arrangements for care, health, nurturing, education and protection of rights of the vulnerable particularly children, the elderly, orphans, the ill and persons with disabilities.
3. Identifying the intended primary beneficiaries of specific policies and/or programs e.g. children, the elderly, orphans, the ill and persons with disabilities.
4. Determining positive or negative impacts that each policy/programme can have on reducing the work overloads arising from women's unpaid care work.

The positive or negative impacts that each policy/programme can have on reducing the work overloads arising from women's unpaid care work were estimated using a modification of the

product change analytic technique that estimates costs of goods or services that do not have conventional market prices but are used as inputs in the production of marketed goods. The technique uses impacts of change in availability of a good or service on product revenues as a measure of the value of the change. The product change analytic technique was originally developed by Ellis and Fisher (1987) to measure the economic costs of the environmental change. For instance, measuring impacts of environmental change (e.g. pollution of a lake) by measuring the impacts of the change on product revenues (e.g. amounts of fish catches) as the measure of the value of the change.

The product change analytic technique is applicable to estimation of the costs of opportunities foregone when women and girls undertake unpaid care work because care work has both direct user values (reduced material outcomes) and indirect user values (reduced social outcomes). Women's and girls' labour in agriculture and income generation has direct user values while the labour provided in caretaker roles has indirect user values. Similarly, volunteer time provided by girls and women during community work has direct user values (time foregone for formal employment activities, agricultural production and income generation) and indirect user values (time foregone for leisure). Direct user values embedded in opportunity costs and volunteer time were estimated using the market prices of changes in output (agricultural produce, income etc) they cause.

SO 4: Civil Society Organisations at the national level that Action Aid work can with on unpaid care work related to the different policy areas

This required:

1. Generating a broad list of Civil Society Organisations working in areas of alleviating the work overloads of women's unpaid care work
2. Documenting each CSO's areas of intervention e.g. nutrition, ECE, water and sanitation, vulnerable children and orphans, HIV/AIDS, the elderly etc
3. Identifying the challenges and successes each CSO's is facing in implementing its programmes and projects.
4. Identifying indicators for challenges and successes for each CSO
5. Recommending areas of partnerships between ActionAid and the different CSOs.

1.6 Methodology

1.6.1 Study Design

The ToR dictated use of qualitative research designs in collection and analysis of secondary (desk review) and primary (key informant) data. A longitudinal design was also used in addressing SO 3 (4). The longitudinal design was not used in the strict sense of tracing same respondents over a period of time. But rather in the loose retrospective approach that allowed for generating information on positive or negative impacts that each policy/programme can have on

reducing the work overloads arising from women's unpaid care work.

1.6.2 Study Areas

The desk review was conducted in Kampala where pertinent documents were obtained from the National Council for Children (NCC), Ministry of Health (MoH), Ministry of Education and Sports (MoES), Ministry of Labour, Gender and Social Development (MoLGS), Ministry of Lands, Water and Environment, Ministry of Energy and Minerals (MoEM), UNICEF, KCCA and its Divisions and leading NGOs in interventions aimed at reducing the work overloads arising from women's unpaid care work. Data was also collected from Bwaise in Kampala City and Pallisa district where AAIU is already operating.

1.6.3 Sample Size

Key informants were purposively selected due to the knowledge they had regarding the study topic by virtue of the respective offices they held. The Lists of key informants is indicated in appendices I and II.

20 Males were selected from each of the study sites in Bwaise and Pallisa. Half of the males were members of the AAIU project while half were non members. 50 women were also selected from each of the study sites of Bwaise and Pallisa. Again, half the participants were members of the AAIU project while half were non members.

1.6.4 Selection of Respondents

During the desk review, a few key informants were purposely selected from government Ministries and departments at Central and Local government levels and from amongst NGOs to help clarify information obtained from their respective documents. Members of the AAIU project were randomly selected from lists of project members that were obtained from the project managers. Non members were randomly selected from lists of households held by LC chairpersons within areas where the projects were being implemented.

1.6.5 Methods of Data Collection

Data for the desk review were collected from the requisite documentation in various governmental and non-governmental offices. Managers of respective interventions were interviewed by use of key informant interview guides. Male and female members and non members of the AAIU project were interviewed by use of questionnaires that were filled in by Research Assistants.

Secondary Data Sources

1. National Council of Children (NCC)
2. Ministry of Health (MoH)
3. Ministry of Education and Sports (MoES)
4. Ministry of Labour, Gender and Social Development (MoGLSD)
5. Ministry of Lands, Water and Environment (MoLWE)
6. Ministry of Energy and Minerals (MoEM)
7. UNICEF
8. KCCA and its Divisions

9. Action for Children
10. Save the Children in Uganda
11. Katutandike Foundation (St. Balikuddembe Market)
12. KCCA Health Facilities
13. Day Care Centres (how much it costs per child)
14. Child Rights Network
15. Uganda Bureau of Statistics
16. Others provided by AAiU

National Policies Reviewed

The policies that were reviewed included:

1. The Uganda Gender Policy (Republic of Uganda 2007a);
2. The National Integrated Early Childhood Development Policy Framework (Republic of Uganda 2013a);
3. The Draft National Action Plan for the Integrated Early Childhood Development Policy Framework (Republic of Uganda 2013b);
4. The Early Childhood Policy (Republic of Uganda 2007b);
5. The National Water Policy (Republic of Uganda 1999)
6. The Energy Policy for Uganda (Republic of Uganda 2002);
7. The National Orphans and Other Vulnerable Children Policy (Republic of Uganda 2004);
8. The National Policy on Disability in Uganda (Republic of Uganda 2006a);
9. The National Policy Guidelines for TB/HIV Collaborative Activities in Uganda (Republic of Uganda 2006b);
10. The National Health Policy: Reducing Poverty Through Promoting People's Health (Republic of Uganda 2009a);
11. The National Policy for Older Persons: Ageing With Security and Dignity (Republic of Uganda 2009b);
12. Guidelines for Management of ECD Centers (Republic of Uganda (2010a);
13. National Development Plan (2010/11-2014/15) (Republic of Uganda 2010b);
14. Health Sector Strategic Plan III 2010/11-2014/15 (Republic of Uganda 2010c);
15. National Home Based Care Policy Guidelines for HIV/AIDS (Republic of Uganda 2010d);
16. Agriculture for Food and Income Security: Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15 (Republic of Uganda 2010e);
17. The Uganda National Malaria Control Policy (Republic of Uganda 2011a);
18. The Uganda National HIV and AIDS Policy (Republic of Uganda 2011b);
19. The National Employment Policy for Uganda (Republic of Uganda 2011c);
20. The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (Republic of Uganda 2012);
21. Nutritional Care and Support for People Living with HIV/AIDS in Uganda: Guidelines for Service Providers (Republic of Uganda, undated);
22. The National HIV and AIDS Strategic Plan 2007/8 – 2011/12, Uganda AIDS Commission (Republic of Uganda 2007c); and,
23. Home Based-Care for People Living With HIV/AIDS: National Home-Based Care

Programme and Service Guidelines (Republic of Kenya 2002). Also reviewed were cash transfer programmes.

1.7 Data Analysis

Qualitative secondary and primary data were analysed by content analysis along the major themes expressed in the SOs. These were: nature of existing programs, policies or interventions; geographic coverage of the programs, policies or interventions; policy frameworks with regard to their focus and status of implementation; and, civil society organisations at the national level that Action Aid can work with on unpaid care work related to the different policy areas.

Broad categories were developed to differentiate and describe information obtained from programme/project documents and ideas expressed by key informants and women respondents. These broad categories were further broken down to indicate the nature of existing programs, policies or interventions, geographic coverage of the programs, policies or interventions, policy frameworks with regard to their focus and status of implementation and civil society organisations at the national level that Action Aid can work with on unpaid care work related to the different policy areas.

Quantitative data were analysed with the help of the statistical package for social scientists software (SPSS.PC). Raw frequencies were initially generated and served as a basis for generation of cross-tabulations including multiple correlations.

Section Two: Existent Programs, Policies or Interventions for Addressing Unpaid Care Work

2.0 Introduction

According to the National Employment Policy for Uganda, women in Uganda constitute the majority of unpaid workers as they are responsible for most of the care economy (Republic of Uganda (2011c). Uganda, however, lacks national policies specifically designed for reducing the burdens of women's unpaid care work. Nonetheless, there are a number of policies which although not designed to specifically reduce the burden of women's unpaid care work, their implementation inadvertently reduces the burdens. The national policies are spread across different sectors including the MoGLSD, NCC, MoH, MoES, MoLGS, MoLWE and MoEM.

2.1 The Uganda Gender Policy

As earlier mentioned in the introductory part of this report, unpaid care work is propagated, legitimized and justified by gendered social and cultural norms, beliefs and values associated with femininity and masculinity. These include the roles of boys and girls and men and women in society and subsequently, attitudes towards paid/unpaid work and working within and outside the home. The gendered social and cultural norms, beliefs and values create unequal gender relations in societies where males are accorded higher social status while females are accorded lower social status. The Uganda Gender Policy (UGP) is an affirmation of the Government of the Republic of Uganda's unequivocal commitment to take actions that will bring about more equal gender relations. The policy seeks to ensure that all Government policies and programmes, in all areas and at all levels, are consistent with the long-term goal of eliminating gender inequalities (Republic of Uganda 2007a).

The policy gives a clear mandate to the Ministry of Gender, Labour and Social Development and other Line Ministries to mainstream gender in all sectors. It sets priority areas of action at the National, Sectoral, District and Community levels. The ultimate objective of the policy is to evolve a society that is both informed and conscious of gender and development issues and concerns (ibid).

A situation analysis informing the UGP notes that women continue to suffer very high time burdens in pursuing their livelihood strategies. Citing the World Bank's 2005 publication entitled **Uganda Strategic Country Gender Assessment**, the UGP reveals that women work considerably longer hours than men (between 12 and 18 hours a day, with a mean of 15 hours), compared with an average male working day of 8 to 10 hours. Women also bear the brunt of domestic tasks, in addition to agricultural and other productive work. The time and effort required for these tasks, in almost total absence of even rudimentary domestic technology, is staggering. Women for example are faced with difficulties of combining employment with care-giving, particularly to children and the sick. In addition, a large part of women's contribution at household level tends to be non-monetary care work, hence does not directly go into what is generally understood as material, which is more socio-economically valued. This has a negative effect on food security, household income, children's schooling, participation in community life, health, and overall productivity (ibid).

2.1.1 Goal, Objectives and Guiding Principles of the UGP

The goal of the UGP is therefore to achieve gender equality and women's empowerment as an integral part of Uganda's socio-economic development. The purpose of the policy is to establish a clear framework for identification, implementation and coordination of interventions designed to achieve gender equality and women's empowerment in Uganda. The policy is a guide to all stakeholders in planning, resource allocation, implementation, monitoring and evaluation of programmes with a gender perspective.

Amongst the objectives of the UGP are:

1. To reduce gender inequalities so that all women and men, girls and boys, are able to move out of poverty and to achieve improved and sustainable livelihoods;
2. To address gender inequalities and ensure inclusion of gender analysis in macro-economic policy formulation, implementation, monitoring and evaluation (ibid).

These objectives have implications for addressing the burdens of women's unpaid care work if care work is construed in terms of existent gender inequalities and its value is computed and recorded in macro-economic analysis and documentation, respectively.

2.1.2 Policy Priority Action Areas

The UGP's priority interventions and action areas are arranged into four thematic areas; livelihoods, rights, governance and macro-economic management. The interventions and proposed strategies are derived from the situation analysis section of the policy document. Responsibility for undertaking these interventions lies with central government ministries, departments and agencies, local governments, civil society organisations and the private sector.

2.1.3 Gender and Livelihoods Priority Action Area

The livelihoods' thematic area has implications for addressing the burden of women's unpaid care work. The UGP defines livelihoods as the means of earning a living which include sources of revenue, employment, occupation or trade. Gender has a strong influence on improved livelihoods. A major challenge to improved livelihoods is the prevalence of poverty, which is manifested in inadequate access, control and ownership of assets, resources, incomes, and power. The manifestations impact differently on men and women given the gender relations and division of labour in a given society

Three priority livelihood constraints identified for redress under this policy are gender differences in livelihoods, time poverty and inequalities in access to and control over productive resources. These are compounded by lack of time and labour saving technologies which hinder productivity as well as livelihood choices of men and women. Women's contribution, particularly care provision, is not sufficiently captured in the system of national accounts too. Government is committed to address these concerns by reducing gender inequalities so that all women and men, girls and boys, are able to move out of poverty and to achieve improved and sustainable livelihoods (ibid). Amongst the specific strategies for reducing gender inequalities are developing and promoting labour and time saving technologies for poor women and men; and, developing strategies to eradicate the child labour incidence, particularly the exploitation of

the girl child (ibid). These strategies have bearing on reducing the burden of unpaid care work undertaken by women and girls.

2.1.4 Institutional Framework for Implementing the Uganda Gender Policy

Implementation of the Uganda Gender Policy is multi sectoral. It is premised that the pursuit of gender equality and women's empowerment is a responsibility for all sectors in the development arena. All actors in the public and private sectors have a role to play in the implementation of this policy. Institutions are expected to identify entry points and opportunities for networking and collaboration to ensure synergy and maximum impact in addressing gender inequality. The cross cutting nature of gender implies that the different actors/sectors have the responsibility to finance the gender mainstreaming interventions pertinent to their respective sector (ibid).

On a more specific note, Ministry of Finance, Planning and Economic Development is tasked with the responsibility of monetizing the contribution of the care/domestic economy of women's and men's contribution in the national accounts (ibid). This could help in advocacy for recognizing the significance of unpaid care work, women's and girls' contribution there-in, the constraints unpaid care work imposes on women and girls' productivity, education, skills acquisition and income generation. It would further help in providing a rationale for developing, disseminating and adopting technologies aimed at reducing the burden of women's unpaid care work and redistributing care responsibilities within households and communities amongst both genders.

2.1.5 The National Integrated Early Childhood Development Policy Framework

The National Integrated Early Childhood Development Policy Framework defines early childhood development (ECD) as the period of a child's life from 0 to 8 years (Republic of Uganda 2013a). Further, that it is the process through which children grow and thrive physically, mentally, socially, emotionally and morally. ECD is therefore a range of policies, programs and services that address children's basic needs; health care, nutrition, emotional, psycho-social stimulation, sanitation and hygiene, protection, cognitive development, among others (ibid). Early childhood development is very much linked to caring work. For children aged 0 to 8 to grow and thrive physically, mentally, socially, emotionally and morally, they require attention of caretakers who most often than not are women and girls. Taking care of this age group is socio-culturally a responsibility of women and girls, which within households and community settings is not remunerated. Thus, ECD care giving is part and parcel of women's unpaid care work.

The National Integrated Early Childhood Development Policy Framework points out that there are very few children benefiting from institutionalized ECD centres such as Early Childhood Development Centres, kindergartens, nursery schools and day care centres (ibid). In 2008, ECD enrollment stood at 89,296 children yet the number of children aged 3-5 years was approximately 3.5 million in the same year. Many Children in the ECD age range remained excluded but received care within their respective homes (ibid). These children undoubtedly constituted additional burdens of unpaid care work to women.

The National Integrated Early Childhood Development Policy Framework focuses on the following within specific sectors:

Education Sector

- Universalisation of pre-primary education through establishing ECD Centres in all Primary Schools
- Inspection of all ECD Centres
- Creation of a separate budget line on ECD
- Enforcement of the MoES Education Sector ECD Policy provisions
- Support the initial training of ECD teachers to address issues of quality of ECD teachers

Health Sector

- Adequate funding for Immunization, observance of child days throughout the country and issuance of Child Health cards to all immunized Children.
- Awareness creation about antenatal care and safe motherhood and child delivery.
- Awareness creation and access to PMTCT Services and Programmes
- Awareness creation on full term breastfeeding.
- Provision of appropriate facilities for child survival including lighting and safe water
- Ensure availability of drugs and treatment for children aged 0 -8 who are HIV positive
- Reduction in maternal mortality, under 5 mortality and infant mortality levels

Social Development Sector

- Awareness creation about ECD
- Birth and Death Registration of all children at the national and local levels in collaboration with relevant officers
- Ensure compliance with set standards and guidelines by service providers
- Enforcement of laws and policies with ECD provisions
- Integration of ECD issues into existing policies
- Work with all sectors to ensure that review and updating of their policies and strategic programs adopt recommendation of this policy framework

Water and Environment Sector

- Ensure provision of safe water and sanitation to communities, daycare centers, maternity centers and other health facilities.
- Promote positive sanitation and hygiene practices including hand washing amongst others.

Agriculture Sector

- Ensure food security and proper nutrition
- Ensure that households are empowered to provide food for pregnant mothers and young children.
- Ensure proper food handling and management competencies.

2.1.6 Policy Target Groups

The National Integrated Early Childhood Development Policy Framework targets a number of stakeholders both primary and secondary:

Primary Targets;

These include all children including orphans and vulnerable children (OVC) and children with disabilities (CWDs) from conception to age eight. Within this age range, there are four major categories: conception to birth, birth to 3, 3 to 5, and 6 to 8. Although these children all have the same holistic needs, which consist of nutrition, love, care, health, nurturing, protection, early stimulation and training, the emphasis and focus of providing for these needs varies depending on the age category. In addition, special attention must be focused on the needs and rights of OVC and CWDs.

Under primary targets, the policy also targets parents, teachers and other caregivers who provide care for children including grandparents, relatives and others within home settings.

Secondary Targets

These are service providers who include government ministries, bodies and other government arms, churches, CSOs, communities etc.

2.1.7 Implementation of the IECD Policy Framework

Amongst the guiding principles of the policy is one that stresses family as the first line of response in ECD service delivery. The policy therefore recognizes parents and families as the primary caregivers and health providers. Hence, parents and families need to be supported and empowered to ensure that they effectively play their roles.

The policy framework provides a co-ordination mechanism and explicitly defines the role of key stakeholders in the provision of ECD services. It however recognizes the fact that the needs of children are integrated in nature, are cross cutting and that it is not possible for any one sector working alone to meet all of these complex requirements. For example, a malnourished child has delayed development, thus requires both nutritional and education interventions. A child surrounded with poor sanitation and unsafe water is prey to illnesses that cause developmental delays and ill health. A child under political unrest is traumatized, cannot enjoy the right to education, health and his/her right to life is at a risk. It is therefore essential that all sectors of government and society work together to support the holistic development of young children, while supporting their parents and legal guardians in their role of primary caregivers. A strong public-private sector and civil society partnership is an essential factor to achieve this vital objective (ibid).

2.1.8 Institutional Implementation Arrangements

The IECD policy framework highlights the need to place ECD in the broader context of national plans and policies including the National Development Plan. It is cognizant of the fact that ECD cuts across all government sectors and sections to the smallest unit of society. Therefore, its implementation calls for a multi-sectoral approach that in turn calls for the active involvement of all stakeholders at different levels of society, individually and collectively from the national to the lowest local government.

2.1.9 National Level Inter-Sectoral ECD Technical Steering Committee

According to the IECD policy framework, the Ministry of Gender, Labour and Social Development is the lead agency in its implementation. The Ministry's key role is to put in place a robust inter-Sectoral ECD Technical Steering Committee whose major responsibility is to provide overall ECD technical guidance and oversee the implementation of the IECD Policy Framework from the central to the lower local governments, advocate and lobby for inclusion and appropriate planning and budgeting of ECD interventions in sector plans and budgets at all levels (ibid).

The ECD Secretariat

To operationalise and support the Inter-Sectoral ECD Technical Steering Committee, an ECD Secretariat is to be established within the Department of Youth and Children, Ministry of Gender, Labour and Social Development. The MoGLSD will designate two Officers from the Department, supported by the Commissioner for Children Affairs, for the secretariat. The major role of the ECD Secretariat will be to support the Inter-Sectoral ECD Technical Steering Committee through preparation of National Level multi-sectoral quarterly and annual, strategic ECD plans for integration into sectoral and lower local government plans. All sectors, government bodies, CSOs, FBOs, children, parents, family etc are stakeholders in implementation of the framework. However, given that ECD is evolving, dynamic and multi-faceted, the stakeholders listed may not be exhaustive.

Local Governments

District Level

Existing local government structures and systems at district, municipal, county and sub-county/division, parish and village levels, families, parents and individual children will participate in implementing the framework. All local government structures shall work in collaboration with relevant ministries, government bodies and CSOs at the national level (ibid).

Sub-County Level

At Sub-Country level, the Sub County Chief will be responsible for ECD issues and will work with the Assistant Community Development Officer (ACDO), the Sub County Water and Sanitation Coordination Committee (SWSCC), the Sub County OVC Coordination Committee (SOVCC), NGOs at that level amongst other stakeholders. The Sub-County chief will present their reports to the CAO (ibid).

Parish Level

The Parish Chief will be responsible for ECD and will work with Local Council Chairpersons to implement the IECD Policy (ibid).

Village Level

The head of the Village Health Team (VHT) is mandated to advocate for ECD services in collaboration with CBOs in those villages. These will link up with the families, parents and children. The VHTs will report to the Parish Chief (ibid).

2.2 The Draft National Action Plan for the Integrated Early Childhood Development Policy Framework

A Draft Action Plan has been developed to guide the implementation of the IECDP framework and together with the policy framework, it will be disseminated to the lowest level of implementation (Republic of Uganda 2013b). The major goal of the Action Plan is to provide direction and guidance to all ECD stakeholders (primary, secondary and otherwise) in the implementation of ECD Programmes and to harmonize all existing ECD Policies for holistic development of all children aged 0 to 8 years (ibid).

The Action Plan recognizes all the existing ECD related policies and applauds the role they continue to play in the wellbeing of all children aged 0-8. However, children need integrated services for holistic and/or balanced growth and development because of the multiple and inter-dependent nature of the needs of a child. Therefore, in order to focus on balanced needs of children, there was need for an overarching integrated comprehensive Action Plan which would among others;

- (i) amalgamate and harmonize all ECD sector-based policy statements and programs to ensure better coordination and harmonized ECD service delivery to all children aged 0-8 years, including OVC and CWDs.
- (ii) establish clear coordination and implementation guidelines of ECD services from the national to local governments which will lead to improved access to quality and relevant ECD services to all children across the country including OVC and CWDs.
- (iii) form the springboard from which other ECD sector policies may be strengthened, developed and reviewed (ibid).

2.2.1 Sectoral ECD Responsibilities

ECD in the Health Sector

A healthy environment and status determines not only a child's survival but also its escaping of lifelong impairments. Poor health amongst children is responsible for loss of cognitive and proper physical development, poor performance in school and diminished income earning opportunities and increased vulnerability later in adult life. Governance and coordination of health services delivery in Uganda is fundamentally the responsibility of Ministry of Health. Immunization is the first health intervention as it protects children from contracting immunisable

diseases. The eight vaccine-preventable diseases include tuberculosis, diphtheria, whooping cough, tetanus, hepatitis B, haemophilus influenzae, polio and measles (ibid). Providing treatment to children when sick is another health ECD related intervention which reduces women's burden of unpaid nursing care work.

ECD in Social Development Sector

There are a number of ECD issues under the Social Development Sector that need attention by various stakeholders including the MoGLSD, MoJCA, Uganda Police's Child and Family Protection Unit, Prisons Service, CSOs etc;

Orphans and Other Vulnerable Children

Approximately 2.43 million children have been orphaned and 8 million are either critically or moderately vulnerable (ibid). A quarter of households in Uganda have at least one orphan in an average family size of 6 members. According to the OVC Situation Analysis Report, only 11% of 8.1 million OVC in dire need were reached with external support services, implying that it is women and girls within households who bear the biggest burden of caring for the OVCs.

Children with Disabilities and Other Special Needs Children

The Draft National Action Plan for the Integrated Early Childhood Development Policy Framework notes that there are about 1.22 million CWDs across the country with challenges in seeing, hearing, communicating, mobility or moving, touching, learning, emotional, physical, among others. Of the 1.22 million CWDs, only 5% are able to access education within inclusive setting in the regular schools while about only 10% access education through special schools and annexes (USDC Report 2011). Most CWDs have no access to preventive measures or basic care. In Uganda, only about 10% of CWDs who require rehabilitative health services actually access them (ibid). Again, this places considerable burden of care on women and girls.

ECD in the Water Sector

The Draft National Action Plan for the Integrated Early Childhood Development Policy Framework points out that clean and safe water is vital to the survival and development of a child without which deficiencies in development set in. Without reliable water supplies and basic sanitation, children are constantly exposed to infections and diseases that threaten their lives and prevent absorption of many essential nutrients. Children of all ages are harmed by poor quality water and sanitation; these effects are also compounded by poor standards of hygiene notably, the lack of hand washing with soap (ibid). Again, the effects of poor quality water and sanitation rub onto women in form of added burdens of unpaid health care work.

ECD in the Works and Transport Sector

The Ministry of Water and Transport is mandated to develop roads and improve transport in the country. However, transport services have been left to the private sector. The Ministry concentrates on developing the infrastructure in form of roads, airports and ferry landing sites. The roads section has two categories of work; mechanical which uses machines and manual especially on small roads. It is policy that at least 30% of the workforce especially on roads must be females aged 18 and above. This age group is sexually active and many of them are pregnant or may become pregnant while at work, others may be having babies at the time of work.

Although, the Ministry currently has no proper guidelines, in developed countries, shades, play and day care centres are normally set up within camps where women workers are allowed to come in with a baby sitter. The contractors are also supposed to install safe drinking water utilities and ensure proper hygiene and sanitation in the camps. This reduces the child care burden for women workers. However, there is a dire need for ECD guidelines under the MoWT to guide the proper handling of ECD issues (ibid).

ECD in the Agriculture Sector

There is no available information about ECD requirements in the Agriculture Sector, but it is clear that malnutrition and food security, critical elements of ECD are directly linked to this sector (ibid). Since malnutrition and food security are traditionally women's responsibilities whose lack further leads to poor health of children, the burden imposed adds the burden of women's unpaid care work. There is therefore need to address ECD needs within the agricultural sector as not only a way of enhancing ECD but also reducing the burdens of women's unpaid care work that emanate there from.

2.2.2 Policy Target Groups of the Draft National Action Plan for the Integrated Early Childhood Development Policy Framework

The Draft Action Plan targets a number of stakeholders both primary and secondary.

Primary Targets

These include all children including OVCs and CWDs from conception to age eight. Within this age range, there are four major categories: conception to birth, birth to 2, 3 to 5, and 6 to 8 years. Although children in all these ECD age categories have the same holistic needs, consisting of nutrition, love, care, health, nurture, protection, early stimulation and training, emphasis and focus of providing for these needs varies depending on the age category. In addition, special attention must be focused on the needs and rights of OVC and CWDs.

Under this category, the Action Plan also targets parents, teachers and other caregivers who provide care for children including grandparents, relatives and others in a home setting.

Secondary Targets

These are largely service providers who include government ministries, bodies and other government arms, churches, CSOs, communities etc.

2.3 The Early Childhood Development (ECD) Policy for the Education Sector (MoES)

The ECD policy for the Education Sector defines ECD as a process through which young children aged between 0-8 years grow and thrive physically, mentally, socially, emotionally and morally (Republic of Uganda 2007b; 2). The purpose of the ECD policy is to provide guidance for optimal holistic development of healthy and productive children aged between 0-8 years in Uganda as well as enhance partnerships that promote holistic approaches to early childhood development and effective learning/teaching processes appropriate to that age group. The policy objective is intended to be achieved through supporting, guiding, coordinating, regulating and promoting quality and relevant ECD services for children aged 0-8 years (Republic of Uganda 2007b; 6).

2.3.1 Policy Target Groups

The ECD policy primarily targets young children and ECD service providers, namely parents and other care givers especially teachers, nursery nurses etc (Republic of Uganda 2007b; 7). However, ECD facilities such as ECD centres, nursery schools, kindergartens and day care centres are largely in the hands of private sector and CSOs. Hence, the MoES' impetus to develop a sectoral policy for ECD to govern and guide the private sector. Nonetheless, in places where CSOs are not providing ECD services, access to the services is limited to children from rich and middle income families that can afford the costs of private sector provided services; paying school fees, buying uniforms and transporting children to nursery/ day care centers. An interview with the Assistant Commissioner for Pre-Primary Education revealed that even in urban areas where the prevalence of pre-primary schools is high, many children from poor communities such as slums and children whose parents are employed in low income jobs often cannot afford the costs of such schools, thus miss out on the ECD services. As a result, parents are lured to send underage children to primary schools where they are exposed to primary one class work which is not age appropriate. The Assistant Commissioner added that this has created a wide gap between the primary school joining experiences of children from poor and rich backgrounds; children from poor families who have not attended pre-primary education find more difficulties in coping when they join primary school compared to those who have had a pre-primary experience.

In addition to preparing children for primary school, ECD facilities liberate parents' especially mothers' time to attend to other productive and non productive roles within and outside the household. For ECD facilities substitute for mothers' caretaker roles for pre-school children. However, the ECD policy for the educational sector did not contemplate this contribution of ECD policy during its formulation. That is why the ECD policy is left largely to the private sector for implementation.

2.3.2 Geographical Coverage of the ECD Policy for the Educational Sector

Although the ECD Policy for the Educational Sector recognizes the need for equal access for all children aged 0-8 in Uganda to ECD services irrespective of their geographical location, the delivery of ECD services for children below 6 years (before primary one) still remains the responsibility of the private sector (Republic of Uganda 2007b; 14). According to the Assistant Commissioner for Pre-primary Education, the absence of government's role in the delivery of ECD services has denied children from poor families access to such services. Furthermore, because of the profit driven motive of private sector actors, pre-primary schools and ECD centres are more prevalent in urban areas where more people can afford to pay for the services. The Assistant Commissioner noted that the policy has been much more implemented in the urban areas of the central region of Uganda specifically in the Town Councils, Municipalities and Kampala City. The Assistant Commissioner added that the high population density in the urban areas guaranteed the availability of children for enrollment in the Day Care Centers (ECD centers that provide ECD services for aged children below 3 years), Home Based ECD centers (ECD centers that provide ECD services for children aged between 3-5 years and operate within homes of individuals) and nursery schools/kindergartens (schools that provides ECD services for children aged between 3-5 years and are mainly profit making). Thus, majority mothers in rural areas and the poor amongst urban areas shoulder the burden of child care themselves, thereby increasing the burden of unpaid care work.

2.3.4 Responsibility for Implementation of the ECD Policy for the Educational Sector

The ECD Policy for the Educational Sector (ibid) and the Guidelines for ECD Centers (Republic of Uganda 2010a) state that the implementation of the policy is a responsibility of all actors in the private and public sectors with the MoES acting as a lead agency at national level in overseeing the policy implementation. However, the responsibilities of each actor are clearly spelt out in the guidelines for ECD centers:

(A) The local governments are charged with;

1. Setting up ECD centers which are community based
2. Interpreting the policy to the communities
3. Ensuring that the policy is implemented
4. Making regular visits to ECD centers, Home Based ECD centers, Day Care centers, Nursery schools and Primary Schools
5. Implementing Local Government bye-laws
6. Maintaining regular records of institutions, their enrolment and staff
7. Licensing and registering ECD centers/Nursery schools
8. Supervising and monitoring ECD programmes
9. Ensuring that the basic requirements and minimum standards are adhered to
10. Identifying community priorities and making supportive budgetary provisions in line with national priorities through investing in ECD as a human resource development strategy
11. Nominating an officer in the DEO's office to take on responsibilities of ECD Focal Point Officer
12. Providing a multi-sectoral framework to address childhood development and educational needs and rights
13. Including ECD programs in their development work plans

In addition, the Sub-County Councils have responsibility of recommending for licensing and registration of the centers, maintaining a data base on the activities of the center and supervising and monitoring activities of the center. Village councils do make recommendations for licensing and registration of centers, overseeing activities of the centers, collecting and keeping data on activities of the centers and mobilizing parents to play their roles (Republic of Uganda 2007b).

(B) Non-Government Organisations (NGOs and CBOs) Participate in Implementation of the ECD Policy through:

1. Working with Local Councils to mobilize communities and parents to play their respective roles in ensuring child care, protection, security, nutrition, good health and education
2. Participating in establishing ECD centers
3. Participating in the development of teaching/learning materials
4. Sharing some of their best practices, experiences and lessons in the field of ECD programs elsewhere
5. Directly financing their choices in the areas of ECD

(C) Proprietors and Founding Bodies who Establish and Own ECD Centers Across the Country have the Following Roles to Play

1. Ensuring that their institutions meet the minimum required standards and are duly licensed and registered
2. Ensuring that each institution has a management committee
3. Mobilizing parents and communities to be responsible and send their children to ECD centers
4. Ensuring that the ECD center environments encourage proper up-bringing of children through moral and spiritual guidance and counselling
5. Encouraging parents and communities to send their children to attend health clinics, ECD centers, nursery schools and primary schools
6. Establishing ECD centers
7. Monitoring ECD programs and informing the relevant authorities on their findings
8. Mobilizing resources for their centers

(D) Management Committees of ECD Centers/Nursery Schools

1. Holding regular meetings with committee members and parents

2. Providing overall direction for implementation of the policy
3. Ensuring that there are development plans so that the care and services provided are appropriate and of good quality
4. Ensuring accountability for funds invested and custody of facilities and property
5. Monitoring the use of resources to benefit children as the key beneficiaries
6. Working with and providing the linkage between parents, care givers, teachers, communities and government
7. Undertaking public fundraising functions such as charity walks and public appeals to support child development programs
8. Undertaking leadership to upgrade or improve and develop facilities, amenities and a safe environment for child care, development and education
9. Providing exemplary leadership
10. Ensuring that centers are licensed and registered (ibid).

11. (E) Parents/Guardians have Responsibilities for

1. Providing basic child survival requirements such as feeding of the children at centres, sanitation and hygiene facilities, medical care, shelter, clothing and parental love and care
2. Preparing the child to attend the Day Care/ECD centers or Nursery school and enrolling the child
3. Providing a safe home environment
4. Ensuring discipline for improvement of the child's behavior
5. Providing guidance and direction for positive emotional and physical growth
6. Contributing labour and/or material support for improvement of the ECD centers/schools/environments
7. Monitoring the progress of the child
8. Transporting or escorting children to and from the centers or schools
9. Contributing towards the security and safety of children and their ECD centers/schools
10. Monitoring quality of discipline and care imparted by institutions and their personnel
11. Participating in community mobilization activities that support improved child

development, care and learning at home, ECD centers and/or schools

12. Responding to government programs that enhance ECD development; care, nutrition, health, security, protection and survival
13. Ensuring that children have something to eat during break time
14. Participating in school/center activities

However, in practice, most of the responsibilities of implementing the policy are borne by districts and parents/caregivers. According to the Assistant Commissioner, Pre-Primary Education, the failure of the Central Government to fund the implementation of ECD policy has left districts with the responsibility of ensuring proper implementation of the policy. Worse still, much of the responsibility of implementing the ECD policy for the educational sector lies with the private sector which is profit driven while the government's role stops at supervising. The Assistant Commissioner added that more than not, supervision is not carried out appropriately due to districts' lack of finances for supervision.

2.3.5 Funding of the ECD Policy for the Educational Sector

According to the Assistant Commissioner, Pre-Primary Education, the ECD policy is funded by CSOs through offering direct support to ECD centers and parents/guardians. The Assistant Commissioner said that government does not invest any funds in the implementation of the ECD policy and that monitoring of the ECD centers is not allocated any money at district levels. The Assistant Commissioner highlighted that the CSOs that support the implementation of the ECD policy do support ECD centers directly through subsidizing of services and/or providing services free of charge. Notable CSOs that fund ECD programmes include:

- Save the Children in Uganda supports ECD centers in Karamoja region
- Plan Uganda supports ECD centers in the central region
- UNICEF (supports ECD centers in Kyegyojo, Kyegegwa and Kabarole districts and the districts of Gulu, Moroto, Amulu, Kitgum)

2.3.6 The Impact of the Policy on Women's Unpaid Care Work

The ECD Policy for the educational sector has registered an increase in the enrolment of children into ECD centers over the past years and has further aided the preparation of children for joining primary school. However, women's unpaid work especially caring and nurturing of children has not reduced. The Assistant Commissioner, Pre-Primary Education explained that the work of preparing food, caring for children etc simply shifted to different hours of the day with most of the work being done during the early morning hours when the children are going to school and in the evening or afternoon when they return home. The Assistant Commissioner added that in urban areas where children have to be dropped/walked to school and picked in the afternoon or evening hours, women still bear disproportional burdens of performing such tasks.

In addition, the policy impacts on women from poor and rich households and urban and rural women differently. The Assistant Commissioner, Pre-Primary Education observed that since the provision of the ECD services is entirely in the hands of private sector which is profit oriented,

most of the children from the poor households cannot access the ECD services and this leaves the work of nurturing and caring for children to be entirely borne by women. The Assistant Commissioner further noted that the absence of government's direct involvement in the implementation of the ECD policy has led to the low levels of establishment of ECD centers in rural areas where it is less profitable for the private sector. This denies rural children access of ECD services while rural based women are preoccupied with caring and nurturing children throughout the day.

2.4 The National Health Policy

The National Health Policy identifies malaria, HIV/AIDS and tuberculosis as the leading causes of morbidity and mortality in Uganda (Republic of Uganda 2009a). Seventy percent of overall child mortality is due to malaria, ARIs, diarrhoea and malnutrition. Non communicable diseases (NCDs) are an emerging problem and they include hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness and injuries. The increase in NCDs is due to multiple factors e.g. adoption of unhealthy lifestyles and the ageing population. Uganda has the World's second highest accident rate, with over 20,000 road accidents and 2,334 fatalities in 2008. Neglected tropical diseases (NTDs) are still common and so is domestic violence, rape, sexual abuse, abuse of children which are often related to excessive use of alcohol.

The National Health Policy however notes that seventy five percent of the disease burden in Uganda can be prevented through health promotion and prevention. This is because the major determinants of health in Uganda include lack of access to safe water, poor sanitation and living conditions especially in rural areas and urban slums, resulting in poor health and high malnutrition levels, especially amongst under-fives, low levels of literacy, cultural beliefs, unhealthy life styles, uptake of risky behaviours and the prevailing poverty (ibid).

Improvement in socio-economic status indicators of the population can therefore improve the health status of the Ugandan population. The National Health Policy demonstrates a direct relationship between poverty and incidences and prevalence of malaria, dysentery and diarrhea because they are more prevalent among the poor compared to the rich. Despite the fact that the proportion of people living below the poverty line significantly declined from 52% in 1992 to 31% in 2005, Uganda remains one of the poorest countries ranking 145 on the Global Human Development Index. Far more people live below the poverty line in Northern Uganda (64.8%) than in other regions. Linkages between poverty and poor health outcomes for women and girls are magnified in the post-conflict areas of Northern Uganda where incidences of early marriages stand at 43.1%, maternal mortality ratio (MMR) is 700/100,000 (national is 435/100,000); contraceptive prevalence rate (CPR) is 12% (national is 23%); teenage pregnancy rate is 43% (national is 25%); HIV prevalence rate is 10.5% (national average is 6.4) (Manyire 2013). The National Health Policy further states that level of education attained constitutes one of the major determinants of health. For instance, prevalence of diarrhoea, ARIs and fever among under-five children decreases with the higher the educational level of the mother. Yet, ensuring that children remain in school is a major challenge as the school dropout rates are high: only 49% reach Primary 5 due to poverty, amongst other reasons (Republic of Uganda 2009a).

Lack of a universal national health insurance scheme makes the poor more vulnerable in terms of affordability and choice of health provider. Approximately 60% of Uganda's population seek

care from Traditional and Complimentary Medicine Practitioners (TCMPs), e.g. herbalists, traditional bone setters, traditional birth attendants, hydrotherapists and traditional dentists before visiting the formal sector. Many traditional healers remain unaffiliated and their qualifications suspect. The number of health facilities in the public sector and the PNFPs has been growing from 1,979 and 606 in 2004 to 2,301 and 659 in 2006, respectively, resulting in 72% of the population living in a 5 km radius of a health facility. Even though an Essential Medical Equipment list has been drawn, problems exist relating to procurement delays and the lack of funds. Most facilities and equipment are in a state of disrepair and lack of transport is a major handicap especially in newly created districts. Rehabilitation of buildings and maintenance of medical equipment is not regularly done. Many health facilities remain uncompleted or poorly constructed (ibid).

Amongst the guiding principles of the National Health Policy is gender sensitivity. It is stated that a gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs (ibid). The policy further notes that prevalence of diarrhoea, ARIs and fever amongst children aged under-five decreases with the increases in educational levels attained by mothers, indicating that prevalence of preventable diseases is indeed a gender issue. However, these are the only references made to gender in the policy. Nonetheless, the National Development Plan does acknowledge that women are the main health care providers in the households (Republic of Uganda 2010b). This implies that women do carry the added burden of unpaid health care work within households. Preventive care could therefore not only reduce the burden of disease by 75% but would also reduce the burden of women's unpaid care work.

2.5 The National Policy Guidelines for TB/HIV Collaborative Activities in Uganda

The burden of women's unpaid health care work is heightened by promotion of the home based care approach for care for the persons living with AIDS at the community level which ostensibly has the advantage of relieving the already over strained health facilities. The National Policy Guidelines for TB/HIV Collaborative Activities in Uganda espouse a comprehensive patient care package which includes the management of opportunistic infections (including TB), palliative care, and the provision of antiretroviral drugs (Republic of Uganda 2006b). The Health Sector Strategic Plan III 2010/11-2014/15, however admits that currently, very limited palliative care services are available (Republic of Uganda 2010c). Palliative care is an approach that improves the quality of life of patients and their families faced with problems associated with diseases that are not responsive to cure, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other symptoms, physical, psychological and spiritual. Thus, the burden of palliative care is shifted onto women and girls within households.

Besides the unpaid health care burden placed onto women and girls, HIV/AIDS affects households by reducing labor, agricultural production and income, which then lead to food insecurity. This limits the capacity of affected household to access food or quality care and adopt appropriate health and nutritional responses to HIV/AIDS (Republic of Uganda, undated). Again, the burden of securing household food security is placed onto women and girls.

Guidelines for Service Providers for Nutritional Care and Support for People Living with HIV/AIDS in Uganda

The Guidelines for Service Providers for Nutritional Care and Support for People Living with HIV/AIDS in Uganda define the actions that service providers need to undertake in order to provide quality care for and support to PHAs at various contact points including VCT, antenatal care (ANC), postnatal care, community visits, home-based care, agricultural extension, and education (Republic of Uganda, undated). The guidelines seek to assist the different categories of HIV/AIDS infected/affected people: men, pregnant and lactating women, adolescents, young children, severely malnourished children, food insecure households/areas and people on medication (ibid). The guidelines are however mute on reducing women's unpaid care work in securing food.

2.6 The National HIV and AIDS Strategic Plan 2007/8 – 2011/12

The National HIV and AIDS Strategic Plan 2007/8 – 2011/12 is cognisant of the fact that women bear the brunt of caring for sick family members and are more likely to be rejected, expelled from the family home and denied treatment, care and basic human rights (Uganda AIDS Commission 2007). Further, that when parents are infected and affected, the girl children often have take up the burden of illness care, leading to a high drop out from school. The strategic plan is also aware of the growing burden of orphans to be cared for and the overstretched culture of extended family support and fostering by the elderly such that adolescents are sometimes becoming heads of families or being lost to life on the street (ibid). Most of the adolescents who become heads of families are females.

Thus, Goal 3 of the National HIV and AIDS Strategic Plan 2007/8 – 2011/12 is to mitigate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels. The priority areas associated with the goal include:

- Provide psychosocial support to PHAs, OVC, and other disadvantaged groups, specifically targeting women and girls;
- Provision of formal and informal education, vocational and life skills development for OVC, PHAs, IDPs, PWDs and disadvantaged groups;
- Ensure sustainable community and household livelihood and economic empowerment;
- Ensure access to services that meet basic social needs of PHAs, OVC, PWDs, IDPs, women, girls and other disadvantaged groups affected by HIV and AIDS;
- Ensure legal and appropriate social and community safety nets to benefit PHA households, OVCs, women, girls and other disadvantaged groups affected by HIV and AIDS;
- Ensure sensitisation and awareness creation on human rights and protection mechanisms;
- Ensure provision of the non-tuition costs and essential requirements to OVC in formal education (ibid).

None of the priority areas of the National HIV and AIDS Strategic Plan 2007/8 – 2011/12 however aims at addressing the burdens of care imposed by HIV/AIDS.

2.7 The Uganda National HIV and AIDS Policy

One of the policy objectives of the Uganda National HIV and AIDS Policy is to minimize the socio-economic consequences of HIV and AIDS on the population and promote involvement of the infected and affected in development efforts (Republic of Uganda 2011b). Amongst the policy's principles is sensitivity and commitment to gender equity which underpins all AIDS policy making, programme planning and implementation. The policy acknowledges the impact of HIV/AIDS on household productivity, income and savings, hence the need to examine and mitigate such impacts to promote social and economic progress at all levels. As such, mitigation at individual and community levels is one of the policy strategies. Again, no mention is made of mitigating the added burden of caring for the HIV/AIDS afflicted in the policy.

2.8 The National Home Based Care Policy Guidelines for HIV/AIDS

The National Home Based Care Policy Guidelines for HIV/AIDS have a specific section for addressing gender concerns (Republic of Uganda 2010d). The guidelines acknowledge that the majority of home based care (HBC) givers and volunteers are women who already face other burdens women face as a result of their feminine gender identity, including vulnerability to poverty, denial of women's property and inheritance rights and violence (ibid). The HBC policy guidelines therefore contend that HBC programs should be planned and structured to avoid exacerbating existing gender inequality (ibid). The guidelines further state that HBC should not be promoted as "women's work". Special information and sensitization programmes are necessary to make men assume greater responsibility to safeguard and protect the health of women and children and respect women's sexual rights. The socio-economic benefits of safe motherhood and Planned Parenthood should be emphasised. Other issues to be considered by HBC programs in relation to men include:

- Sensitizing men in gender issues and the promotion of the health of their spouses and children by encouraging use of health services and discouraging social cultural practices that endanger the lives of women and children
- Review, amend and enforce the Affiliation Act to ensure that a man provides adequate paternal support for his family (ibid).

Evident in the National Home Based Care Policy Guidelines for HIV/AIDS is that gender issues considered refer to the broader vulnerability and marginalisation of women in society. Specific attention to addressing the burden of women's unpaid health/nursing care work is lacking in the policy guidelines, cognizance of the fact that majority of HBC givers and volunteers are women notwithstanding.

Uganda's HIV/AIDS related policies could borrow a leaf from Kenya's Programme and Service Guidelines for National Home-Based Care for People Living With HIV/AIDS, whose principles of home-based care transcend focus on clinical and PLWHAs and further focus on principles that aim at reducing the burden of care imposed on family members especially women and girls (Republic of Kenya 2002). The principles include:

- Targeting social assistance to all affected families, especially children.
- Caring for caregivers, in order to minimize the physical and spiritual exhaustion that can come with the prolonged care of the terminally ill.
- Instituting measures to ensure the economic sustainability of home care support.
- Building capacity at all levels; household, community, institution.
- Addressing the differential gender impact of the HIV/AIDS epidemic and care for persons living with HIV/AIDS (ibid).

Kenya's Programme and Service Guidelines for National Home-Based Care for People Living With HIV/AIDS are aware that families and caregivers, like PLWHA, have physical, psychological, and social/spiritual needs that must be met in order to maintain family solidarity and well-being. The guidelines mention that because the burden of caring for someone who is very ill or dying is constant and heavy, the family may also need help with household, farm, or other chores (ibid). Amongst nursing care requirements mentioned by the guidelines are home care kits containing gloves, cotton wool, disinfectants, and basic medicines and time and transport implications for those providing the care. These definitely reduce the burden of unpaid nursing care work in attending to PLWHA. The guidelines further specifically mention the burden of care placed onto women. There is need therefore for promoting and strengthening income-generating activities amongst women and provision of cash transfers to women in households caring for HIV/AIDS afflicted persons (ibid).

For as put by Garbus and Marseille (2003), since Uganda's health care system is under extreme strain because of HIV/AIDS, Ugandan households bear the largest share of the HIV/AIDS burden. The additional cost of illness associated with AIDS is devastating for already impoverished Ugandan families. The household cost of AIDS treatment (which must be paid in cash, out-of-pocket) competes with other crucial expenditures, such as food, shelter, and educational expenses. The burden of AIDS care falls heavily on girls and women, including elderly women. This scenario has numerous consequences in terms of girls' curtailed education and thus limited opportunities for employment in the formal labor force, which may be related to vulnerability to acquiring HIV (ibid).

Garbus and Marseille (2003) added that there are a growing number of child-headed households as a result of AIDS-related orphanhood, and such families are particularly vulnerable. Orphan guardians are under considerable strain, and many households do not have sufficient resources to take in more children. Although standby guardians appointed by parents are predominantly male, women ultimately assume much of the caring responsibilities for orphaned children. In addition, many orphans are subjected to excessive labor demands from their guardians. Most affected are female orphans, who are better substitutes for undertaking their female guardians' unpaid care work than male orphans are for their male guardians.

Uganda's HIV/AIDS policies should therefore urgently recognize carers looking after people living with HIV/AIDS as a missing part of the treatment equation. The invisible and unvalued contribution of unpaid care workers impacts negatively on the wellbeing of carers and their families. For both the PLWHA who are accessing treatment and those who require treatment but do not have access to it are cared for at home mostly by women and children, especially girls. There is need to amplify the voices of carers to make the links between the dignity and rights of carers and the economics of policy and programme decisions on HIV/AIDS.

2.9 The Uganda National Malaria Control Policy

The Uganda National Malaria Control Policy recognizes malaria as one of the most debilitating diseases in Uganda in terms of morbidity, mortality and economic losses (Republic of Uganda 2011a). The goal of malaria control policy is therefore to control and prevent malaria morbidity and mortality, as well as to minimize social effects and economic losses attributable to malaria. In order to achieve this, the malaria control programme endeavours to implement on a national scale a package of effective and appropriate malaria control interventions. The major interventions include the use of Long Lasting Insecticide-Treated Nets (LLINs), early and effective case management, indoor residual spraying (IRS), Intermittent Preventive Treatment of pregnant women (IPTp) and IEC/BCC (ibid). A nearly 20% reduction in malaria outpatient cases observed over the years has been attributed to improvement in IPT coverage, early home and community treatment of children with fever, insecticide treated nets (ITN) coverage and the IRS consolidation and expansion programme. The policy aims at increasing the percentage of targeted structures for indoor residual spraying (IRS) in epidemic areas to 80% actually sprayed by 2015 and increasing from 42% to 100% the percentage of households having at least one ITN by the same year (ibid). This would play a crucial role in reducing the burden of women's unpaid health/nursing care work.

2.10 The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights define Family Planning (FP) as the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods (Republic of Uganda 2012). Birth spacing has been acknowledged as essential for promoting the health of mothers, children and fathers. Hence, to provide information and services that enable individuals and couples to decide freely and responsibly when, how often and how many children to have, the Ministry of Health formulated the Family Planning and Contraceptive Service Delivery Policy. The policy aims at increasing access to quality, affordable, acceptable and sustainable family planning services to everyone who needs them and promotion of strong integrated FP information and services in the health sector at all levels and within various sectors (Republic of Uganda 2012). The Ministry of Health believes that this will be realized through; expansion of service delivery points, improvement of communication through community based and social marketing approaches, training of service providers to enhance technical skills and improve attitudes, guaranteeing that availability of FP commodities and supplies at all levels, improvement of FP logistics management, enhancement of political and community support and participation in FP activities, improvement of record keeping and strengthening of the follow-up, supervision and referral systems (ibid).

2.10.1 Policy Target Group

The policy targets every individual who is sexually active irrespective of their age or mental status. However the policy outlines priority groups as;

- Post abortion and post-partum clients
- Adolescents
- Women with current or past obstetric, medical and surgical conditions likely to worsen with pregnancy and child birth e.g. sickle cell disease, hypertension, diabetes, mellitus, psychiatric conditions and caesarean section etc
- Individuals/couples infected with HIV
- People in difficult circumstances such as commercial sex workers and those in conflict areas
- Survivors of rape, defilement and other forms of SGBV
- Women with five or more live births
- Women who have undergone repair of vaginal and/or rectal fistula
- Women who have a pregnancy interval of less than 2 years
- Young and nulliparous women who want to delay their first pregnancy
- Men

Although the policy puts emphasis on males' involvement, most of the FP methods target women. According to the Principal Medical Officer, Reproductive Health, Ministry of Health, the fact that the widely used FP methods in Uganda are for women consumes a lot of women's time more especially the time they spend lining up for FP services in Health Units. The Principal Medical Officer added that the sector's effort to ensure male involvement in FP by forcing women to come with their husbands during antenatal often increases the time taken to obtain FP services. This is mainly due to poor infrastructure at health units such as small rooms which cannot accommodate large numbers of clients. Thus, when women turn up with their husbands, the number increases and often, they are forced to wait under tree sheds. Given the thin staffing especially in rural areas, more than often, women spend a whole day to access services especially when they go for antenatal care. However, the Principal Medical Officer, Reproductive Health, explained that much as majority of the lower cadre staff who offer FP services are women, the policy is silent about their (lower cadre staff) social life. She further explained that on many occasions, nurses and midwives work over time and the extended hours of work constrains performance of their domestic work.

2.10.2 Geographical Coverage of the Policy

The policy covers the entire country and targets every individual who is sexually active (ibid).

However, according to the Principal Medical Officer, Reproductive Health, the diversity of culture, norms and beliefs in Ugandan societies brings in the non-uniformity in the implementation of the policy. Further, that some communities believe in large numbers of children and that in such communities, the use of FP services is low. Whereas in almost all Ugandan cultures polygamy and early marriages have largely remained accepted ways of life, the desire to have large number of children differs between rural and urban areas. It is still believed by many rural based Ugandans that large families are a source of cheap labour and prestige in society. But in urban areas the high cost of living always dictates a lower number of children. Thus, the desire to have large number of children in rural areas and the fact that they use rudimentary technologies in accomplishing domestic work makes rural based women bare a large burden of unpaid care work compared to their urban counterparts.

2.10.3 Responsibility for Implementation of the Policy

The responsibility of implementing the policy is largely the work of the public sector with the Ministry of Health taking a leading role in the supervision of the policy implementation. However, the policy guidelines mainstream the involvement of the private sector and development partners who participate in the planning, promotion and delivery of sexual and reproductive health services.

2.10.4 Funding of the Policy

The policy is funded by both the government and development partners. However, according to the Principal Medical Officer, Reproductive Health, development partners' funding mainly concentrates at the Ministerial level leaving districts with limited funds to implement the policy. The Principal Medical Officer added that much as the FP services are needed at the community levels, limited funds do reach the district and community levels.

Development partners notably UNFPA focuses mainly on Adolescent Sex and Reproductive Health (ASRH), FP, HIV prevention and young people's health. WHO provides technical support, UNICEF focuses on the health of children and mothers and as such promotes FP too. USAID focuses on all aspects of health including FP, CDC provides technical support and UN Women focuses on mainstreaming gender in the planning and delivery of health services including FP.

2.10.5 Impact of the Policy to Women's Unpaid Care Work

The use of FP services promotes child spacing which has a direct positive effect on the health of mothers and children. However, poor implementation of the policy mainly due to negative cultural practices and limited resources results into poor health of mothers and children. This often increases the burden of unpaid care work to women. The Principal Medical Officer, Reproductive Health, added that when a family member falls sick, it is always the woman to look after that member even when the woman herself is sick. This is because it is believed in all Ugandan cultures and religions that such type of work is supposed to be performed by women. The Principal Medical Officer also stressed that the inefficiencies in the FP service delivery that result in spending a lot of time to access the services add a considerable burden to women's unpaid care work. Women spend much of their time waiting for the health services yet they have to go home and cook, wash clothes, clean the home, care for children etc. This constrains performance of such tasks.

2.11 The National Water Policy

The National Water Policy sets the framework for management and development of water resources and guides development efforts through:

- (i) Promoting better provision of urban and rural water supply and sanitation,
- (ii) Promoting water for agricultural production, (amongst others) (Republic of Uganda 1999).

The policy states that improved water supply and sanitation services have major social, economic and health impacts on life in general. Some of the benefits from water supply and sanitation also have a positive effect on investments in other sectors, such as education and industry. The guiding principles of the policy recognize the essential role of women in the provision, management and safeguarding of water and emphasise women's participation in institutional development (ibid).

The National Water Policy further provides that in rural areas, the basic service level for water supply means provision of 20 to 25 litres per capita per day from a public water point (protected spring, hand pump, equipped shallow well or borehole, or tap stand on gravity-fed scheme), preferably within 1000 metres of all households. The service level in built-up areas and peri-urban zones, where public water points are introduced, is also 20 to 25 litres per capita per day, with a maximum walking distance not exceeding 200 metres. Each public water point should serve not more than 300 persons. The difference in elevation between a household and the water point should not exceed 100 metres (ibid). Since its women who are mostly involved in water collection, these service criteria reduce the burden of water collection.

With regard to health and hygiene education, the National Water Policy recognizes women's important role in improved health of their families and in changing the behavior of children. The policy therefore encourages women's involvement in health promotion. The policy further promotes women's involvement through training in design, construction, operation and management of improved water supply and sanitation facilities. The key premise is that women and men should have equal opportunity to participate fully in all aspects of community management.

The policy further provides for the inclusion of women in the operation and maintenance (in rural and peri-urban areas) of water sources. At village levels, Water Source Committee (WSC) should have a minimum of half of the members as women representatives. The Water Source Committees collect funds for regular maintenance and repairs, and are in all respects responsible for the maintenance of the sources (ibid).

2.12 The Energy Policy

Uganda's energy policy aims at meeting the energy needs of Uganda's population for social and economic development in an environmentally sustainable manner (Republic of Uganda 2002). One of the policy objectives is to provide affordable energy services for households and community based services including water supply and sanitation, health, education, public lighting and communication in order to improve the social welfare of the rural population. Uganda's energy policy states that biomass (firewood, charcoal and crop residues) constitutes

over 90% of total energy consumption in the country. It provides almost all the energy used to meet basic needs of cooking and water heating in rural and most urban households, institutions and commercial buildings. Most of the traditional energy technologies (wood and charcoal stoves and charcoal production kilns) currently used in Uganda are inefficient. Some initiatives to conserve biomass resources have been undertaken by Government and the private sector, including NGOs. They include the promotion of improved stoves as well as afforestation. However, the impact of these efforts is still limited (ibid).

The Ministry of Energy and Mineral Development (MoEMD) meets its objective of providing affordable energy to households by:

- a) Achieving a sustainable level of energy security for low income households so as to reduce poverty at household levels;
- b) Improving the efficiency in the use of biomass resources, recognizing that biomass will remain a dominant source of energy, especially in the rural areas, for the foreseeable future.
- c) Specifically targeting provision of energy to productive activities such as home-based industries in order to directly raise household incomes
- d) Sensitizing women on energy source and technology choices in order to reduce the labour and health burdens associated with biomass energy use (ibid).

Though the policy recognizes energy as one of the basic needs of the poor and energy services for the household and community to be a priority in a poverty eradication programme, households particularly those in rural areas are faced with energy poverty (absence of sufficient choice in accessing adequate, affordable, reliable, quality, safe and environmentally benign energy services to support economic and human development). It is apparent that there exists energy poverty at all levels in Uganda, particularly at household level in the rural areas. Evidence of energy poverty can be found in the low levels of consumption of modern energy forms (electricity and petroleum products), the inadequacy and poor quality of electricity services and the dominant reliance on wood fuel sources (ibid).

According to the Senior Energy Officer, Ministry of Energy and Mineral Development, women are not paid for the work they do within the households and as a result they do not participate in choosing the cooking devices they use. The Senior Energy Officer added that women struggle to feed their families and that most of the meals that are not bought are prepared by women who unfortunately have little or no influence on choice of cooking device(s) they use. Further, that women especially those in rural areas just use the available methods of cooking even though they are unfriendly to their health. The Senior Energy Officer stressed that since the role of cooking is taken for granted to be women's work and because it is time consuming due to use of poor cooking methods, women hardly find time to engage in productive work.

2.12.1 Policy Target Groups

The Energy policy for Uganda targets the entire country's population by meeting the energy

needs of the Uganda's population for social and economic development in an environmentally sustainable manner. Although the MoEMD recognizes the need to develop a comprehensive Household Energy Plan to adequately address issues related to shortages and inefficient use of biomass and affordability of modern energy services, households particularly those in rural areas still use inefficient methods of cooking. According to the Senior Energy Officer, MoEMD, the use of energy devices for cooking that do not save time and are laborious often keep men away from participating in cooking, leaving the burden of cooking to women. The Senior Energy Officer added that a clean kitchen with modern cooking facilities such as biogas, cooking stoves etc can attract men to cooking.

2.12.2 Geographical Coverage of the Policy

The policy covers the entire country. However, according to the Senior Energy Officer, MoEMD, the demand for energy is high and the Ministry often implements the policy and projects in areas where there is high demand; these are in most cases urban areas. He added that in implementing projects, the Ministry not only focuses on provision of labour saving technologies alone but also puts emphasis on income generation. For example, the Ministry imparts skills of making energy saving cooking stoves and brickets (charcoal made out of waste) and provides raw materials to beginners. The Senior Energy Officer further explained that it is mostly women who join such projects and sale products to earn income which enables them to solve some household problems. The Senior Energy Officer said that such skills are friendlier to women whose movements are most times restricted to their homes. In addition, the Senior Energy Officer said that women who use such modern cooking devices do not need to be at the cooking source all the time; they can be able to engage in other activities which often include making baskets and mats especially in rural areas. All this adds to income of households. The Senior Energy Officer however noted that although the Ministry has not done any study to find out the time saved when women use such devices, the Ministry always use inference to know that such devices reduce the time spent in cooking.

2.12.3 Responsibility of Implementation of the Policy

The Energy Policy for Uganda is implemented by the MoEMD which supervises its implementation including projects. However, other partners (CSOs and Development partners) support the implementation by providing funds and sometimes participate in the actual implementation of projects.

2.12.4 Funding of the Policy

According to the Senior Energy Officer, MoEMD, the energy policy is funded by government and development partners especially UNDP, GIZ, WWF (Wild Wide Fund for Nature) who sometimes fund the actual implementation of some project activities while some have small NGOs that they fund to promote modern technologies. The Uganda Domestic Biogas Program (UDBP) implemented by Heifer International, Uganda, promotes the use of biogas energy. The program aims at improving the livelihood and quality of rural and peri-urban farmers in Uganda through full utilization of biogas benefits. The program targets small holder farmers practicing diary and piggery farming.

According to the Communications Officer, Heifer International, Uganda, biogas is a much cheaper source of energy for cooking and lighting in rural homes compared to firewood, charcoal

and kerosene. The latter lead to environmental degradation through cutting of trees and emission of harmful gasses, respectively. The Communications Officer revealed that a family of four cooking with a 9m³ biogas digester can save over UGX 100,000/= per month. The Communications Officer added that with the use of biogas, cooking can be done in a shorter time and moreover in a cleaner and smoke free environment with less health risks like cancer, respiratory complications and eye problems related to use of firewood and charcoal. For example, cooking time for beans can be reduced from one hour to 30 minutes when using biogas. The Communications Officer further added that biogas not only lessens time spent on cooking but also improves domestic hygiene; use of bio-toilets improves domestic hygiene because the toilets do not have a bad smell and neither do they attract flies. Bio-toilets do not fill up and as a result, the contents cannot sip through walls and floor of the digester thus protecting the water table from filth.

Biogas also heats faster, hence reducing the time spent on cooking. Women are therefore left with more time for income generating activities while school going children can have more time for revision, moreover using brighter biogas lamps. Due to use of biogas, men and boys can participate in cooking thus lessening the burden of cooking from women. However, when asked if Heifer International, Uganda, has ever estimated the time taken to accomplish other tasks related to biogas usage like feeding and cleaning the digester and collecting cow dung, the Communications Officer said that though it takes some consider time to produce biogas, their program has never estimated the time spent on work related to biogas production. The Communications Officer added that although Heifer International, Uganda, has never estimated the time taken, much of the work related to production of biogas is done by women.

2.12.5 Impact of the Energy Policy on Women's Unpaid Care Work

The use of modern technologies particularly energy saving stoves, bricks and biogas in cooking within households reduces the time spent on cooking and also attracts men's and boys' participation in cooking. This reduces women's burden of cooking thus saving time for participating in productive work. It should be noted that when women allocate their time to productive work, their income is often allocated to improving family welfare which in turn improves the health of household members. In addition, the fact that such technologies keep the kitchen and the entire household clean improves household hygiene and thus health of household members. Improved health of the household members does not only increase the productivity of the household but also lessens the would-be burden to women and girls of caring for the sick.

2.13 The National Policy on Disability in Uganda

The National Policy on Disability in Uganda points out that four out of every 25 persons in Uganda are persons with disabilities (PWDs) (Republic of Uganda 2006a). The most commonly observed disabilities were loss and limited use of limbs (35.3%), spine injuries (22.3%), hearing difficulties (15.1%), sight difficulties (6.7%), difficulty in speech and conveying messages (3.9%), mental retardation (3.6%), mental illness (3.6%), and others at 9.6%. The Northern Region has the highest rate incidence of disability rate at 4.4% (ibid).

Generally, PWDs are vulnerable by virtue of their impairment and negative societal attitudes arising from fear, ignorance, superstitions, neglect and lack of awareness. As a result, PWDs have inadequate access to services, information, resources as well as limited participation in the

socio-economic development process. Consequently, the majority depend on their families and communities for survival. The burden of care for PWDs falls mostly on women.

The burden of care for PWDs is not helped by one of the guiding principles of the policy which states that the family is the basic unit for providing care and support to PWDs. PWDs should benefit from the family and community care and protection. It is therefore, the responsibility of the parents or caregivers to PWDs to provide food, clothing, housing, love, care, education, health and other basic services that promote and protect the rights of PWDs (ibid). The policy is silent on what resources caregivers will use to provide care to PWDs, including limitations on care givers' time.

Under UPE policy, government provides free education to all children in primary schools. There are 150,559 children with disabilities under this programme, of whom 82,537 are males and 68,022 are females. Approximately 4500 PWDs have been trained in vocational skills in the Vocational Rehabilitation Institutions since 1967. The Special Needs Education (SNE), under Ministry of Education and Sports addresses issues of children with learning difficulties. The programmes under Kyambogo University play a key role in training teachers and other professionals in special needs education and rehabilitation. Furthermore, Government put in place rehabilitation and resettlement scheme that include vocational rehabilitation services, sheltered workshops that focus on employable skills training and orthopaedic workshops for provision of assistive devices to PWDs. These programmes help reduce the burden of caring for PWDs because they empower them to become self-reliant (ibid).

Despite the above existing programmes, scarcity of appropriate educational, scholastic and instructional materials, inadequate training of staff handling concerns of PWDs, outdated and limited skills in vocational rehabilitation centres, inaccessible physical structures at schools, high costs of assistive devices and assistive services such as guides, helpers as well as interpreters are major factors which hinder PWDs education and skills training. Therefore, poor access to education in childhood means that a high proportion of PWDs remain illiterate and unskilled. Issues relating to PWDs are not well highlighted in education and training curricula at all levels. Furthermore, public education programmes often use languages and images that are not comprehensible to most PWDs. Physical accessibility and affordability to programmes are major education and skills training limitations that constrain participation of PWDs.

2.13.1 Responsibility of Implementation of the Policy

Since disability issues are multi-dimensional, implementation of the policy is multi-sectoral at the national, local government and community levels. In addition to the central government and local authorities, other actors include parents and other caregivers, CSOs, the community, Disabled Persons' Organisations (DPOs) and the private sector. The MoGLSD is the lead agency and spearheads the co-ordination of the policy. The Ministry develops and disseminates guidelines for operationalising the policy. Other Government Ministries, Departments and Agencies are responsible for effective implementation of the relevant aspects of the policy in their respective sectors within their mandates. Local authorities do coordinate, supervise and mobilise resources and disseminate information at district and lower levels. The private sector designs and constructs PWD-friendly infrastructure and other social facilities in addition to efficiently delivering services targeting PWDs and contributing resources for disability

interventions.

Disabled persons organisations do strengthen the capacity of their members, promote the dignity and welfare of PWDs and supplement government efforts in delivery of services to their members. Other Civil Society Organisations do mobilise resources for service delivery and build capacities of PWDs and caregivers. Communities (local councils, clan, traditional, cultural, religious and opinion leaders) are entrusted with:

- Identifying and strengthening social support networks and mechanisms for PWDs and their families;
- Participating in implementing interventions and linking PWDs to service providers;
- Promoting understanding, guidance and support, which PWDs need to become fully productive members of the community;
- Identifying and addressing cultural and traditional norms and practices that adversely impact on PWDs.

Parents and other caregivers are expected to play the primary role of taking care of PWDs. They therefore identify, provide care and support and offer psychosocial counseling and guidance (ibid).

2.14 The National Policy for Older Persons

Older persons are defined by the United Nations as people aged 60 years and above. In Uganda, older persons contribute immensely to the creation of wealth, support and care for children including HIV/AIDS orphans, creation of social cohesion and conflict resolution in their communities and the nation as a whole (Republic of Uganda 2009b). Older persons make valuable contributions to society as guardians of traditions and cultural values which are passed on from generation to generation. The Government is cognizant of the valuable contributions older persons make and is committed to enhancing their potentials by establishing a framework to address their concerns and needs (ibid).

According to the 1991 Uganda Population and Housing Census, the population of older persons was 686,260 (4.1%) of the total population of 16,671,705. This population increased to 1,101,039 (4.6%) as per the Uganda Population and Housing Census results of 2002. The Uganda National Household Survey (UNHS) Report 2005/06 estimated the population of older persons at 1,200,000 of which 53% were female while 47% were male. This population increase has profound consequences at individual, community and national levels (ibid).

The majority of older persons live in rural areas where poverty is rife, economic opportunities are limited, ill-health is common and health services are inadequate. They work in the agricultural sector, which is characterised by fluctuations in produce prices, irregular income and low returns to labour. About 85% of the active older persons are engaged in crop farming with no social security, rendering them totally vulnerable. Their economic situation is worsened by

the burden of looking after orphans and other vulnerable children left by the youths and younger adults who have succumbed to the HIV/AIDS pandemic (ibid).

The National Policy for Older Persons indicates that older persons are the worst hit by food insecurity and poor nutrition. They mainly feed on carbohydrates and take only one meal a day. Inadequate food intake and poor diet pre-dispose older persons to malnutrition, ill health, emaciation and chronic energy deficiency. Nutrition research and interventions tend to focus on the needs of under-fives, lactating mothers and other younger population groups. This focus has resulted in a failure to acknowledge the food and nutritional needs of older persons. The nutrition assessments and training curriculum also do exclude older persons (ibid).

The National Policy for Older Persons also asserts that ill-health is a major source of worry and stress among older persons. Common health problems of the older persons include hypertension, stroke, diabetes, heart diseases, trachoma and blindness that often lead to complications and permanent incapacitation. Poor health reduces the capacity of older persons to generate income, curtails their productivity and compels them to depend on other people. Older persons can hardly afford the costs of travelling to the health facilities at the sub-district or in urban centres where they could access the comprehensive Uganda National Minimum Health Care Package provided by the Health Sector. Their health problems are compounded by the lack of money for seeking appropriate medical attention or buying drugs for non-communicable diseases (ibid).

2.14.1 Rationale for the National Policy for Older Persons

The Uganda National Policy for Older Persons promotes and contributes to the attainment of Uganda's development goals through informing other policies, programmes and sectoral plans. It provides a framework for:

- i. Enhancing the recognition of the roles, contributions and potentials of older persons in the development process;
- ii. Strengthening the informal and formal community based support systems and actions for older persons' dignity;
- iii. Promoting actions that encourage older persons to pass on knowledge to the younger generation;
- iv. Guiding, coordinating and harmonizing interventions for older persons by stakeholders; and,
- v. Promoting research on issues of older persons (ibid).

Amongst the policy strategies is promoting family and community based care approaches for older persons in accordance with socio-cultural set ups. This recognizes that the family is the primary source of care and support to the older persons. The policy emphasizes community based management of older persons. However, in exceptional cases where the immediate families may not be in existence, stakeholders will be encouraged to establish homes for the landless and homeless older persons (ibid). Suffice to note that although the policy recognizes that the family is the primary source of care and support to the older persons, it does not

explicitly mention the support the family is provided with. Neither does the policy mention the added burdens of unpaid care work undertaken by women in caring for the elderly nor how the burdens could be reduced.

2.15 Expanding Social Protection (ESP) Programme in Uganda

Expanding Social Protection (ESP) programme in Uganda was designed in 2009 as a five-year programme under the MoGLSD (Bukuluki and Watson 2012). It is funded by the UK Department for International Development (DFID), Irish Aid, and UNICEF. The current funding level is £41 million (about UGX 160 billion). In addition, starting from the financial year 2011/12, the Government of Uganda committed \$50,000 plus in-kind support estimated at UGX 6 billion over the five years of the programme (ibid). By the end of the pilot phase, the Ugandan Government contributions are expected to reach at least \$900,000 per year (ibid).

The purpose of the ESP Programme is to embed a national social protection system that benefits the poorest people among the population, as a core element of Uganda's national policy, planning and budgeting processes. Social Protection is concerned with measures to ensure an adequate, acceptable standard of living for a country's most vulnerable and excluded citizens; a means to ensuring dignity and the rights of citizens, which is also enshrined in Uganda's Constitution.

The aim of ESP Programme is to reduce chronic poverty and improve life chances for poor men, women and children through direct income support programmes (also known as cash transfers, social transfers or social assistances) that provide small, regular payments of money (by government), to vulnerable individuals and families to provide a minimum level of income security. Examples of direct income support include senior citizen grants, child grants, disability grants or vulnerable family grants.

ESP is structured around two core elements:

(i) Policy

The objective of this element of the Programme is to put in place a policy framework for Uganda that guarantees and guides implementation of social protection in the country. Under this element, the ESP seeks to strengthen leadership on social protection issues across various institutions (Ministries, Departments and Agencies) of the Government of Uganda to implement social protection. This calls for a coordinated government approach to ensure that the requisite policy framework, funding, institutions and human resources are in place to support the social protection agenda in Uganda.

(ii) Direct Income Support Pilot

This part of the Programme is responsible for the implementation of the two pilot schemes: The Senior Citizens Grants and the Vulnerable Family Grants. Under the Senior Citizens Grants, older persons 65 years of age and above (but 60 years in the case of Karamoja region) receive Uganda shillings 23,000 (about US\$8 per month). The Vulnerable Family Grants are paid out to

households with low labour capacity owing to age, physical disability, etc. and high dependency ratios. It also reaches households with a high proportion of older people, people living with HIV or AIDS, widows, children and people with disabilities. Both schemes are being piloted in 14 districts in the country.

2.15.1 Coverage of the ESP Programme

The Programme is currently piloting in the following districts: Apac, Kole, Kaberamaido, Katakwi, Moroto, Napak, Nakapiripirit, Amudat, Kiboga, Kyankwanzi, Kyegegwa, Kyenjojo, Nebbi and Zombo. By September, 2012, the Programme was reaching 31,038 beneficiaries and it was scheduled to reach a target of 60,000 beneficiaries by December 2012. It is expected that by June 2013, the two grants will have reached 95,000 households, potentially up to 500,000 individuals in all the sub-counties of the 14 pilot districts.

2.15.2 Rationale for the ESP Programme

More than 7.5 million Ugandans are living in poverty while in rural parts of Northern Uganda the poverty rate is as high as 49 per cent. Nearly 40 per cent of households are vulnerable to poverty, living just above the poverty line. Between 2005/6 and 2009/10, the poorest experienced almost no change in their consumption. Inequality is also increasing; in 2009/10, about 45 per cent of income was controlled by the richest 20 per cent of the population compared to 9.4 per cent of the income held by the poorest 20 per cent. 16 per cent of Ugandan children below 5 years are underweight while 38 per cent are stunted. 9 per cent of people still eat only one meal a day (ibid).

Despite significant investments in health and education, the poorest and vulnerable are failing to access basic services. Less than 70 per cent of children from the poorest households are enrolled in primary school; and are 5 times more likely to delay in school than children from richer households. Financial constraints are cited as a key barrier to accessing health services yet sickness is cited as the major reason for dropping out of school (ibid).

Therefore, the poorest and most vulnerable among Uganda's population are failing to benefit from and/or contribute to Uganda's growth and development. Social protection represents an opportunity to address these imbalances.

2.15.3 Impact on Women's Unpaid Work

Bukuluki and Watson (2012) observed many positive effects of the cash transfers both at individual, household and community levels. At individual level, improved self-esteem, personal status and empowerment were reported; beneficiaries took pleasure in for example, being able to buy new clothes or shoes for themselves; at the same time, being more "presentable" allowed them to interact more with others, hence solidifying social contacts. At household level, the cash transfer improved beneficiaries' capacity to meet basic needs, including basic needs for children under their care, and helped to improve relations between parents and their children/relatives because of reduced dependency. At the community level, the effects were felt both in terms of boosting the local economy and improving relations between beneficiaries and the wider community (ibid).

Beneficiaries also reported greater ability to buy food and invest in productive assets as a result of the cash transfer, which shows potential for improving nutrition and food security in the long term. Cash transfers further played an important role in enhancing access to education for orphans and other vulnerable children by providing older people with the means to acquire the materials and meet the requirements associated with attending school such as uniforms, books and stationery. Discussions revealed that meeting these needs for vulnerable children resulted into improved enrolment and/or retention of children in school (ibid).

Bukuluki and Watson (2012) did not investigate the impact of cash transfers on women's unpaid work. We could therefore not discern what the impacts these programmes could have had on women's unpaid work. Nonetheless, Stewart and Sudhanshu (2008) reported that social cash transfers are increasingly being called for as an AIDS mitigation measure to help families cope with increasing dependency ratios and the associated burden of care and to protect the health and human capital development of orphans and other vulnerable children. Adato and Bassett (2012) added that cash transfers may have particular advantages for girls in the context of HIV and AIDS. Girls are at risk of being withdrawn from school because they are often the ones who bear the burden of care for children and ill adults in HIV-affected households. Staying in school may have benefits for girls in addition to education. In Malawi and South Africa, trials are under way to examine the impact of randomized cash transfer interventions that provide cash transfers conditioned on school attendance (ibid). In both countries, girls are targeted because the incidence and prevalence of HIV are higher among young adult females than among males of the same age.

One of the opportunities under exploration in Southern Africa is for early childhood development (ECD) services. Many aspects of the HIV/AIDS epidemic can jeopardize early childhood development. Young children depend on caregivers, who may be overworked and demoralized, and possibly ill themselves and therefore less attentive to children and less able to meet their needs (ibid). In this regard, cash transfers may help reduce incidences of women's unpaid care work (ibid).

However, Farrington, Harvey and Slater (2005) noted that in Zambia, women were less able to keep control of cash compared to in-kind alternatives, for example food. This was due to male dominance in spending patterns. Farrington et al added that whilst cash transfers may have equalising impacts on bargaining power within some households, negotiating household power relations can be a long and painful process and cash transfers do not provide a magic bullet in this regard. In some contexts, women expressed a preference for food over cash because they are better able to control its use. On the contrary, a study of the Child Support Grant in South Africa which looked at intra-household dynamics and the role of women as the primary caregivers and thus the cash recipients, found that although there were some tensions with male partners over the Child Support Grant, for the most part, the receipt of benefits by women was accepted without problems (Adato and Bassett 2012).

2.16 National Orphans and Other Vulnerable Children Policy

The National Orphans and Other Vulnerable Children Policy (NOP) aims at promoting social protection of poor and vulnerable children. Such children include orphans, those who live on the

streets, those that toil under exploitative conditions of labour as well as those that suffer sexual abuse and other forms of discrimination. The NOP intends to contribute to the improvement of the quality of life of such children and their families (Republic of Uganda 2004). The implementation of this policy involves other Government Ministries, local authorities, civil society organisations, the private sector, orphans and other vulnerable children themselves, communities as well as the families they live in.

Amongst the guiding principles of the policy is making the family and community the first line of response. The policy recognizes the family as the basic unit for the growth and development of children. A strong family unit with a caring adult is a pre-requisite for the reintegration of orphans and other vulnerable children. Care giving outside the family by the community, which is the second line of defence, will foster an atmosphere of a family-like nature to ensure that the family does not disintegrate further in the face of HIV/AIDS, conflicts and other causes of vulnerability. However, Government officials and other actors with child protection responsibilities should recognise that immediate threats to children's safety and well-being may also come from their families and communities (ibid).

The strategies of the National Orphans and Other Vulnerable Children Policy include direct interventions whereby support is provided to vulnerable children and families such that their capacity to sustain themselves is strengthened and provision of residential care for orphans and other vulnerable children as a last resort. Another strategy is to promote awareness of the impact of vulnerability on male and female children who are care givers.

2.16.1 Target Groups

The categories of children targeted by the policy include:

- Orphans and orphan households
- Children affected by armed conflict.
- Children abused or neglected.
- Children in conflict with the law.
- Children affected by HIV/AIDS or other diseases.
- Children in need of alternative family care.
- Children affected by disability.
- Children in 'hard-to-reach' area
- Children living under the worst forms of labour
- Children living on the streets.

Unfortunately, the National Orphans and Other Vulnerable Children Policy does not have any strategies for reducing the burden of women's unpaid work in caring for orphans and other vulnerable children.

2.17 The Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15

The Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15, recognises the dominance of women in the agricultural sector (83 percent) compared to 71 percent men who work there-in (Republic of Uganda 2010e). The Investment Plan further acknowledges that a substantial amount of women's time is taken up in providing care work. The Agriculture Sector

Development Strategy and Investment Plan, 2010/11-2014/15, thus contends that investments in improving smallholder agriculture will help women more than it would in most other areas of investments. Further, that if the investment is carefully targeted, the gender benefit can be considerable (ibid). Citing a multi-country study by Blackden and Bhanu (1998), the Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15, notes that in Kenya, if women farmers received the same level of agricultural inputs and education as men, their yields would increase by more than 20 percent; in Tanzania, reducing the time burden of women increased household cash incomes for smallholders by 10 percent, labour productivity by 15 percent, and capital productivity by 44 percent; and in Zambia, if women could invest in agricultural inputs, including land, to the same extent as their male counterparts, total output could increase by up to 15 percent (Republic of Uganda 2010e). However, the Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15, focuses more on increasing women's agricultural productivity than reducing their unpaid care work labour burdens. For example the Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15, cites a MoFPED study conducted in 2008 which concluded that a 1 percent improvement in productivity in agriculture in Uganda would not only disproportionately benefit women but also contribute an extra 0.4 percent growth to GDP (ibid). Thus, one of the strategies and investment programmes of the agriculture sector is enhancing production and productivity. Under this programme is a sub-programme that specifically focuses on labour saving technologies and mechanization. But the labour saving technologies that will be promoted are oxen and ploughs and tractors.

The principle followed is that mechanization is only an input like any other, such as fertilizer or seed or crop protection chemicals. As such the type and degree of mechanization should be decided by the producer to best suit his/her business and his/her own particular circumstances. Suitability of methods is therefore just one of a number of choices that the farmer has to make. Since the decision on whether and how to mechanize is often made for a complicated mix of reasons, economic decisions should be paramount (ibid). Paradoxically, since society considers unpaid care work as “naturally” suited for women, reduction of its burdens is least likely to be the reason for mechanization. In fact, mechanization is likely to increase women's labour burdens for large areas are likely to be opened up, thus increasing the time spent in weeding, harvesting and processing (all predominantly women's roles), unlike concomitant technologies like simple mechanical planters, weeders, harvesters and processors are equally developed and adopted.

2.18 Policies Related to Paid Domestic Work

Uganda currently lacks a policy governing paid domestic care work carried out by maids who are informally employed within households especially in urban areas. However, according to Kasozi, (2013), Government is in the process of establishing a policy and legal framework to address the plight of domestic workers in the country. Under the policy, government will set up professional standards, a monitoring mechanism and develop an effective registration system for domestic workers. Kasozi (2013) quoted the State Minister for Labour, Employment and Industrial Relations, as saying that the policy seeks to recognise domestic work as real work that demands rights.

“We are taking a keen interest on all employment sectors but domestic

workers have been left out. Since the majority are working under unsafe conditions, government is getting interested,”

said the Minister, adding that a Cabinet paper had been approved.

Paid domestic work is very prevalent in Uganda because it relieves adults within households to engage in paid work outside the household. Children (people aged below 18 years) are also hired as domestic workers. However, domestic workers often lack clear terms of service from their employers, they are usually over worked, not paid or underpaid. A survey of adult domestic workers carried out in 2005 in the districts of Kampala, Lira, Iganga and Mbarara showed that average daily hours put in by domestic workers ranged between 12 to 14 while two out of ten workers did not get any rest break during the day. 40 per cent had rest breaks of less than one hour while 64 per cent had no days off at all (Platform for Labour Action 2007). More than two-thirds began their duties between 6:00 am and 7:00 am while 60 per cent stopped working between 10:00 pm and midnight (ibid).

The long and unpredictable working hours impose a high cost on domestic workers' health and well-being and in turn, erode their efficiency and quality of service they provide to their employers' households (ILO 2012). The principal challenge therefore to policy-makers is formulating working time measures that protect domestic workers' interests while taking into account the needs of the households that employ them (ibid).

Domestic workers, particularly girls, are also prone to the risk of sexual exploitation by male employers and boys in homes where they work. The adoption of a new international labour standard on promoting decent work for domestic workers, which calls for its ratification and implementation, provides an opportunity to support initiatives on decent work for domestic workers.

Section Three: National Level Civil Society Organisations that Action Aid Work Can With On Unpaid Care Work Related to Different Policy Areas

3.1 Introduction

There are several Civil Society Organisations (CSOs) that are carrying out work related to women's unpaid care work. These include Plan, Uganda, Action for Children, Katutandike Foundation and Save the Children in Uganda, amongst others. Most of these CSOs' focus is on early child care and education. There are also national institutions that deliver services especially in health and utilities such as water.

3.2 Plan Uganda

Plan Uganda is implementing an Early Childhood Community Development (ECCD) project called the Community Led Action for Children (CLAC) whose goal is to enable children enjoy their right to a good and healthy start in life. A good and healthy start in life is the foundation for enabling children reach their full potential for enjoying their survival, development, protection and participation rights in later stages of life (from middle childhood to productive adulthood). Plan Uganda recognizes the value of investing in ECCD especially for the most vulnerable children, hence ensures that parents, care givers and communities are empowered to provide proper care and support to children. The project is implemented in the districts of Luwero, Lira, Alobtong, Kamuli, Tororo and Kampala and particularly focuses on poor communities.

Plan Uganda ECCD project has four components:

i) Parenting Education

Plan recognizes that parents and the family environment are the primary sources of children's experiences and influences. It therefore provides parenting education sessions to parents and care givers to enhance their understanding of the importance of children's early years, increases their confidence in parenting and improves their ability to provide effective care and stimulation to children. According to the project manager, Plan Uganda, primary caregivers of children aged between 0 and 8 years and of children from vulnerable families are targeted. Fathers are also deliberately sought out for parenting education due to the need for them to get them interested and involved in ECCD activities.

ii) Community Managed ECCD Centers

Under this component, Plan's goal is to have 100% of children aged below six years (the age group preceding joining primary school in Uganda) receive high-quality early learning for early social support and readiness for school. According to the project manager, children enrolled into early learning programs have the opportunity to socialize with peers, build early literacy and form relationships and experiences that promote readiness for school. Community Managed ECCD Centers target children from families identified as the most vulnerable who are late to enroll or likely to miss out altogether. Women play a vital role in building and managing the ECCD centers; women collect all the building materials apart from the iron sheets that are provided by Plan Uganda while men participate in actual construction of the centres. In addition,

women provide the play materials used by children in the ECD centers.

iii) Facilitating Smooth Transition to Primary School

Plan Uganda facilitates consultative dialogues with children, parents, leaders and primary school staff to understand the needs of children in lower primary (ages 6-8) and generate proposals on how these can be addressed.

iv) Advocacy, Partnerships and Collective Action

This component focuses on strengthening the ECCD coordination forums at national and district levels to form strategic partnerships with the government and other CSOs that contribute to national and district level ECD policy dialogues and engagements. Plan Uganda also builds awareness amongst key stakeholders of the importance of ECCD and strengthens communities' capacities to influence, promote, expand and sustain ECCD programs. Plan Uganda further documents and disseminates the CLAC approach to contribute to the growing evidence based ECCD programming. In this regard, Plan Uganda is a suitable partner for Action Aid in Uganda to work with on unpaid care work programmes that relieve women of the burden of caring for pre-school children and free their labour time to engage in other productive activities.

3.2.1 Impact of Plan Uganda's ECCD Project on Women's Unpaid Care Work

Plan Uganda's project manager for the ECCD project confessed that although Plan Uganda has never computed the amount of time spent by women on unpaid care work, the ECCD project generally reduced the amount of time spent by women on unpaid care work. For women are the primary socialization and caring agents of children and once caring work is shifted to teachers at the ECCD centers, women's unpaid care work in looking after children is reduced.

3.3 Action for Children

Action for Children (AFC) understands women's unpaid care work as work which women do at home and is not remunerated. According to the Program Manager, AFC, the organisation does not have projects that directly target the lessening of the burden of women's unpaid care work. However, the Program Manager noted that in implementing their projects, they often end up reducing the burden of women's unpaid care work. For example, AFC's Family Preservation Project focuses on strengthening community response to child care. The project imparts onto community members child caring skills such as feeding and maintaining proper hygiene for children. The Program Manager noted that although this may not directly reduce the burden of unpaid care work for women, when children do not fall sick due to healthy environment and good hygienic practices, women are saved the burden of unpaid care work while nursing sick children. The Program Manager added that AFC directs its efforts towards ensuring that children are maintained in school by providing scholastic materials. This reduces the burden of women's unpaid care work of caring for young ones.

In addition to family preservation, AFC provides food supplements to HIV positive children which are often easy to cook i.e. take little cooking time which saves the time spent on cooking. The Program Manager further noted that their community HIV/AIDS preservation, care and

support project targets people within their homes. Together with other partners such as Reproductive Health and Capacity Systems Link Limited, AFC is able to provide HIV testing and counseling and Sexual Reproductive Health services to people from within their communities. Although Family Planning knowledge does not reduce the burden of women's unpaid care work in the short run, in the long run when the women have a manageable number of children, their burden of unpaid caring for children is lessened.

However, the Program Manager noted that women's unpaid care work has not lessened over time due to continued use of poor technologies to accomplish domestic work, existing cultural norms which place the burden of unpaid care work onto women and lack of clear efforts to ensure that the available modern technologies reach the poor. He expounded that women particularly in rural areas continue to use rudimentary methods of cooking and collect water from long distances both of which consume a lot of time. He further added that technologies such as water harvesting, piped water, gas cookers etc have not been widely spread to reach a sizable number of rural community members.

He also explained that cultural norms that are not supportive to the lessening of women's unpaid care work often increase the burden of domestic work to women. He stated that in their program areas of Apac and Lira, men wake up in the morning at about 6:00am to go to the garden to dig with their wives but when they finish at around 10:00am, men go home leaving the women to collect firewood and obtain food. And when women reach home from the fields, they have to fetch water all because these types of work are considered feminine. Even in urban areas where children attend kindergarten at early age, it is women who take them to school in the morning, prepare their meals, ensure that their school uniforms are clean and pick them from school.

3.4 ANPPCAN, Uganda

ANPPCAN, Uganda, implemented an Early Childhood Development (ECD) project aimed at prevention of HIV/AIDS and child abuse through reducing gender related vulnerability to abuse and HIV/AIDS amongst children in Rakai District. The project built capacity of 200 service providers from community based organizations within the project target areas in promoting gender socialization practices that reduce vulnerability of children to HIV/AIDS and child abuse. The project further raised community awareness among 2,500 community members about ECD and equipped 600 caregivers with gender socialisation skills for reducing vulnerability to HIV/AIDS and child abuse. The project was implemented through production and dissemination of information materials, radio talk shows, TV talk shows, radio spots, training workshops and through organizing stakeholders' consultative meetings and lobbying at national level for the formulation of an integrated Early Childhood Development Policy.

The training workshops focused on current gender socialization practices and values that expose children to abuse and HIV/AIDS; ECD and HIV/AIDS; addressing the problems of child abuse and HIV/AIDS through balancing power relations among boys and girls (and later men and women); child rights and ECD; the role of social skills in protection of children; how parents unconsciously impart wrong social skills and values onto their children; the role of the parents in the inculcation of social skills and behaviour amongst children; introduction to the need for inculcating life and social skills onto children; methods of inculcating life skills especially feeling-processing skills, training children to be independent, skills for establishing positive

behaviour, building self esteem amongst children, communication skills and assertiveness; protection of children aged 0-8 from child abuse and neglect; and, case intervention in event of child abuse during the ECD period.

So successful was putting into practice the knowledge and skills parents/guardians had gained about ECD that even caregivers who were not sensitized wished they had been sensitised too and adopting gender role diffusion; for example, they were encouraging girls and boys to go to school and paying fees for both gender, they were encouraging boys to share domestic work with girls etc. Interestingly, gender socialization had rubbed onto adults too. Males were beginning to share domestic work like fetching water and firewood with females.

3.5 Katutandike Foundation

Katutandike Foundation seeks to address the challenges facing market women traders who have young children. Market policies in Kampala do not allow children in markets yet they need their mothers' attention. Where children are allowed in the markets, they are exposed to unsafe environments like being placed into boxes, being placed under market lockers to restrict their movements and/abandonment while their mothers are working. This violates the children's right to play and thus poor development. Katutandike aimed at helping mothers working in markets have good environments for children's growth and development. Katutandike supports ECD centers located around markets by providing support for early learning (play toys, mobile toilet potties, benches, sleeping areas etc) while in turn, the ECD centers enroll children of market women traders at subsidized rates.

Katutandike Foundation works with other stakeholders who include the following:

- a) KCCA which is responsible for setting up ECD centers within markets, interpreting the programme to the market vendors and ensure that the programme is implemented
- b) Market Authorities who enforce and meet the utility bills
- c) Mothers who take turns in playing the caretaker roles at ECD centers on a voluntary basis.

Katutandike Foundation supports the implementation of policy, carries out training and equips the ECD centers.

3.5.1 Challenges Faced

According to the Executive Director, Katutandike Foundation, the organisation faces challenges because they work with privately owned ECD centers and thus have limited control over their (privately owned ECD centers) operations. For example, many market women with little children arrive at the market as early as 4:00am to purchase their merchandise from farmers, but this early, the private ECD centres are yet to open. As a result, Katutandike Foundation has engaged KCCA and market authorities to open up ECD centers within the markets early enough. The Executive Director however added that although it is a KCCA policy to have ECD centers in markets, there is hardly any market with such facilities as yet.

3.5.2 Impact of Katutandike Foundation's ECD Market Project on Women's Unpaid Care Work

Market vending is a demanding job that requires paying a lot of attention to continuously streaming in customers. It is thus difficult to combine with child care. When children are taken to ECD centers, the burden of nurturing is taken over by a knowledgeable person relieving the others the burden of nurturing/caring. In addition, because children are kept in clean and safe environments and are further provided with good nutritional services and other health services such as immunization, their morbidity rates reduce, which also reduces the mothers' burden of caring for sick children.

3.5.3 Area of Coverage

The Katutandike ECD project covers the area of Kampala particularly Nakawa, Kalerwe and Kamwokya markets and are in final stages of implementing the project in the fishing communities.

The Executive Director, Katutandike Foundation, suggested some technologies that can lessen the burden of women's unpaid care work. These include:

- Energy saving stoves built using locally made materials and permanently stationed in one location. They emit little smoke and consume smaller amounts of fire wood compared to the traditional 3 stone fire hearth. These stoves do not require the woman to sit near them to regulate the amount of fire required, hence women can combine cooking with other work.
- Brickets: These are charcoal like fuel that are made out of waste material like banana peels and are used on charcoal stoves.
- Boreholes enable women to collect water not from far distances.
- Water tanks for harvesting water
- Solar energy.

The Executive Director however advised that in order to have real impact on reducing the burden of women's unpaid care work, a lot of sensitization must be undertaken about the importance of sharing domestic work and adopting labour saving technologies. Further, that higher institutions of learning should be encouraged to develop innovations aimed at lessening the time burdens of unpaid care work such as cooking, washing and food preservation.

3.6 Victorious Kindergarten and Day Care Center, Central Branch

Whereas Katutandike Foundation is a private not for profit organisation, Victorious Kindergarten and Day Care Center is a private for profit organisation offering near similar services as Katutandike Foundation. It was therefore important to equally document the services of a private but for profit organisation in as far reducing women's unpaid care work is concerned.

According to the Headmistress, Victorious Day Care Center provides day care services to children aged 3 years and above while for children aged below 3, day care services can be arranged under special arrangement with the parents. Services offered include day care services on week days, weekends and holidays. Parents more especially those engaged in business often leave their children with the Day Care Center when they are away on business trips.

Fees charged for day care services vary with the duration of service required and age of child. For children aged below 3 years, day care charges are negotiable between the headmistress and parents. However, charges for children aged below 3 years are high because the children need much more care and attention compared to those aged above 3 years. Children on full day care services are charged 580,000/= per term which covers tuition, meals and scholastic materials. The term consists of 3 months and full day care services cover only working days.

According to the headmistress, day care work relieves mothers of nurturing and caring responsibilities which allows them to fully participate in paid work. The headmistress noted that mothers working for pay cannot effectively balance caring for children and working for pay; often, women particularly those engaged in business put their children in a corner or box and attend to their businesses. Children are ignored and thus their brains do not develop like those of children exposed to early learning through more interaction with the mother/caretakers. In addition, the headmistress said that day care services provide safety and security to children and because parents know that their children are safe and secure, they concentrate more on their work. She added that at her school/day care centre, both men and women participate in bringing children to the school/day care centre in the mornings but in the afternoons or evenings, other people are sent to pick the children and the majority of these are females who are mainly relatives to the parents and maids.

3.7 Heifer International, Uganda

Heifer International, Uganda, promotes the use of biogas energy through a programme called the Uganda Domestic Biogas Program (UDBP). The program aims at improving the livelihood and quality of rural and peri-urban farmers in Uganda through utilization of biogas energy. The program targets small holder farmers practicing diary and piggery farming. According to the Programs Officer, Heifer International, Uganda, biogas is a cheaper source of energy for cooking and lighting in rural homes compared to firewood, charcoal and kerosene, whose use leads to environmental degradation through cutting trees and emission of harmful gasses. The Programme Officer explained that a family of four using a 9m³ biogas digester for cooking can be able to save over 100,000/= per month. The Programme Officer added that when using biogas, cooking can be done in a shorter time and moreover in a clean and smoke free environment with less health risks such as cancer, respiratory complications and eye problems related to use of firewood and charcoal. For example, the Programme Officer said that cooking time for beans can be reduced from one hour to 30 minutes when using biogas.

As a result, women are left with more time for income generating activities while school going children can have more time for revision and moreover on a brighter biogas lamp. The Programme Officer added that due to the use of biogas, men and boys can participate in cooking thus lessening women's time spent on cooking. However, when asked if they have ever estimated the time taken to accomplish other tasks related to biogas usage like feeding and

cleaning the digester and collecting cow dung, the Programme Officer said that though it takes some amount of time to produce biogas, their program has never estimated the time spent on the work related to biogas production.

The Programme Officer further added that biogas does not only lessen the time for cooking but also improves hygiene; use of bio-toilets highly improves hygiene because such toilets do not emit bad smells and do not attract flies. Further, that bio-toilets do not fill up, hence the contents cannot seep through walls and floors of digesters which protects the water table from filth. By improving sanitation and hygiene, the Uganda Domestic Biogas Program inadvertently reduces women's burden of unpaid care work for taking care of the sick.

3.8 The Impact of the Programme on Women's Unpaid Care Work

The use of modern cooking technologies such as energy saving stoves, bricks and biogas within households reduces the time spent on fetching fuel wood and cooking and also attracts men's and boys' participation in cooking. This reduces women's time spent in cooking thus saving time for participating in productive work. It should be noted that when women allocate their time to productive work, their incomes are often allocated to improving family members' welfare which in turn improves the health of household members. In addition, the fact that such technologies keep kitchens and the entire homes clean improves hygiene and ultimately, the health status of household members. Improved health status of the household members does not only increase the productivity of the household but also lessens the would-be burden to women and girls of caring for the sick.

Other development partners and CSOs working in energy provisioning include UNDP, GIZ and Wild Wide Fund (WWF) for Nature.

3.9 Kampala City Council Authority (KCCA) Central Division

Interviews held with the Medical Officer, KCCA, Central Division, elicited that donors have been supporting KCCA to provide communal water stand pipes in poor communities especially in Kisenyi zones 1, 2 and 3, Kamwokya zones 1, 2 and 3, and Old Kampala, Kagugube zone. In addition to providing safe water, these provisions also inadvertently reduced the extended time burdens faced by family members who collect water from distant locations. The Medical Officer however observed that many community members did not use water from those stand pipes due to user fees charged. The Medical Officer explained that majority of the poor community members found it difficult to pay 100/= per 20 litre jerrycan of water fetched from stand pipes and instead fetched water from protected and unprotected springs where water was freely available. Yet, water from unprotected springs is often contaminated with faecal material hence a threat to health due to water borne diseases. Paradoxically, most families that cannot afford paying 100/= per 20 liter jerrycan of stand pipe water are the poor who simultaneously resort to self medication when sick; they only seek professional medical services when illnesses worsen which prolongs lengths of sickness in their households. This adds additional burdens of unpaid health/nursing care work to women in such households.

In effort to reduce prevalence of disease arising from poor sanitation amongst poor communities in Kampala City, the Belgian government through the Kampala Integrated Environmental Management Project (KIEMP) constructed community toilets. The toilets are managed by user

committees which are simultaneously entrusted with their maintenance. However, the Medical Officer, KCCA, noted that although user fees are charged on monthly basis, often the money is embezzled which leads to poor maintenance, which in turn keeps the toilets very dirty, a factor that increases community exposure to diseases.

3.10 Kisenyi Health Center IV

The officer in-charge, Kisenyi Health Center IV, said that the most demanded health services at the health centre are antenatal care services, family planning services and child related health services. The in-charge added that the biggest number of patients are children who are often brought by women, further underscoring the role of women (the mothers and female relatives) in caring for the sick. She added that on average, each staff attends to over 200 patients a day. Further, the in-charge noted that women caretakers wait in queues for long hours to be attended to while those from poor households often cannot afford to buy drinks for sick children while waiting to be attended to. Others beg for transport fare back home from health workers who in most cases cannot provide it because they earn very little salary. The in-charge further added that because women have to go back home and perform domestic chores, they are always worried when they spend long at the health unit waiting to be attended to. She further explained that often men beat women when they find household chores not done e.g. when they find food not ready, the house is dirty, clothes not ironed etc irrespective of whether they had to take the child to the health unit. The worries and fears of men's reaction make women susceptible to health problems such as high blood pressure, according to the in-charge. Thus, there is need for sensitization about the importance of sharing domestic work amongst men and women if the women's unpaid care work burden is to be reduced. The in-charge also added that more health workers need to be recruited in order to shorten the time women spend at the health unit. She further suggested the need to find ways of reducing on drug stock outs at health units which cause women to visit the health unit several times checking whether the drugs are available.

3.11 Uganda Bureau of Statistics (UBOS)

UBOS computes time spent on unpaid care work by persons aged 14-64. This includes collecting firewood and fetching water (including travel time), construction of own dwelling/farm building, milling and other food processing activities etc (Republic of Uganda 2010f). The Principal Statistician, UBOS, explained that UBOS broadly categorizes work into two; economic and non-economic work where by non-economic work is work that benefits the household but does not earn direct income to the one doing it. The Principal Statistician further explained that during Household Surveys, UBOS investigates the number of hours spent weekly on unpaid care work but do not compute its monetary value. The Principal Statistician added that UBOS does not suggest any recommendations for reducing burdens of unpaid care work. According to the Uganda National Household Survey (Republic of Uganda 2010f), women spend longer hours than men carrying out unpaid care work because men generally engage less in domestic work. Rural residents also spend more time on unpaid care work (26%) compared to 10% of their urban counterparts (ibid).

3.12 Programmes at District and Sub County Levels for Reducing Women's Unpaid Care Work

Interviews with Pallisa district and sub county technical staff revealed that although all the staff had not heard of the concept "women's unpaid care work", they all had an understanding of it;

all said that it is work done by women within households but is not paid for and is not recognized as work within households and communities. Examples given included visiting health centers, collecting fire wood, serving eats and drinks to visitors, cooking, bathing children etc. Asked how unpaid work affected women's health, all district and sub county staff said that it reduces rates of antenatal attendance, caused fatigue, stress, headaches, backaches, respiratory complications etc. Only two out of the ten district and sub county technical staff interviewed said that unpaid care work had no effect on women's capacity to engage in productive activities. The rest of the staff reported that because of unpaid care work, women had less time to engage in productive work. Other staff said that even when women do engage in productive work, they concentrate less, hence, less productivity and output.

The two staff who were of the view that unpaid care work had no effect on women's capacity to engage in productive activities justified it by saying that unpaid care work was part of the roles of females in society and was therefore for mutual co-existence. They added that women do not do all the work alone within households; they are given a helping hand but convention has it that only women who do household work which is not true. It was added that unpaid care work is not done all the time; there is time for other activities if one really wants to undertake them but because of poverty, there is no extra income to invest in other productive activities.

With regard to existence of district/sub county level departmental policies/programs/projects for reducing the work burdens of women's unpaid care work, nine of the ten interviewed staff said that none existed. Only the sub county chief, Katiriyo, Sub County, mentioned gender mainstreaming, Community Driven Development (CDD) programmes and local government management service delivery (LGMSD) programmes for constructing roads, rehabilitating bore holes, supporting income generating activities etc. as having the potential for reducing the burden of unpaid work for women.

Six of the ten staff interviewed said that their departments did not have any labour saving technologies for reducing the work burdens of women's unpaid care work. The four staff who answered in affirmative mentioned energy saving stoves, public grinding machines, cassava chippers and groundnuts shellers. It was however noted that adoption of energy saving technologies was slow because people still do not know how to use and/or to construct them. There were also preference problems because people believed that food cooked on these stoves tasted differently from that cooked over traditional three stone fire hearths.

Expectedly, none of the technical staff interviewed had ever quantified the the amount of time women put into unpaid care work. One interviewee was actually irritated by the concept and retorted thus:

the concept is very complex..... we quantify.... then what do we do with the results.....it is like we consider women to do a lot of work without any assistance..... if you quantify something, then we need to find out how to pay for the services

Pallisa District NAADS Coordinator

Again, none of the staff interviewed had ever quantified into monetary terms the amount of time women put into unpaid care work.

Amongst the recommendations made for reducing the burdens imposed on women by unpaid care work were introduction of small scale but modern labour saving technologies, sharing care responsibilities amongst household members and hiring labour. Marrying another wife(s) and having many children were also recommended by one technical staff.

Asked what challenges could be faced in attempting to reduce the burden of unpaid care work at individual, household and community levels, district and sub county technical staff mentioned several:

- Resistance from women who would think that their traditional gender roles are getting usurped
- Fear of gossiping about men who help with care work
- Ridicule from parents, in-laws and community members as one who is bewitched
- Shame and stigma from community members
- Fear that men will not have time to perform roles that define them masculine
- Fear that work may not be done in time within homes because women will relax

Suggestions made for addressing the challenges included:

- Sensitization about the importance of sharing care responsibilities
- Sensitizing communities to change their attitudes towards helping women with unpaid care work within homes
- Encouraging children to help their families
- Incorporating unpaid care work within school curricula such that children grow up knowing the value of females' unpaid care work
- Adjusting the school time table to enable children first help with care work at home and then go to school e.g. school could start after 9:00 am and end at 3:00 pm so that children can have time to rest after school and later, participate in unpaid care work

With regard to recommended suggestions to government for reducing the burden of unpaid care work on girls and women, the following were made by district and sub county staff:

- Passing policies that can help reduce women's time, for example time spent at health

centers

- Investing in, and promoting labour saving technologies
- Building more social and physical infrastructure
- Recognising women's contributions in unpaid care work
- Recruitment of more staff in health units
- Introduction of Functional Adult Literacy programmes within communities that highlight burdens of unpaid care work
- Promoting rural electrification, but it should be affordable

The following challenges were anticipated in government's attempts to reduce the burden of unpaid care work:

- Government is not supportive of such programs; unpaid care work is not amongst the government priorities
- The government is very slow/bureaucratic in implementing programmes
- Lack of funding

3.13 Estimation of the Monetary Value of Women's Unpaid Care Work

Since neither the district and sub county technical staff nor the Uganda Bureau of Statistics had ever quantified into monetary terms the amount of time women put into unpaid care work, it was imperative that this study conducts the estimation. This would be helpful in recognizing the monetary value of women's unpaid work and in putting the burdens it bestows onto women and girls into public consciousness, thus generating public debate on the need for its redress including the attendant resource requirements.

The estimation was conducted in 17 major activities which action Aid in Uganda considers the core of women's unpaid care work. The activities are: subsistence agriculture; home-based careering; collecting firewood; collecting water; preparing food/cooking; cleaning the house; washing clothes; shopping; feeding a child; bathing and dressing a child; playing with a child; helping a child with school work; accompanying a child to school or clinic; being in charge of a child; feeding a disabled, old or sick adult; bathing a disabled, old or sick adult; and, accompanying an adult to health clinic or other public services. The estimation used the would be costs of paying for a service or a good if that service/good had not been provided free of charge by women as part of their unrecognised and unpaid care work. Table 1 overleaf indicates

the monetary value of household level unpaid services and good provided by women as estimated by urban and rural male and female participants and non participants in Action Aid in Uganda's community organising project.

Table 1 shows that subsistence agriculture had the highest average monetary value of UGX 4,000; monetary costs were higher in urban areas averaging UGX 8,500 while the rural average was UGX 4,000. This is consistent with the higher costs of wage labour in urban areas. subsistence agriculture was followed by accompanying an adult to health clinic or other public services that was estimated at UGX 2,412. Although this work is not carried out on a daily basis, it is often carried out by women when occasions do arise, and the costs are transport in nature. Washing clothes had the lowest monetary value of UGX 260 followed by collecting water at UGX 812. The monetary value was higher in urban areas compared to rural areas. Overall, for the 17 activities constituting women's unpaid care work, the average daily monetary value was UGX 25, 895, approximately US \$ 10.

Table 1: Estimated Daily Monetary Values of Household Level Services and Good Provided by Women’s Unpaid Care Work

	Urban				Rural				Average Costs
	Male Participant	Female Participant	Male Non Participant	Female Non Participant	Male Participant	Female Participant	Male Non Participant	Female Non Participant	
Activity	Estimated Daily Costs in UGX				Estimated Daily Costs in UGX				
Subsistence agriculture	7,000	10,000	N/A	N/A	4,000	3,000	4,000	4,000	4,000
Home-based carer	2,000	3,000	2,000	1,750	800	1,000	2,500	1,200	1,781
Collecting firewood	2,500	3,000	N/A	3,000	2,000	1,500	1,500	2,000	1,937
Collecting water	1,500	1,500	800	1,000	200	500	400	600	812
Preparing food/cooking	2,100	1,850	2,500	2,000	1,750	500	3,000	1,000	1,837
Cleaning the house	1,800	1,300	1,800	1,000	2,400	400	600	500	1,225
Washing clothes	300	180	450	200	300	200	250	200	260
Shopping	1,500	1,300	1,000	750	900	750	800	600	950
Feeding a child	2,000	2,000	1,000	1,000	600	500	500	500	1,012
Bathing and dressing a child	1,750	1,500	1,000	1,750	400	500	400	300	950

	Urban				Rural				Average Costs
	Male Participant	Female Participant	Male Non Participant	Female Non Participant	Male Participant	Female Participant	Male Non Participant	Female Non Participant	
Activity	Estimated Daily Costs in UGX				Estimated Daily Costs in UGX				
Playing with a child	1,750	2,000	1,500	1,000	500	350	500	350	994
Helping a child with school work	2,200	2,500	2,000	2,000	900	500	1,900	550	1,562
Accompanying a child to school or clinic	2,000	2,000	2,000	2,000	1,000	600	700	600	1,362
Being in charge of a child	2,500	2,000	2,000	2,500	600	600	700	600	1,437
Feeding a disabled, old or sick adult	3,000	2,500	2,500	2,500	750	1,000	1,000	700	1,733
Bathing a disabled, old or sick adult	4,000	2,800	2,500	1,500	500	500	500	750	1,631
Accompanying an adult to health clinic or other public services	2,500	2,500	2,000	1,500	3,500	2,000	3,500	1,800	2,412
Total Average Estimated Daily Monetary Value of Women's Unpaid Care Work Within a Household									25, 895

The monthly monetary values of women's unpaid care work amounted to UGX 776,850, approximately US \$ 302 as illustrated in Table 2. Admittedly, not all activities are carried out on a daily basis though most are. However, for purposes of uniformity, we computed monetary values for all the activities.

Table 2: Estimated Monthly Monetary Values of Household Level Services and Good Provided by Women’s Unpaid Care Work

	Urban				Rural				Average Costs
	Male Participant	Female Participant	Male Non Participant	Female Non Participant	Male Participant	Female Participant	Male Non Participant	Female Non Participant	
Activity	Estimated Monthly Costs in UGX				Estimated Monthly Daily Costs in UGX				
Subsistence agriculture	210,000	300,000	N/A	N/A	120,000	90,000	120,000	120,000	120,000
Home-based carer	60,000	90,000	60,000	52,500	24,000	30,000	75,000	36,000	53,437
Collecting firewood	75,000	90,000	N/A	90,000	60,000	45,000	45,000	60,000	58,125
Collecting water	45,000	45,000	24,000	30,000	6,000	15,000	12,000	18,000	24,375
Preparing food/cooking	63,000	55,500	75,000	60,000	52,500	15,000	90,000	30,000	55,125
Cleaning the house	54,000	39,000	54,000	30,000	72,000	12,000	18,000	15,000	36,750
Washing clothes	9,000	5,400	13,500	6,000	9,000	6,000	7,500	6,000	7,800
Shopping	45,000	39,000	30,000	22,500	27,000	22,500	24,000	18,000	28,500
Feeding a child	60,000	60,000	30,000	30,000	18,000	15,000	15,000	15,000	30,375
Bathing and dressing a child	52,500	45,000	30,000	52,500	12,000	15,000	12,000	9,000	28,500

	Urban				Rural				Average Costs
	Male Participant	Female Participant	Male Non Participant	Female Non Participant	Male Participant	Female Participant	Male Non Participant	Female Non Participant	
Activity	Estimated Monthly Costs in UGX				Estimated Monthly Costs in UGX				
Playing with a child	52,500	60,000	45,000	30,000	15,000	10,500	15,000	10,500	29,812
Helping a child with school work	66,000	75,000	60,000	60,000	27,000	15,000	57,000	16,500	47,062
Accompanying a child to school or clinic	60,000	60,000	60,000	60,000	30,000	18,000	21,000	18,000	40,875
Being in charge of a child	75,000	60,000	60,000	75,000	18,000	18,000	21,000	18,000	43,125
Feeding a disabled, old or sick adult	90,000	75,000	75,000	75,000	22,500	30,000	30,000	21,000	52,312
Bathing a disabled, old or sick adult	12,000	84,000	75,000	45,000	15,000	15,000	15,000	22,500	35,437
Accompanying an adult to health clinic or other public services	75,000	75,000	60,000	45,500	105,000	60,000	105,000	45,000	71,312
Total Average Estimated Monthly Monetary Value of Women's Unpaid Care Work Within a Household									776,850

The annual monetary values of women's unpaid care work are indicated in Table 3 below. They amount to UGX 9,322,200, approximately US \$ 3,624 which is 7 times the per capita income of Uganda of US \$ 506. Women's unpaid care work therefore has a very high monetary values for should be recognized in national statistics and used to lobby for addressing the burdens it

imposes on women.

Table 3: Estimated Annual Monetary Values of Household Level Services and Good Provided by Women's Unpaid Care Work

	Urban				Rural				Average Costs
	Male Participant	Female Participant	Male Non Participant	Female Non Participant	Male Participant	Female Participant	Male Non Participant	Female Non Participant	
Activity	Estimated Annual Costs in UGX				Estimated Annual Costs in UGX				
Subsistence agriculture	2,520,000	3,600,000	N/A	N/A	1,440,000	1,080,000	1,440,000	1,440,000	1,440,000
Home-based carer	720,000	1,080,000	720,000	630,000	288,000	360,000	900,000	432,000	641,250
Collecting firewood	432,000	1,080,000	N/A	1,080,000	720,000	540,000	540,000	720,000	730,286
Collecting water	540,000	540,000	288,000	360,000	72,000	180,000	144,000	216,000	292,500
Preparing food/cooking	756,000	666,000	900,000	720,000	630,000	180,000	1,080,000	360,000	661,500
Cleaning the house	54,000	39,000	54,000	30,000	72,000	12,000	18,000	15,000	36,750
Washing clothes	9,000	5,400	13,500	6,000	9,000	6,000	7,500	6,000	7,800
Shopping	45,000	39,000	30,000	22,500	27,000	22,500	24,000	18,000	28,500
Feeding a child	720,000	720,000	360,000	360,000	218,000	180,000	180,000	180,000	364,750
Bathing and dressing a child	630,000	540,000	360,000	630,000	144,000	180,000	180,000	1,080,000	468,000

	Urban				Rural				Average Costs
	Male Participant	Female Participant	Male Non Participant	Female Non Participant	Male Participant	Female Participant	Male Non Participant	Female Non Participant	
Activity	Estimated Annual Costs in UGX				Estimated Annual Costs in UGX				
Playing with a child	630,000	720,000	540,000	360,000	180,000	126,000	15,000	10,500	322,687
Helping a child with school work	66,000	75,000	60,000	60,000	27,000	180,000	684,000	198,000	168,750
Accompanying a child to school or clinic	720,000	720,000	720,000	720,000	360,000	216,000	252,000	216,000	490,500
Being in charge of a child	900,000	720,000	720,000	900,000	216,000	216,000	252,000	216,000	517,500
Feeding a disabled, old or sick adult	1,080,000	900,000	700,000	900,000	270,000	360,000	360,000	252,000	602,750
Bathing a disabled, old or sick adult	252,000	1,008,000	900,000	540,000	180,000	180,000	180,000	270,000	438,750
Accompanying an adult to health clinic or other public services	900,000	900,000	720,000	546,000	1,260,000	720,000	1,260,000	540,000	855,750
Total Average Estimated Annual Monetary Value of Women's Unpaid Care Work Within a Household									9,322,200

Section Four: Conclusions and Recommendations

4.1 Conclusions

This policy scoping study sought to answer the following research question: what policy interventions are needed to recognise, reduce and redistribute unpaid care work? To answer the research question, the study had to establish the nature of existing programs, policies and/or interventions that may have an impact on unpaid care work; their geographical coverage; their implementation mechanisms; and, ascertain national level civil society organisations that Action Aid can work with on unpaid care work related to the existing different programs, policies and/or interventions established. The study adopted largely qualitative research designs in collection and analysis of secondary and primary (key informant) data.

The study revealed that Uganda lacks national policies specifically designed for reducing the burdens of women's unpaid care work. Nonetheless, there are a number of policies which although not designed to specifically reduce the burden of women's unpaid care work, their implementation inadvertently reduces the burden. The national policies are spread across different sectors including the MoGLSD, NCC, MoH, MoES, MoLGS, MoLWE and MoEM.

Unpaid care work and the burdens it imposes on women and girls arises from unequal gender relations in societies which accord males higher social status while females are accorded lower social status. The unequal gender relations further restrict females to the private sphere within households while males work within the public sphere beyond households. Yet, work within the private sphere is not economically valued and is not prestigious. Aware of the unequal gender relations in society, of the Government of the Republic of Uganda formulated the Uganda Gender Policy (UGP) in 1997 which was revised in 2007 to spearhead actions that could bring about more equal gender relations. Amongst the specific policy strategies for reducing gender inequalities are developing and promoting labour and time saving technologies for poor women and men and developing strategies to eradicate the child labour incidence, particularly the exploitation of the girl child. These strategies have bearing on reducing the burden of unpaid care work undertaken by women and girls. The UGP further tasks Ministry of Finance, Planning and Economic Development with monetizing the contribution of the care/domestic economy of women's and men's contribution in the national accounts. This could help in advocacy for recognizing the significance of unpaid care work, women's and girls' contribution there-in, the constraints unpaid care work imposes on women and girls' productivity, education, skills acquisition and income generation. It would further help in providing a rationale for developing, disseminating and adopting technologies aimed at reducing the burden of women's unpaid care work and redistributing care responsibilities within households and communities amongst both genders.

Government also formulated the National Integrated Early Childhood Development Policy Framework aimed at addressing the health care, nutrition, emotional, psycho-social stimulation, sanitation and hygiene, protection and cognitive development needs of children aged 0-8 years. Taking care of this age group is socio-culturally a responsibility of women and girls, which within households and community settings is not remunerated, thus part and parcel of women's unpaid care work. The National Integrated Early Childhood Development Policy Framework delineates implementation responsibilities for the educational, health, social development, water and environment and agricultural sectors. The targets of the Policy Framework include all children

including orphans and vulnerable children and children with disabilities from conception to age eight and parents, teachers and other caregivers who provide care for children including grandparents, relatives and others within home settings. A Draft Action Plan has been developed to guide the implementation of the National Integrated Early Childhood Development Policy. Given its holistic nature, implementation of the National Integrated Early Childhood Development Policy has potential for reducing the burdens of women's unpaid nurturing work for it would reduce the time and resources women spend in nursing and socializing children and in providing food, water, fuel wood etc required in nurturing children.

The Education Sector has developed its own Early Childhood Development Policy aimed at providing guidance for optimal holistic development of healthy and productive children aged between 0-8 years as well as enhancing partnerships that promote holistic approaches to early childhood development and effective learning/teaching processes appropriate to that age group. The ECD policy primarily targets young children and ECD service providers especially parents, teachers, nursery nurses etc. However, ECD facilities such as ECD centres, nursery schools, kindergartens and day care centres are largely in the hands of private sector and CSOs. In places where CSOs are not providing ECD services, access to the services is limited to children from rich and middle income urban based families that can afford the costs of private sector provided services; paying school fees, buying uniforms and transporting children to nursery/ day care centers. Majority urban poor and rural children are excluded thus transferring the care burdens to women who are not paid for the work.

The National Development Plan of Uganda does acknowledge that women are the main health care providers in the households. This implies that women do carry the added burden of unpaid health care work within households. Yet, the National Health Policy notes that seventy five percent of the disease burden in Uganda can be prevented through health promotion and prevention because the major determinants of ill health in Uganda are lack of access to safe water, poor sanitation and living conditions especially in rural areas and urban slums. Amongst the guiding principles of the National Health Policy is gender sensitivity. It is stated that a gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs. The policy further notes that prevalence of diarrhoea, ARIs and fever amongst children aged under-five decreases with the increases in educational levels attained by mothers, indicating that prevalence of preventable diseases is indeed a gender issue. However, these are the only references made to gender in the policy. Preventive care could therefore not only reduce the burden of disease by 75% but would also reduce the burden of women's unpaid care work.

The burden of women's unpaid health care work is heightened by promotion of the home based care approach for care for the persons living with AIDS at the community level which ostensibly has the advantage of relieving the already over strained health facilities. The National HIV and AIDS Strategic Plan, 2007/8 – 2011/12, is however cognisant of the fact that women bear the brunt of caring for sick family members. The strategic plan is also aware of the growing burden of orphans to be cared for and the overstretched culture of extended family support and fostering by the elderly such that adolescents are sometimes becoming heads of families or being lost to life on the street. Most of the adolescents who become heads of families are females. Nonetheless, although Goal 3 of the National HIV and AIDS Strategic Plan, 2007/8 – 2011/12, is to mitigate the social, cultural and

economic effects of HIV and AIDS at individual, household and community levels, none of its priority areas of action address the burdens of unpaid nursing care work imposed on women and girls by HIV/AIDS. Similarly, the National Home Based Care Policy Guidelines for HIV/AIDS do not address the burden of women's unpaid health/nursing care work, cognizance of the fact that majority of home based care givers and volunteers are women notwithstanding.

The Uganda National Malaria Control Policy recognizes malaria as one of the most debilitating diseases in Uganda in terms of morbidity, mortality and economic losses. The goal of malaria control policy is therefore to control and prevent malaria morbidity and mortality, as well as to minimize social effects and economic losses attributable to malaria. This would play a crucial role in reducing the burden of women's unpaid health/nursing care work of malaria patients.

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights acknowledges birth spacing as essential for promoting the health of mothers, children and fathers. The policy therefore aims at increasing access to quality, affordable, acceptable and sustainable family planning services to everyone who needs them and promotion of strong integrated FP information and services in the health sector at all levels and within various sectors. Although the policy puts emphasis on males' involvement, most of the FP methods target women which consumes a lot of women's time more especially the time they spend lining up for FP services in Health Units. In addition to poor implementation of the policy mainly due to negative cultural practices and limited resources, time constraints have resulted into poor health of mothers and children, often increasing the burden of unpaid nursing care work to women and girls.

The National Water Policy recognizes the essential role of women in the provision, management and safeguarding of water and emphasises women's participation in institutional development. The Policy further recognizes women's important role in improved health of their families and in changing the behavior of children. The policy therefore encourages women's involvement in health promotion. Furthermore, the policy stipulates service criteria for availing enough safe water within reasonable distances in urban and rural areas. Since its women who are mostly involved in water collection, these service criteria reduce the burden of water collection.

Uganda's Energy Policy states that biomass (firewood, charcoal and crop residues) constitutes over 90% of total energy consumption but the traditional energy technologies (wood and charcoal stoves and charcoal production kilns) used in Uganda are inefficient. Thus, sensitizing women on energy source and technology choices in order to reduce the labour and health burdens associated with biomass energy use is one of the policy strategies. This would reduce the burden of fuel wood collection, which is largely unpaid work performed by women and girls.

The National Policy on Disability in Uganda points out that the burden of care for PWDs falls mostly on women. The burden of care for PWDs is not helped by one of the guiding principles of the policy which states that the family is the basic unit for providing care and support to PWDs. Hence, it is the responsibility of parents or caregivers to PWDs to provide food, clothing, housing, love, care, education, health and other basic services that promote and protect the rights of PWDs. The policy is silent on what resources caregivers should use to provide care to PWDs, including limitations on care givers', especially women and girls' time.

The Uganda National Policy for Older Persons points to financial, food security and health vulnerabilities of the elderly and the policy recognizes the family as the primary source of care and support to older persons. The policy however does not explicitly mention the support the family is provided with to care for the elderly. Neither does the policy mention the added burdens of unpaid care work undertaken by women in caring for the elderly nor how the burdens could be reduced. Nonetheless, the Expanding Social Protection (ESP) programme in Uganda was designed in 2009 provides Senior Citizens Grants of Uganda shillings 23,000 (about US\$8 per month) to older persons of 65 years and above (but 60 years in the case of Karamoja region). The grants are being piloted in the districts of Apac, Kole, Kaberamaido, Katakwi, Moroto, Napak, Nakapiripirit, Amudat, Kiboga, Kyankwanzi, Kyegegwa, Kyenjojo, Nebbi and Zombo. The impact of cash transfers on women's unpaid work are yet to be ascertained.

The National Orphans and Other Vulnerable Children Policy aims at promoting social protection of poor and vulnerable children. The guiding principles of the policy is making the family and community the first line of response. Like National Policy on Disability in Uganda and the Uganda National Policy for Older Persons, the National Orphans and Other Vulnerable Children Policy recognizes the family as the basic unit for the growth and development of children. Unfortunately, like the other two policies, the National Orphans and Other Vulnerable Children Policy does not have any strategies for reducing the burden of women's unpaid work in caring for orphans and other vulnerable children.

The Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15, recognises the dominance of women in the agricultural sector and further acknowledges that a substantial amount of women's time is taken up in providing care work. However, the Agriculture Sector Development Strategy and Investment Plan, 2010/11-2014/15, focuses more on increasing women's agricultural productivity than reducing their unpaid care work labour burdens. Thus, one of the strategies and investment programmes of the agriculture sector focuses on labour saving technologies and mechanization, particularly, oxen and ploughs and tractors. Since society considers unpaid care work as "naturally" suited for women, reduction of its burdens is least likely to be the reason for mechanization. In fact, mechanization is likely to increase women's labour burdens for large areas are likely to be opened up, thus increasing the time spent in weeding, harvesting and processing (all predominantly women's roles), unlike concomitant technologies like simple mechanical planters, weeders, harvesters and processors are equally developed and adopted.

Uganda currently lacks a policy governing paid domestic care work carried out by maids who are informally employed within households especially in urban areas. However, Government is in the process of establishing a policy and legal framework to address the plight of domestic workers in the country. Under the policy, government will set up professional standards, a monitoring mechanism and develop an effective registration system for domestic workers.

There are several Civil Society Organisations carrying out work related to women's unpaid care work that Action Aid in Uganda could work with on the different policy areas discussed above. Amongst these is Plan Uganda which is implementing an Early Childhood Community Development (ECCD) project called the Community Led Action for Children (CLAC) whose goal is to enable children enjoy their right to a good and healthy start in life. The project is

implemented in the districts of Luwero, Lira, Alobtong, Kamuli, Tororo and Kampala and particularly focuses on poor communities.

Another CSO is Action for Children whose Family Preservation Project focuses on strengthening community response to child care. Although the Family Preservation Project does not directly target the lessening of the burden of women's unpaid care work, it does end up reducing the burden of women's unpaid care work. For example, the project imparts onto community members child caring skills such as feeding and maintaining proper hygiene for children. Thus, when children do not fall sick due to healthy environment and good hygienic practices, women are saved the burden of unpaid care work while nursing sick children. AFC also directs its efforts towards ensuring that children are maintained in school by providing scholastic materials. This reduces the burden of women's unpaid care work of caring for young ones.

ANPPCAN, Uganda, implemented an Early Childhood Development (ECD) project aimed at prevention of HIV/AIDS and child abuse through reducing gender related vulnerability to abuse and HIV/AIDS amongst children in Rakai District. So successful was putting into practice the knowledge and skills parents/guardians had gained about ECD that even caregivers who were not sensitized wished they had been sensitised too and adopting gender role diffusion; for example, they were encouraging girls and boys to go to school and paying fees for both gender, they were encouraging boys to share domestic work with girls etc. Interestingly, gender socialization had rubbed onto adults too. Males were beginning to share domestic work like fetching water and firewood with females.

Katutandike Foundation seeks to address the challenges facing market women traders who have young children. Katutandike helps mothers working in markets to have good environments for children's growth and development through supporting ECD centers located around markets by providing support for early learning (play toys, mobile toilet potties, benches, sleeping areas etc) while in turn, the ECD centers enroll children of market women traders at subsidized rates. The Katutandike ECD project covers the area of Kampala particularly Nakawa, Kalerwe and Kamwokya markets and are in final stages of implementing the project in the fishing communities.

Victorious Kindergarten and Day Care Center represents private for profit organisations offering near similar services as Katutandike Foundation. Victorious Day Care Center provides day care services to children aged 3 years and above while for children aged below 3, day care services can be arranged under special arrangement with the parents. Services offered include day care services on week days, weekends and holidays. Parents more especially those engaged in business often leave their children with the Day Care Center when they are away on business trips. Day care services relieve mothers of nurturing and caring responsibilities which allows them to fully participate in paid work.

Heifer International, Uganda, promotes the use of biogas energy through a programme called the Uganda Domestic Biogas Program that aims at improving the livelihood and quality of rural and peri-urban farmers in Uganda through utilization of biogas energy. Using biogas, cooking can be done in a shorter time and in a clean and smoke free environment with less health risks such as cancer, respiratory complications and eye problems related to use of firewood and charcoal.

Improved health status of the household members does not only increase the productivity of the household but also lessens the would-be burden to women and girls of caring for the sick. It also reduces the time spent in collecting fire wood.

All Pallisa district and sub county technical staff had an understanding of the concept “women’s unpaid care work”, but nine of the ten interviewed staff said that there were no district/sub county level departmental policies/programs/projects for reducing the work burdens of women’s unpaid care work. Neither the district and sub county technical staff nor the Uganda Bureau of Statistics had ever quantified into monetary terms the amount of time women put into unpaid care work. It was therefore imperative that this study conducts the quantification. This would be helpful in recognizing the value of women’s unpaid work and in putting the burdens it bestows onto women and girls into public consciousness, thus generating public debate on its redress including the attendant resource needs.

Subsistence agriculture had the highest average monetary value of UGX 4,000; monetary costs were higher in urban areas averaging UGX 8,500 while the rural average was UGX 4,000. This is consistent with the higher costs of wage labour in urban areas. Subsistence agriculture was followed by accompanying an adult to health clinic or other public services that was estimated at UGX 2,412. Overall, for the 17 activities constituting women’s unpaid care work, the average daily monetary value was UGX 25, 895, approximately US \$ 10. The monthly monetary value of women’s unpaid care work amounted to UGX 776,850, approximately US \$ 302 while the annual monetary values of women’s unpaid care work are indicated in Table 3 below. They amount to UGX 9,322,200, approximately US \$ 3,624 which is 7 times the per capita income of Uganda of US \$ 506. Women’s unpaid care work therefore has very high monetary values for which it should be recognized in national statistics and its significance in the economy acknowledged both of which should be used to lobby for addressing the burdens it imposes on women.

For unpaid care work is physically demanding yet women use rudimentary technologies and in many cases, the work is carried out under poor psychological, sanitation, hygiene and environmental conditions. Combined, the physical demands and poor psychological, sanitation, hygiene and environmental conditions affect women’s health, including reduced rates of antenatal attendance and general health seeking behaviour, cause fatigue, stress, headaches, backaches, respiratory complications etc. The demands and conditions further affect women’s capacity to engage in productive activities and seek skills enhancement opportunities. Since girls are better substitutes for their mothers than boys are for their fathers, their engagement in unpaid care work affects their school enrolment, attendance, performance and completion rates too. This perpetuates the cycle of poverty amongst women who due to fewer skills are condemned to carrying out unpaid care work within the confines of households. It is in this context that the following recommendations are made for policy, programme and project interventions needed to **Recognise, Reduce and Redistribute** unpaid care work.

4.2 Recommendations

Recognising Women's Unpaid Care Work

1. UBOS and the Ministry of Finance, Planning and Economic development should conduct national surveys and document the monetary values of women's unpaid care work to enhance its recognition.
2. Planning and statistics Departments are districts should also conduct district surveys and document the monetary values of women's unpaid care work to enhance its recognition.
3. CSOs, local communities and households should also be equipped with the simple skills for estimating values of women's unpaid care work to bring its monetary values to their active consciousness.
4. Action Aid in Uganda in partnership with CSOs doing work related to reducing the burdens of women's unpaid care work should conduct intense advocacy and lobby for recognition of women's unpaid care work using estimates of its monetary value.

Reducing Women's Unpaid Care Work

5. Social and economic national policies need to appreciate not only the value of women's unpaid care work in their strategies but also appreciate the burdens and constraints the work places onto women and girls.
6. Each social and economic policy needs to be cognizant of the added burdens of unpaid care work it places onto and devise strategies of reducing the burdens.
7. There is need for concerted national and local government and CSO efforts to bring water and cleaner energy sources nearer to households.
8. Agricultural technologies like simple mechanical weeders, planters, harvesters and processors are required for reducing the burdens of women's unpaid care work in small holder agriculture.

Redistributing Women's Unpaid Care Work

9. Stigma attached to males sharing care work needs to be addressed through consciousness awakening within households and communities that enables males to unlearn gendered role behaviour and learn to participate in care work within households.
10. Efforts should also be made to enable women unlearn the gendered role behaviours that legitimize and justify males' exclusion from unpaid care work. This way, females will not feel that males are "invading their domains".
11. Boys should be encouraged very early in life to participate in unpaid care work.

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Appendix I: List of Key Informants Interviewed in Kampala

1. The Assistant Commissioner, Pre-Primary Education, Ministry of Education and Sports
2. The Senior Energy Officer, Ministry of Energy and Mineral Development
3. The Minister of State for the Elderly and Persons with Disabilities, Ministry of Gender, Labour and Social Development
4. The Principal Medical officer-Reproductive, Health Ministry of Health
5. The Programme Assistant-HIV/AIDS Control Programme, Ministry of Health
6. The Ministry of Agriculture, Animal Industries and fisheries
7. The Programmes Manager, Action for Children
8. The Communications Officer, Heifer Uganda
9. The Medical Officer, KCCA, Central Division
10. The Gender Officer, KCCA, KCCA
11. Two Programme Officers, ANPPCAN, Uganda
12. The Executive Director, UBOS
13. The Principal Statistician, UBOS
14. The Secretary General, National Council for Children
15. In-charge, KCCA Kisenyi HC IV
16. The Headmistress, Victorious Kindergarten and Day Care Center
17. The Project Manager, ECCD, Plan-Uganda
18. The Chief Executive Director, Katutandike Foundation
19. The Programme Assistant, Katutandike Foundation
20. The Senior Policy Analyst, Ministry of Water and Environment
21. The Principal Sociologist, Ministry of Water and Environment

Appendix II: List of Key Informants Interviewed in Pallisa District

1. The Community Development Officer, Pallisa
2. District Agricultural Officer, Pallisa
3. District NAADS Coordinator, Pallisa
4. District Veterinary Officer and Extension, Pallisa
5. District Education Officer, Pallisa
6. Staffing Officer, Katiriyo Sub County
7. Sub County Chief, Katiriyo, Sub County
8. Technical Officer, Accounts, Katiriyo Sub County
9. NAADS Officer Sub County, Katiriyo Sub County
10. Sub County NAADS Service Provider, Katiriyo Sub County

