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THE STATE OF THE UGANDAN CHILD:

An Analytical Overview

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Cover photo: A 17-year old mother of two from Kabarole district, orphaned while in primary three, first became pregnant at age 15. The two fathers of her children have abandoned her and do not provide any support.

THE STATE OF THE UGANDAN CHILD: AN ANALYTICAL OVERVIEW

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CONTENTS

TABLES

FIGURES

LIST OF ACRONYMS

ACPF	African Child Policy Forum
ACT	Artemisinin Combination Therapy
ANC	Antenatal Care
ANPPCAN	The African Network for Prevention against Child Abuse and Neglect
ART	Anti-retroviral Treatment
BCC	Behavior Change Communication
CCIs	Childcare Institutions
CMD	Community Medicine Distributor
CSEC	Commercial and Sexual Exploitation of Children
CSS	Children in Street Situations
DCC	District Chain Linked Committees
DPP	Director of Public Prosecutions
ECD	Early Childhood Development
EMIS	Education Management Information System
EmOC	Emergency Obstetric Care
EMTCT	Elimination of Mother to Child Treatment
EPRC	Economic Policy Research Center
FAC	Formerly Abducted Children
FGM	Female Genital Mutilation
GER	Gross Enrollment Ratio
GIR	Gross Intake Ratio
GoU	Government of Uganda
GDP	Gross Domestic Product
HDI	Human Development Index
HSSIP	Health Sector Strategic Investment Plan
IDP	Internally Displaced People
ILO	International Labor Organization
IMR	Infant Mortality Rate
IPT	Intermittent Presumptive Treatment
IRS	In-door Residual Spraying
IYCF	Infant and Young Child Feeding
J4C	Justice for Children
JLOS	Justice, Law and Order Sector
LLINs	Long Lasting Insecticidal Nets
MDGs	Millennium Development Goals
MGLSD	Ministry of Gender, Labor and Social Development
MoESTS	Ministry of Education, Science, Technology and Sports
MOH	Ministry of Health
NAPE	National Assessment for Progress in Education
NCC	National Council for Disabled Children
NDP	National Development Plan
NER	Net Enrollment Ratio
NGO	Non-governmental Organization
NMR	Neonatal Mortality Rate
NPA	National Planning Authority
PCR	Pupil Classroom Ration
PLE	Primary Leaving Examinations
PMTCT	Prevention of Mother to Child Transmission of HIV
PSR	Pupil to Stance Ratio
PTIP	Prohibition of Trafficking in Persons
PTR	Pupil Teacher Ratio
SCR	Student Classroom Ratio
STI	Sexually Transmitted Infection
STR	Student Teacher Ration
U5MR	Under–five Mortality Rate
UBOS	Uganda Bureau of Statistics
UCE	Uganda Certificate of Examinations
UDHS	Uganda Demographic Health Survey
UHMG	Uganda Health Marketing Group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNAP	Uganda Nutrition Action Plan
UNCRC	United Nations Convention on the Rights of the Child
UNEB	Uganda National Examinations Board
UNHS	Uganda National Household Survey
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development
USE	Universal Secondary Education
USDC	Uganda Society for Disabled Children
UYDEL	Uganda Youth Development Link
VaC	Violence against Children
WFCL	Worst Forms of Child Labor
WHO	World Health Organization

GLOSSARY OF TERMS

Education:

Completion Rate (Primary): is the ratio of the total number of pupils who successfully complete (or graduate from) the last year of primary school in a given year to the total number of children of official graduation age in the population.

Completion rate (Secondary): is the ratio of the total number of students who successfully complete (or graduate from) the last year of secondary school in a given year to the total number of children of official graduation age in the population.

Enrollment: is the total number of pupils/students who have registered in a class or school during the current school year.

Gross Enrollment Ratio (GER) for Primary: refers to the proportion of pupils attending primary schools (P1-P7) to the number of children aged 6-12 in the entire population.

Gross Enrollment Ratio (GER) for Secondary: refers to the proportion of students attending secondary schools (S1-S6) to the number of children aged 13-18 in the entire population.

Gross Intake Ratio (GIR): refers to new entrants in primary grade 1 regardless of age as a percentage of 6 year olds in the population.

Net Enrollment Ratio (NER): is the ratio of primary school children aged 6-12 years to the number of children of the same age range in the population.

Net Intake Ratio (NIR): refers to new entrants to primary grade 1 as a percentage of 6 year olds in the population.

Literacy Rate: is the percentage of population that can read and write a simple message in any language or dialect.

PCR/SCR: is the average number of pupils/students per classroom in primary/secondary education in a given school year.

PLE Pass Rate: is the number of pupils shown as a percentage who were able to successfully pass the primary leaving examinations

PLE Performance Index: is the number of candidates that sat for the PLE examination multiplied by the weight of the highest grade.

PTR/STR: refers to the average number of pupils/students per teacher in a primary/secondary education in a given school year.

Repeaters: pupils/students who are enrolled in the same grade/year for a second (or more) time.

Repetition Rate: proportion of pupils from a cohort enrolled in a given grade at a given school-year who study in the same grade/class in the following school-year.

Retention Rate: is the proportion of the pupils/students enrolled in any school year that continues to be in school the following year.

Survival Rate: is the proportion of pupils who enroll in the first grade or year who reach the final grade or year at the end of the required number of years of study, regardless of repetition.

Survival Rate to Grade 5: refers to the percentage of a proportion of pupils attending the first grade of a primary cycle in a given school-year who are expected to reach grade 5, regardless of repetition.

Transition Rate: is the proportion of pupils/students who progress from the final grade of primary to the first grade of the secondary level to the total number that completed the final grade of the level.

Health:

Child mortality: probability of dying between age one and five

Comprehensive HIV knowledge: percentage of respondents who say: (1) that people can reduce the chances of getting the AIDS virus by using a condom every time they have sex, and (2) that people can reduce the chances of getting the AIDS virus by having sex with just one partner who is not infected and who has no other partners, and (3) that people cannot get the AIDS virus from mosquito bites, and (4) that people cannot get the AIDS virus from sharing food with a person who has AIDS, and (5) that a healthy-looking person can have the AIDS virus.

Incidence: the rate of new (or newly diagnosed) cases of a disease. It is generally reported as the number of new cases occurring within a period of time (e.g., per month, per year).

Infant mortality: probability of dying before the first birthday

Low birth weight: an infant weighing less than 2.5 kg at birth

Morbidity: morbidity is another term for illness.

Mortality: mortality is another term for death. A mortality rate is the number of deaths due to a disease divided by the total population.

Neonatal mortality: probability of dying in the first month of life.

Post neonatal mortality: probability of dying between one month and first birthday.

Prevalence: the proportion of persons in a population who have a particular disease or attribute at a specified point in time or over a specified period of time. It is the total number of cases of a disease existing in a population divided by the total population.

Stunting: stunting, or chronic malnutrition, measured as "height-for-age," which occurs when a child fails to grow to the expected height or length compared to a healthy child of the same age.

Under-five mortality: probability of dying before the fifth birthday.

Under-weight: underweight is often considered a measure of both acute and chronic malnutrition, measured as "weight-for-age," it occurs when a child fails to gain the expected weight compared to a healthy child of the same age.

Wasting: wasting, or thinness, is measured by "weight-for-height" and is often a result of recent illness or weight loss (low weight for height).

Sexually Active: is defined as having had a sexual relationship within the last three months before the survey.

Child Protection

Child protection: all activities associated with preventing and responding to child abuse, violence, exploitation, neglect, and family separation.

Child protection system: a system of laws, policies, procedures, institutional frameworks and practices designed to prevent and respond to child abuse, neglect and exploitation.

Social service system: addresses both the social welfare and protection of vulnerable populations and includes elements that are preventive, responsive and promotive.

EXECUTIVE SUMMARY

The State of the Ugandan Child: An Analytical Overview focuses on four thematic areas, namely: health and nutrition, education, child protection and child participation; with emphasis placed on the girl child. The study relied on secondary data review and primary data collected from key informant interviews (KIIs) at national, district and community levels, as well as Focus Group Discussions (FGDs) with young people aged 14-19 and adult community members from 12 districts. The data was disaggregated to indicate trends in realization of the four categories of child rights at a national level and to depict regional, gender and age differences.

Overall, progress has been made over the last decades towards improving the well-being and realization of the rights of children in Uganda. This is especially in relation to enrollment in education, and the policy and legal frameworks in the different domains. However, progress has not been consistent over the years across the major domains of child well-being, with the situation of the girl child remaining more precarious. There is an urgent need for immediate intervention as well as long term non-conventional interventions to reverse the negative situation affecting the boy and girl child.

The health status of children in Uganda remains poor as reflected in the unmet Millennium Development Goals (MDG) and Government targets. Neonatal mortality is at 27 per 1,000 live births; infant mortality rate (IMR) at 54 per 1,000; and the under-five mortality at 90 per 1,000 live births. Malaria still dominates as the leading cause of death among children below age five, accounting for almost 28.8% of the deaths. The number of children 0-14 years living with HIV was estimated to be 147,394 in June 2015. The HIV prevalence among teenagers aged 10-14 was reported at 1.9% for males and 2.3% for females in 2013. Among young people aged 15-24 years, HIV prevalence steadily rose from 2.9% in 2004/5 to 3.7% in 2011. Malnutrition persists with one in every three children (an estimated 2 million children) stunted.

Almost half of the children in the country were not receiving full immunization as of 2011 when the Uganda Demographic Healthy Survey (UDHS) results were published. The factors underlying this situation range from poor health seeking behavior by caregivers to limited access to quality services. This calls for immediate action to address the barriers hindering timely immunization of all eligible children. Interventions in the health sector should also focus on increasing access to HIV testing for all babies born to HIV positive mothers within the set period, enrolling those who are found to be HIV positive for immediate treatment, and innovatively reaching young people with critical information and services and empowering them with life skills to negotiate safer sex and make informed decisions that keep them safe. Multi-sectoral responses are needed to address malnutrition during the early stages of childhood – the first 1,000 days – by tackling both the immediate causes such as poor infant feeding practices as well as the underlying factors such as cultural beliefs and food security.

Education indicators provide a mixed picture in relation to the Ugandan child. Early childhood Development (ECD) receives little attention and only a few formal interventions focus on the development of children under the age of three. There is little information regarding parenting practices and other informal early childhood development practices and interventions at household and community levels. Enrollment of children in pre-primary education remains very low, due to the limited availability of pre-primary schools, particularly in rural communities, and the predominance of unaffordable private sector provided pre-primary education. While there have been sustained improvements in enrollment in primary and secondary education, owing mainly to the introduction of Universal Primary Education (UPE) in 1997 and Universal Secondary Education (USE) in 2007, retention and transition of children to higher levels has remained low, and more particularly in relation to the girl child. Survival rates through primary level are very low, with data showing that in 2013, about six out of ten pupils who joined primary one made it to primary five, whereas only three in ten of them survived until primary seven. Lack of data on survival rates through secondary level presents a major data gap. According to the Uganda National Household Survey (UNHS) 2013 the two main factors accounting for high dropout and failure to transition to secondary education for girls are child marriage and pregnancy. Other factors relate to high financial costs associated with education, poor attitude towards girls' education, hunger, lack of access to sanitary pads, poor quality of education, poor learning conditions, and teacher absenteeism among others. At primary level, literacy and numeracy remain very low with only 56.2% and 40.1% of pupils reaching a defined literacy level at primary three and six respectively.

The realization of children's rights to protection, principally protection against violence, abuse, neglect and exploitation, continues to be a critical challenge. All forms of violence against children – physical, sexual, and emotional – have been reported to take place within family, school, and community settings, and within childcare and justice institutions. With sexual violence largely affecting the girl child and physical violence mostly affecting the boy child, gender is identified as a key risk factor alongside age, disability, poverty in the household, over crowding in schools, weak law enforcement, big family size, family separation, low level of supervision and normalization of violence practices by care givers and society in general.

Consequently, a large number of children remain vulnerable to abuse, exploitation and violence. These include: children living in extreme poverty; an estimated 2.2 million orphans; estimated 310,000 children heading households; estimated 40,000 children living in childcare institutions; children living on the streets with no adult care - estimated at 10,000; children involved in hazardous work - estimated at 507,000; children murdered through ritual practices; and children under servitude. The situation of the girl child is aggravated by early unsafe sexual debut. More than half (50.5%) of young people aged 25 years and below start sexual activity before turning 18 years old. Early pregnancy stood at 30% in 2011, within the same age group, while early marriages and teenage pregnancies are profoundly higher in the eastern and northern regions. This situation is linked to the low levels of progression to secondary education, limited access to and utilization of family planning methods, and negative cultural practices such as giving girls into marriage as early as age 12. Among young people aged 15-24 years, over 50% experience unmet need for family planning. Only 35.3% of unmarried sexually active young women are using modern methods of family planning. Female genital mutilation affects about 90% of the girls among the Pokot, Sabiny and other communities spread in six districts in north eastern Uganda, yet the prosecution of offenders remains poor owing to weak law enforcement.

Child participation in Uganda is still characterized by fragmented and short-lived initiatives. There are a few formal initiatives where children are able to have their voice heard, but these are limited in scope and their impact is equally not well documented. The issue of power-relations between adults and children in all settings remains a key barrier. While there might be varied forms and levels of child participation at the family level, these are not well documented and there is need for more research in this area. To create an enabling environment for child participation in Uganda, there is need to develop a national child participation strategy to serve as an action plan with specific interventions that are well resourced. A sector wide approach that brings on board several institutions and which specifies role and responsibilities would be critical.

The realization of children's rights in Uganda has mixed outcomes in spite of several interventions over the last two decades. The girl child remains disfavored compared to the boy child – owing to cultural beliefs and practices and the failure to adequately address the nature of vulnerabilities and needs of the girl child throughout her life cycle. Targeted innovative interventions by multiple stakeholders are required to support the realization of children's rights, especially that of the girl child. There are promising practices with some evidence of success that can be improved on and scaled up by both government and non-government organizations in Uganda. These would require commitment to policy, legislation, program and financing from all stakeholders.

PART I:
INTRODUCTION

This report provides up to date evidence on the state of the Ugandan child. The report is a result of an extensive secondary and primary data analysis in the domains of health and nutrition, education, child protection, child participation, and a cross-cutting focus on the girl child. The analysis sought to bring together data on the current state pertaining to key indicators of child well-being in Uganda. Analyses were done for the national and regional level and across the variables of gender and age. The report comprises of an introduction, methods section and key findings organized along the four domains. The last section provides a synthesis of the findings, research gaps and recommendations.

1 INTRODUCTION

1.1 The Country Context

Though Uganda remains one of the world's low and middle-income countries (LMICs), it has made significant economic progress in the last two decades with the annual growth rate in gross domestic product (GDP) averaging 7.1% between 1992 and 2011. However, GDP growth rates have fluctuated sharply, sometimes falling as low as 3.2% due to a decrease in export performance and high inflation, as well as high population growth (AfDB et al., 2013). The percentage of people living below the poverty line decreased from 44% in 1997/98 to 19.7% in 2012/13 hence Uganda exceeded the Millennium Development Goal (MDG) target (i.e. 28%) to halve the proportion of its population living in extreme poverty by 2015. There was an increase in household income as depicted in the increase in per capita income from USD 607 in 2008/09 to USD 788 in 2013/14 (Government of Uganda [GoU], 2015; MGLSD & UNICEF, 2015).

However, income inequality is increasing and 22% of children (4.4 million) still live in income-poor households. Owing to the high Total Fertility Rate (TFR) of 6.2 children per woman, gains in economic growth are often reversed. With more than half of the population (56%) under 18 years, the dependency ratio has increased from 110 in 2002 to 124 in 2014 (Government of Uganda, 2015; MGLSD & UNICEF, 2015). The high dependency ratio puts an economic and social burden on the productive age groups and retards development.

The majority of the Ugandan population lives in rural areas and is employed in smallholder agriculture. Agriculture accounts for a quarter (25.3%) of the country's GDP and employs about 72% of the total labor force—both formal and informal (GoU, 2015).

According to the Uganda National Household Survey (UNHS) 2012/13, about one third of the communities (31%) have at least one Government Primary School. The average distance to a health facility is 3.2 Kms, and 22% of communities have access to agricultural extension workers within their communities (UBOS 2014a). The literacy rate was reported as 71% in 2012/13, while life expectancy was at 54.5 years in 2011/12 (GoU, 2015).

Human capital development remains a major challenge despite investments in health, education and skills development. About nine percent of the labor force is unemployed, while 32% of persons in paid employment are inadequately paid (UBOS, 2014a). A big proportion of the population face social vulnerabilities associated with demographic characteristics such as age, sex, disability, unemployment, and other phenomena such as poverty and disasters.

Human rights violations, especially against vulnerable groups such as children, continue despite the enabling legislations in place. This is partly because the rights-holders and the duty-bearers do not have adequate knowledge about existing laws, and the infrastructure to promote human rights of the vulnerable groups at the Local Government (LG) and community level is weak (MGLSD, 2011c). As a result, there is limited realization and enjoyment of human rights.

1.2 Overview of the Children in Uganda

Provisional results from the 2014 population census data show that about half of the Ugandan population – 34.9 million – comprise of children under 15 years of age; while 17.1 million children (more than 56%) are aged under 18 (UBOS, 2014a). Such a large population of children has various implications for resource allocation and service provision when considered in relation to other population categories. This population composition translates into a high dependency ratio estimated at 124 (Government of Uganda, 2015). In addition, it reflects in the high demand for children's facilities against over-stretched and poorly functioning services in existence. For instance, with 23% of the population aged 6-12 years, about 7.3 million children are in need of subsidized or free primary education. If the same group were to successfully transition to secondary education and were offered subsidized education, the government would have to double the education resources to this population group. Yet the priorities for the young population inevitably have to include health and nutrition, social protection, livelihoods support, and access to other basic services.

Indeed, the trend of education indicators shows a mixed picture in relation to the Ugandan child. On one hand, there are remarkable improvements with regard to access to primary and secondary education, owing mainly to the introduction of UPE in 1997 and USE in 2007. However, school retention and transition to secondary school remain problematic, and more particularly in relation to the girl child. The learning conditions and the quality of education also remain critical areas of concern.

Health indicators for children show very slow progress over the last 10 years. While Uganda has made some progress in reducing under-five mortality from 137 per 1,000 live births in 2005/06 to 90 per 1,000 live births in 2011/12, child and maternal health conditions continue to impose the highest total disease burden with perinatal and maternal conditions accounting for 20.4% (Ministry of Health [MoH], 2010). In 2011, Uganda ranked 26th amongst countries with highest under-five deaths globally (UNICEF, 2012a). Progress in reducing maternal mortality, an underlying factor in child mortality, has been very slow coming from 438 per 100,000 live births to 320 in 2011 (MOFPED, 2013). Based on the rates of progress at the time of writing this report, Uganda was unlikely to achieve Millennium Development Goals (MDG) 4 and 5, which focused on reducing under-five mortality and improving maternal health respectively. It was also unlikely to achieve the goals set in the National Development Plan (NDP) II of reducing the Infant Mortality Rate per 1,000 live births from 54 to 44 and reducing the under-five mortality rate per 1,000 live births from 90 to 51 (MoH, 2013; GoU, 2015). The allocation to health as a percentage of the total government budget reduced from 9.6 percent in 2003 to 8.6% in 2014/15 contrary to the Abuja Declaration target of 15% (GoU, 2015).

Over 8 million children, 51% of the child population, are moderately (43%) or critically vulnerable (8%). Yet child protection is still a major challenge and many children still face abuse and neglect despite the existence of an elaborate legal and policy framework for the protection of children. The child protection challenge is exemplified by the enormous number of vulnerable children who, without immediate intervention, face the risk of exposure to different forms of violence, neglectful treatment and exploitation. The children include those living in extreme poverty, orphans, children in child-headed households, those living in poorly managed childcare institutions, children living on the streets with no adult care, trafficked children, children involved in hazardous work, children murdered through ritual practices and those under servitude.

The girl child in Uganda is more at risk of living in poverty, being exposed to sexual abuse, and faces a higher risk of contracting sexually transmitted infections including HIV/AIDS compared to the boy child. A computation of the girls' vulnerability index underscores the high level of vulnerability of adolescent girls in Uganda (Amin et al, 2013).

Overall, there is urgent need to mobilize resources and efforts and direct them to interventions that can work most effectively to address the plight of Ugandan children as highlighted above.

"The girl child in Uganda is more at risk of living in poverty, being exposed to sexual abuse and faces a higher risk of contracting sexually transmitted infections including HIV/AIDS compared to the boy child."

1.3 Rationale for the Analysis

Benchmarking child well-being is critical in planning and directing development initiatives that are targeted at children. This sector analysis was intended to serve as a baseline study for the Development of a National Action Plan for Child Well-Being and to inform Uganda's child well-being agenda.

1.4 Purpose of the Analysis

The purpose of this analysis was to provide up-to-date evidence on the state of the Ugandan child, with particular focus on children's health, education, child protection, child participation and the girl child. To achieve this purpose, the study sought to analyze the national situation as well as regional variations including gender and age. The analysis also intended to identify any gaps in response to the situation of children as well as any promising practices.

1.5 Methodology

1.5.1 Scope of the study

The analysis examined data from the thematic areas of health and nutrition, education, child protection, child participation and a cross-cutting focus on the girl child. Table 1 presents the description of the major domains and sub-domains under which the analysis was done.

TABLE 1: ANALYSIS DOMAINS AND SUB-DOMAINS

Domain	Sub-domains
Health and Nutrition	• Under-five, Infant and Neonatal Mortality • Nutrition • Child Immunization • HIV and AIDS Among Children • Adolescent Sexual and Reproductive Health • Mental Health
Early Childhood Development and Education	• Early Childhood Development • Primary • Secondary • BTVET and Tertiary Education • Disparities • Investment in Education
Child protection	• Child Vulnerability • Processes and Barriers to Child Protection
Child Participation	• Child Participation in Different Sectors • Barriers to Child Participation

The analysis covered a period of ten to fifteen years, or more where data was available. For some indicators, such as nutrition status, the most recent nationally representative source of data was the 2011 Uganda Demographic and Health Survey (UDHS) (UBOS and ICF International, 2012), and hence this report made use of such data. For variables where more recent data was available up to 2014, this was included. Table 2 shows the main sources of secondary data.

TABLE 2: MAIN SOURCES OF SECONDARY DATA AND THEIR FREQUENCY

Indicators	Source	Frequency of data collection	Comments
Child mortality(neonatal, infant, child) Nutrition (malnutrition, underweight & wasting)	UDHS 2011	Every after five years	These are national indicators. The next UDHS will be conducted in 2016 data. Only interviews women aged 15-49 and males aged 15-54
HIV prevalence among children ART coverage among children	HMIS	Quarterly	Provided national data
Malaria in children	Uganda Malaria Indicator Survey 2014-15	Not known	
Immunization	UDHS 2011	Once every five years	Provides national and regional data
Mental Health	Various studies (see reference section)		Do not provide national or regional coverage
ECD (parenting & community)	Various studies (see reference section)		No national mechanisms that collects data
School Enrollment			
Retention, survival and completion	EMIS	Annual	Provides national coverage
Literacy and numeracy	UWEZO, NAPE and EGRA	Annual	NAPE is a national mechanism
Child vulnerability (orphans)	UNHS 2012/13	Every two years	
Child abuse Violence against children Child participation Girl child	Various studies (see reference section)		
Children in conflict with the law trafficked children	Uganda Police Annual Crime and Traffic Road Safety Reports	Annual	Provides national data

Phase 1: Secondary data review and analysis

Sources of data and data collection methods

The first phase comprised of an extensive data and literature review from national surveys and other smaller studies. The data was extracted and analyzed from Uganda National Household Surveys (UNHS); Uganda Demographic and Health Surveys; Ministry of Health (MoH) Health Management Information System (HMIS); Education Management Information System (EMIS); Gender Based Violence Management Information System (GBV MIS) and administrative government departments such as the Uganda Police. Extensive literature review of both published and unpublished documents was conducted to explain the current child status and identify data gaps so as to inform phase II of the study based on qualitative primary data collection. A three step process was employed during phase I.

1. A 'call for data' issued by the Monitoring Evaluation and learning Program (MELP/USAID) on key sector analysis domains (education, health and nutrition, social protection, and the girl child)
2. Review and validation of data and reports, in order to assess the validity and reliability of the data
3. Analysis and identification of key data gaps

Analysis of secondary data

Much of the secondary data collected during phase 1 of the study was of a quantitative nature. Relevant computer-based packages were used in the analysis including SPSS, Microsoft Excel, and Stata. The analysis was both descriptive and explanatory. Using content analysis, the research team reviewed various reports and publications then made observations and suggested conclusions in relation to the indicators selected for analysis. Once the statistics and other data were analyzed, the research team contextualized the facts and made sense of the emerging trends and situations. The team made proposals for careful consideration during subsequent discussions and development of an encompassing vision aimed at improving the situation of the . During data analysis, emphasis was further placed on validity and reliability of the data, through processes of triangulation, quality checks, data validation and comparison of various data sources.

Phase 2: Primary Data Collection and Analysis

The second phase of this study was based on the data gaps identified in phase one, and sought to fill those data gaps. The data gaps identified from phase one were a lack of explanations for the trends, patterns and status of indicators on the Ugandan child observed in the data; explanations for the regional differences observed in the data; and examples of promising practices. Annex A to D show the outline summary of the specific data gaps that were identified at the end of phase one and, based on these gaps, the data collection plan was developed to accomplish phase two. Much of the data sought in phase two was qualitative, since it sought for explanations and deeper insights.

1.5.2 Geographical coverage and study sites

Primary data was collected at national, district, and community levels. At national level, data collection targeted selected technical staff in government ministries and agencies, non-governmental organizations and other institutions working in the sectors of interest.

At the district level, a sample of districts was purposely selected considering locations where the data of interest was likely to be found. A total of 12 districts were selected from the major regions of Uganda, namely central, northern, eastern, and western. Table 3 below provides details of the sample districts.

TABLE 3: SAMPLE DISTRICTS FROM WHICH PRIMARY DATA WAS COLLECTED

Region	Sampled District	Inclusion Criteria
Kampala	Kampala	Represents typical urban setting
Central 1	Mukono	One of the districts in central Uganda where neonatal mortality, malnutrition and education indicators are poor. It has pastoral and agricultural communities
North	Gulu	Typical post-conflict north
	Arua	One of the districts with high incidence of child malnutrition and experiences cross border issues affecting children
Eastern	Mbale	High incidence of early marriage; issues of adolescent sexuality following male circumcision events
	Bugiri	One of the eastern districts with high prevalence of early child marriages
	Kamuli	High prevalence of early marriage
	Kumi	High prevalence of early marriage
	Pallisa	High prevalence of early marriage
Western	Kiruhura Bushenyi	Pastoralist community with unique cultural beliefs that may affect nutrition status and adolescent sexuality
	Kabarole	One of the western districts that experience high levels of child marriage

1.5.3 Primary data collection methods

Primary data was collected through individual in-depth interviews (IDIs), Focus Group Discussions (FGDs) with selected target groups, and documentation of case studies and promising practices.

In-depth interviews were conducted with policy makers in relevant government ministries (Ministry of Health; Ministry of Education, Science, Technology and Sports, and Ministry of Gender, Labor and Social Development (MGLSD)), and implementers at district level, community level, NGOs, projects, and private sector agencies. Key informants at the district level consisted of selected local government officials that work in the children's sector such as Probation and Welfare Officers, Community Development Officers, Education officials, district health officials and political leadership at sub national levels, as well as staff of Civil Society Organizations (CSO) working with children. Some interviews were also held with nutritionists in Regional Referral hospitals, District Hospitals and Health Center IVs.

At the community level, interviews were conducted with local leaders such as LC chairpersons, religious and cultural leaders and other opinion leaders. Focus Group Discussions (FGDs) were conducted among specific categories of participants including caregivers of children under five (to explore issues of nutrition or malaria prevention) and young girls and boys aged 14-16 and 17-19 (to explore sexual practices and HIV prevention).

During Key Informant Interviews (KIIs) and FGDs, potentially interesting cases and promising practices were identified and followed up for documentation. The criteria for determining promising practices drawn from UNAIDS (1999) and International Labour Organization (2012) was adopted and used focusing on the following parameters.

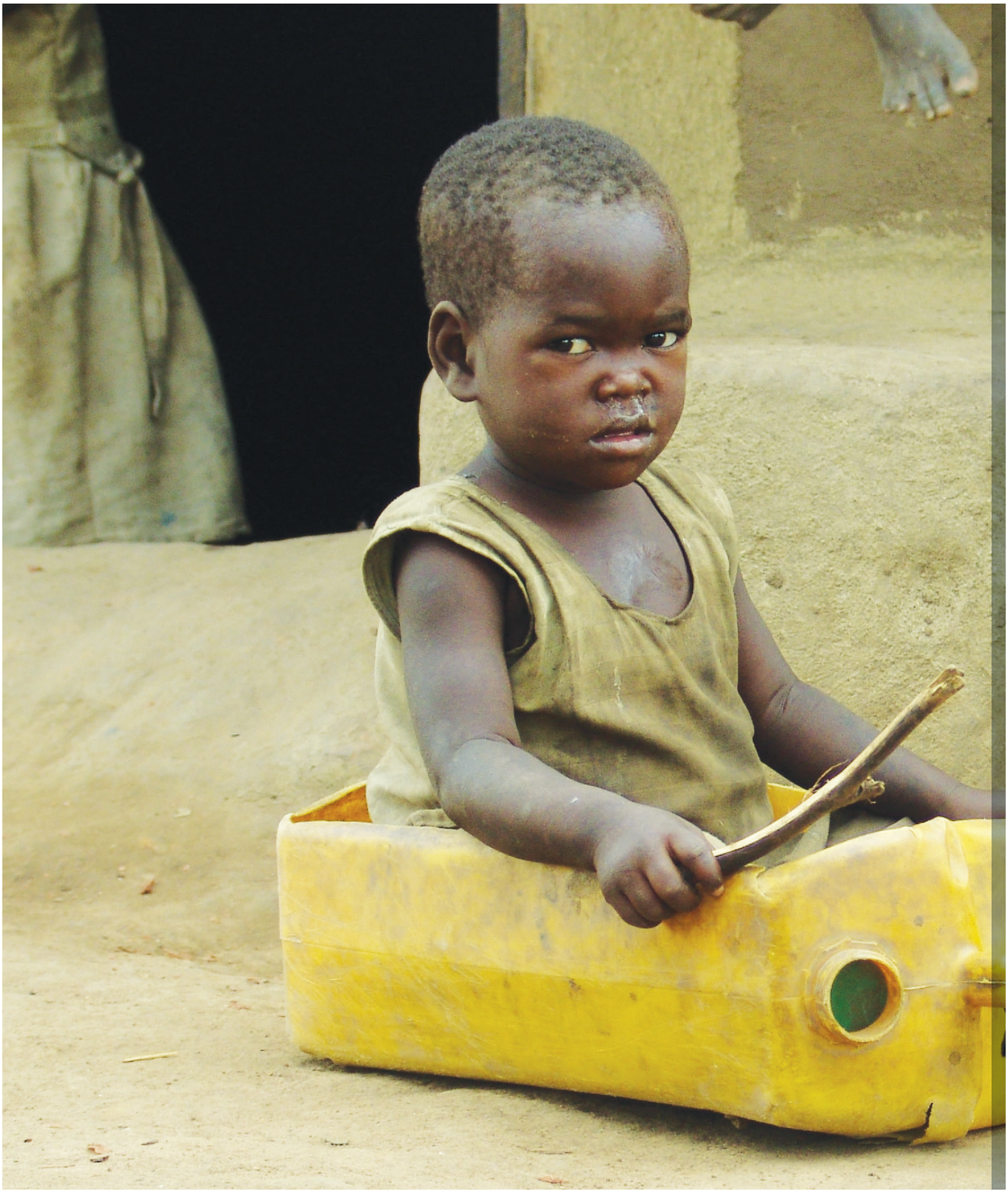
1. Effectiveness (in addressing need and influencing policy & legislations)
2. Efficiency
3. Innovation
4. Replicability
5. Ethical soundness (including opportunity for beneficiaries to participate in design, implementation and evaluation)

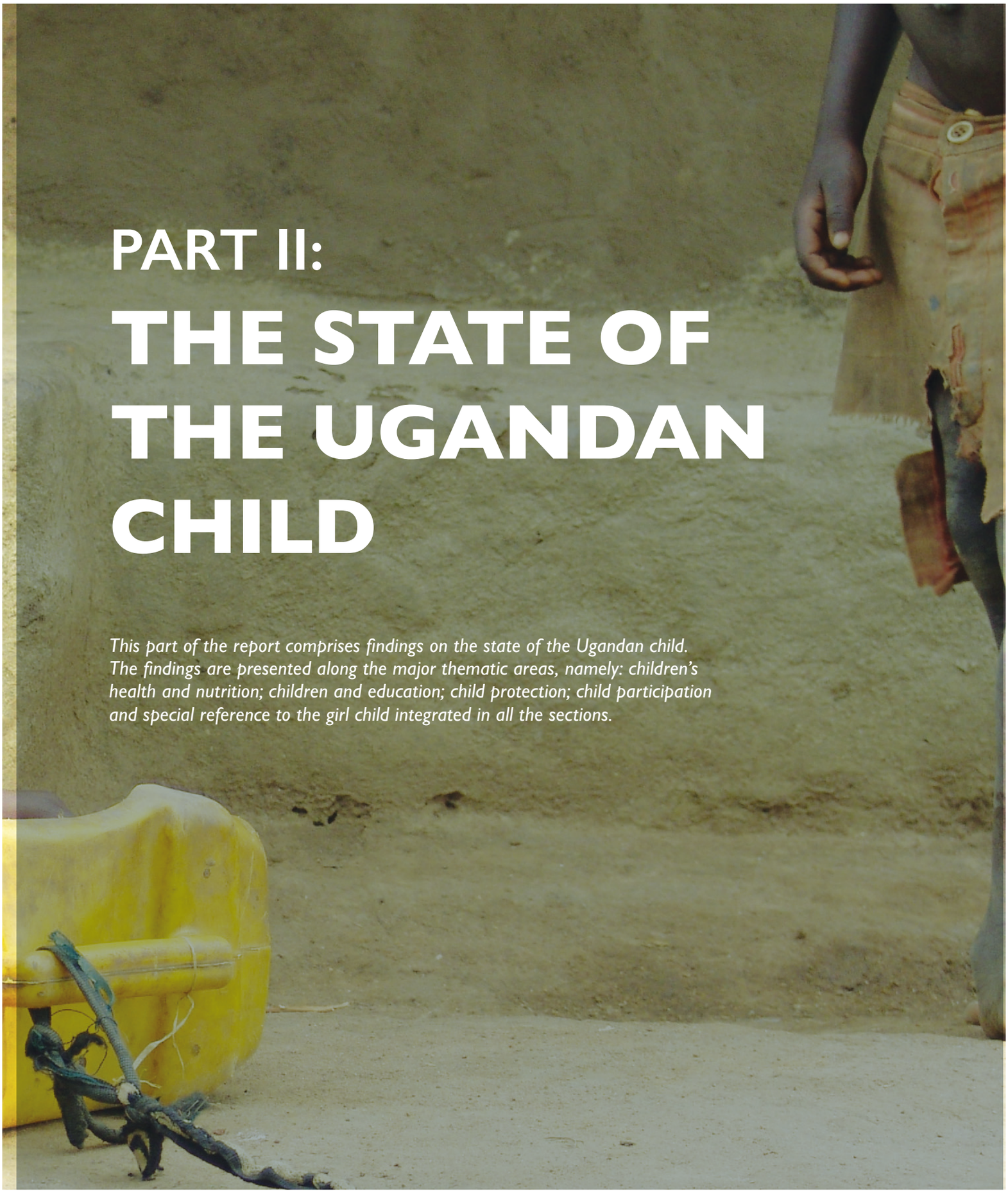
1.5.4 Analysis of primary data

All data from interviews and FGDs were transcribed and summarized into matrices to enable easy identification of key emerging issues and to allow for display for qualitative coding and manual analysis. A thematic and content-driven theme approach was used in the analysis of qualitative data. Thereafter, the qualitative results were integrated with the results from the 1st phase of the study to make one joint report.

1.5.5 Limitations

One of the key limitations of this analysis was in relation to indicators such as health and nutrition, where the latest nationally representative data available was from the 2011 UDHS (UBOS and ICF International, 2012). While some organizations may have conducted studies or collected data on these indicators between 2011 and 2014, such data is of limited geographical coverage and is only used in this report to highlight region or district specific situations. The second limitation was the lack of data on specific themes and sub-themes such as child participation, parenting and early childhood development, and the mental health of children. There has been limited national level research in these areas and no large-scale data exists. Future research should be targeted to fill these gaps. The third limitation was inability to utilize OVCMIS data to benchmark various indicators relating to child welfare due to data inconsistences and inaccuracies.





PART II:
THE STATE OF THE UGANDAN CHILD

This part of the report comprises findings on the state of the Ugandan child. The findings are presented along the major thematic areas, namely: children's health and nutrition; children and education; child protection; child participation and special reference to the girl child integrated in all the sections.

2 CHILDREN'S HEALTH AND NUTRITION

This section focuses on the health status of children in Uganda. The key themes discussed include the policy context for child health, child mortality, HIV/AIDS among children, malaria, nutrition status of children, immunization coverage, and children's mental health. Reproductive health issues are also included in this section to highlight the unique situation of the girl child.

HIGHLIGHTS

- One in every 19 children is at risk of dying before their first birthday and one in every 11 children is at risk of death before or at the age of five
- Only three out of ten children with suspected pneumonia receive antibiotics; only four out of ten children with diarrhea receive ORS and two out of ten receive Zinc tablets
- There were an estimated 5,200 new pediatric HIV infections in 2014
- Almost 5% of babies born to HIV positive mothers tested positive for HIV in August 2015
- In 2015, an estimated 147,394 children aged between 0-14 were living with HIV
- In 2015, 6 in every 10 children aged 0-14 living with HIV and eligible were not receiving ART
- HIV prevalence among people aged 15-24 years was 3.7% in 2011, having increased from 2.9% in 2004/5
- In 2011 only four out of ten young males and females aged 15-24 years had comprehensive knowledge about HIV prevention
- About 2 million under-five children are stunted and 801,000 are under weight
- By 2011, the coverage of full immunization was 51.6%, almost half of children in Uganda are not fully immunized
- One in every four girls aged 15–19 has begun childbearing (is pregnant with their first child or has had a live birth).
- Two in every five women aged 20-24 years were married or in a union before 18 years of age
- Only five in ten unmarried sexually active young women aged 15-19 years reported using a method of contraception
- Only 14 percent of currently married women age 15-19 years reported current use of any contraceptive method
- Nearly six in ten young women aged 15-24 years (58 %) had sex before age 18

2.1 Policy Context

Maternal and child health forms one of the clusters of critical interventions prioritized under the National Health Policy II (2010/11-2019/20) and the Health Sector Strategic Investment Plan (HSSIP) 2010/11-2014/15. Uganda's goals for child survival and child health are well articulated in Vision 2040, the National Development Plan II, and the Health Sector Strategic Investment Plan (HSSIP) (2010/11-2014/15). Reduction of newborn, child and maternal mortality are

some of the key desired outcomes under these policy and planning frameworks. In 2013, GoU developed the Sharpened Reproductive Maternal, Neonatal and Child Health (RMNCH) plan to address MDG 4 and 5. There are also a number of policies and plans relevant to child health and nutrition such as the Uganda Nutrition Action Plan (GoU, 2011). Efforts to roll out these policies and plans are still underway. GoU is also a signatory to various global commitments that aim to accelerate progress in reducing child and maternal mortality. These include for instance the 2011 UN Secretary General's Global Health Strategy Pledge, the 2012 Preventing Premature Births and Deaths "Born too Soon" (BTS) Pledge, the Global Action Plan for Pneumonia and Diarrhea (GAPPD), and The Call to Child Survival – a promise Renewed Pledge (2012) among others (MoH, 2013). Despite these progressive policies and plans, progress in addressing key childhood health problems is still slow as shown in the sub-sections below.

The recently formulated Sustainable Development Goals (SDGs) number 2 and 3 set new targets relevant for nutrition and health respectively, and should provide a new impetus for Uganda to do more on the nutrition and health of its children.

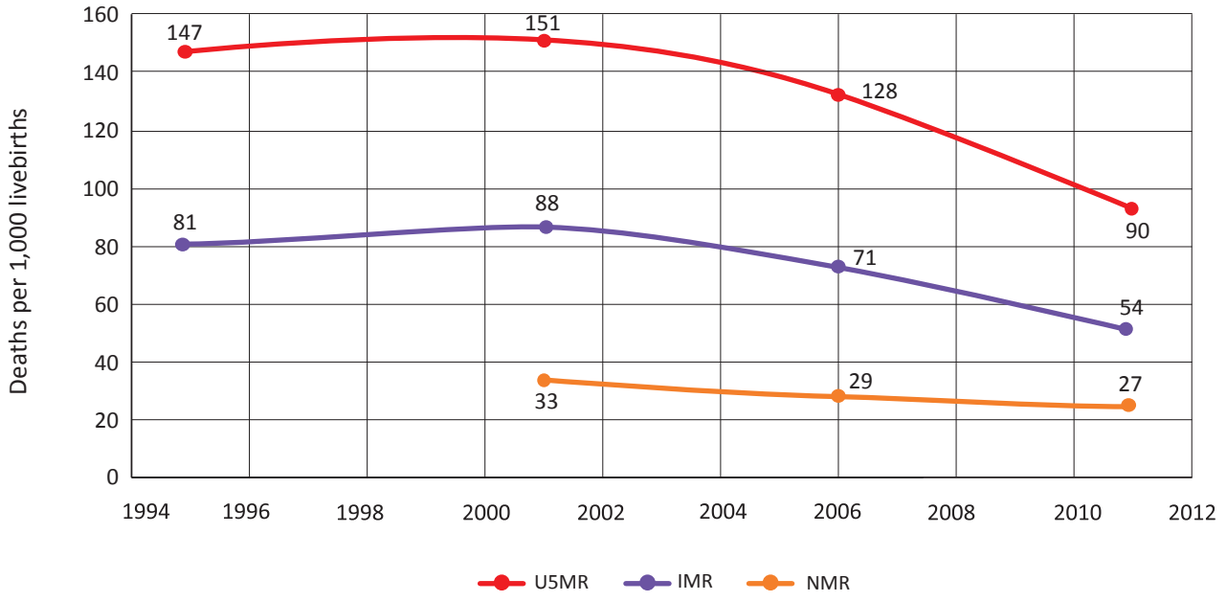
2.2 Under-Five, Infant and Neonatal Mortality

Figure 1 shows the status and child mortality trends, from 1994-2011. Overall, Neonatal mortality rates (NMR) fell from 33 per 1,000 live births in 2001 to 27 per 1,000 live births in 2011; under-five mortality fell from 147 per 1,000 live births in 1995 to 90 per 1,000 live births in 2011, and the infant mortality rate (IMR) fell from 81 per 1,000 live births to 54 per 1,000 live births[1] in the same period. It is clear that the rates for infant and under-five mortality have been declining over the past two decades. However, the rates of decline appear to be slow. Uganda is therefore unlikely to meet its MDG target to reduce under-five mortality to 56 deaths per 1,000 live births and IMR to 31 per 1,000 live births by 2015.

It is estimated that 167,000 children under five and 101,000 under one year die every year (UBOS and ICF International, 2012). This means one in every 19 babies born in Uganda does not live to their first birthday, and one in 11 children will die before the fifth birthday (MoH, 2013).

Neonatal deaths contribute 38 percent of all infant deaths, which is a significant proportion given that these deaths occur in the first month of infancy. Over half of the total newborn deaths occur during the first week of life, mainly in the first 24 hours of life. The principal causes of neonatal mortality (under 28 days of age) are prematurity, birth asphyxia and sepsis (MoH, 2013).

FIGURE 1: TRENDS IN CHILD MORTALITY IN UGANDA 1995 - 2011



Sources: UDHS 1995, 2001, 2006 and 2011.

[1] This is still below the 2015 HSSIP target of 41 per 1,000 live births and the 2015 MDG target of 31 per 1,000 live births.

The 2011 UDHS reveals significant variations in IMR and under-five mortality rates based on gender and residence. IMR was found highest among male children (70 per 1,000 live births) as compared to females (59 per 1,000 live births), and higher among rural homesteads (66 per 1,000 live births) compared to urban households (54 per 1,000 live births). The reasons for the variations in IMR by sex of child are not very clear. The rural-urban differences may be explained by better access to maternal health services as well as higher education levels and social economic status among urban parents compared to their rural counterparts (UBOS and ICF International, 2012).

Further regional analysis shows that only 15 districts account for 36% of child deaths in the country, meaning that high rates of child mortality are concentrated in a few districts or regions. Table 4 shows these regional differences.

TABLE 4: REGIONAL[2] DISAGGREGATION OF CHILD HEALTH INDICATORS (2011)

	Neonatal mortality	Infant Mortality	Under-five mortality
Region			
Kampala	27	47	65
Central 1	44	75	109
Central 2	31	54	87
East central	23	61	106
Eastern	24	47	87
Karamoja	29	87	153
North	31	66	105
West Nile	38	88	125
Western	30	68	116
South-west	33	76	128

Source: Uganda Demographic and Health Survey, 2011

Kampala and the central 2 regions have relatively lower child mortality rates while Karamoja and south-western regions have the highest. The lower child mortality rates in Kampala and the Central 2 region may be explained by better access to maternal health services, especially in Kampala city, the capital, as well as higher education levels of mothers in Kampala and the surrounding peri-urban district of Wakiso which is under the Central 2 region.

The factors underlying high neonatal, infant, and under-five mortality rates are related to poor maternal care seeking behavior among mothers as well as poor maternal health services. The proportion of pregnant women who attend at least four ANC consultations is only 32% (MoH, 2014). Only five out of ten babies are born in the hands of skilled providers and only 11.7% of women deliver in fully functional comprehensive Emergency Obstetric Care (EmOC) facilities. About 15% of all pregnancies develop life-threatening complications and require EmOC (MoH, 2010). Access to postnatal care within the first 7 days of delivery is only about 34% (MoH, 2013). As the story from Kiruhura district below shows, poor functionality of health services and poor ANC seeking behavior are at the center of maternal and infant deaths.

[2] See annex A5 for the districts under each region.

Case Study: Poor access to maternal health services fuels infant deaths in Kiruhura district

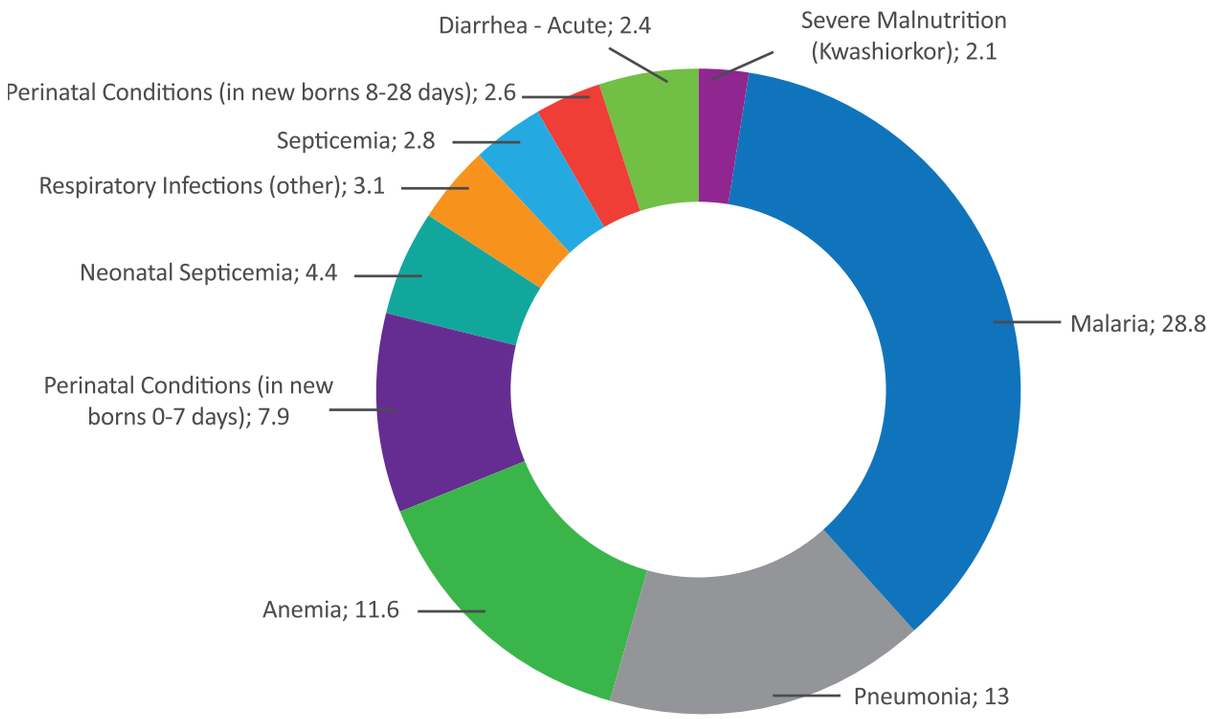
In Kiruhura District, most residents have to travel between 10 to 20 kilometers to reach a Health Center III, where basic maternity services are provided. Only six out of ten of the pregnant mothers in the district attend 4 ANC consultations and only four out of ten deliver in health facilities. The district has two Health Center IVs but these are not optimally functional. Kiruhura HCIV, started caesarian section deliveries in April 2015, because it previously had no functional theatre. Health workers' staffing levels in the district are at 52% of the standard staffing norms. The only hospital in the district, Rushere Hospital, is private and services are paid for—making the services out of reach for the majority. This limits access to emergency obstetric health care in event of complications during delivery. The alternative source of emergency obstetric care services are not near either; the nearest being Mbarara regional referral hospital, a journey of more than 2 hours by public transport. While there is an ambulance car at the district, it is usually not available to people who need emergency services, because it often lacks fuel or is in poor mechanical condition. According to the District Health Officer (DHO), these challenges have contributed to a high level of perinatal deaths in the district and poor performance on most child health indicators: "when you have one fully functional HCIV, it is easier for children to die from anemia because there is no access to blood transfusion services".

The above case highlights the gaps in maternal health services, namely: geographical access, staffing, poor referral and ambulance services, which combine to fuel child deaths.

2.2.1 Causes of child mortality

The main direct causes of death among children under-five continue to be malaria, acute respiratory infections, and anemia, exacerbated by underlying malnutrition (MoH, 2014) (See Figure 2).

FIGURE 2: CAUSES OF IN-PATIENT DEATHS AMONG UNDER-FIVE CHILDREN 2013/14 (%)



Source: Ministry of Health (MoH), 2014

Malaria is the leading cause of death in children under-five accounting for nearly 29% of all inpatient deaths among children under-five. Of the 337,755 malaria cases registered in 2013/14, 236,026 cases (69.9%) were found in children below five years of age, out of which 2,036 lost their lives due to malaria (MoH-HMIS 2014). The total burden is estimated to be higher than reported. The persistence of malaria as the leading cause of death is attributed to several factors among mothers and children. In 2014, 74 percent of children under five slept under an insecticide treated mosquito net (ITN) (Table 5), meaning that almost one quarter of the children were not protected against malaria (UBOS and ICF International, 2015).

Qualitative data shows that failure to use mosquito nets is attributed to complaints of discomfort caused by nets (too much warmth, skin reactions). However, these complaints were found to be more common where recommended procedures for ITN use, such as hanging the net in the shade before use, were not followed.

Nonetheless there is a progressive reduction in prevalence of malaria among the under-five children from 42.4% in 2009 to 19% in 2014 (Table 5). This reduction is the biggest contributor to the overall reduction in under-five mortality (MOFPED, 2013). The decline in the prevalence of malaria has largely been due to the increased use of ITNs reported at 74% in 2014 – made possible through mass net distributions— as well as other interventions such as increased availability of Artemisinin Combination Therapies (ACTs) for the treatment of malaria (UBOS and ICF International, 2015). The proportion of children with fever who were treated with ACT was nearly 67% in 2014-15. If the same efforts can be sustained or improved, it will lead to real progress in tackling the fatalities resulting from malaria.

TABLE 5: MALARIA PREVALENCE AND MANAGEMENT FOR CHILDREN AGED UNDER FIVE

	2009	2011	2014
Prevalence of malaria[1]	42.4%		19%
Proportion of children under five sleeping under ITNs	32.8%[3]	42.8%[2]	74%[1]
Proportion of children with malaria who took anti-malarials (ACT)	23%[3]	64.5%[2]	67%[1]

Source: [1]Uganda Malaria Indicator Survey (UMIS), 2014-15; [2]Uganda Demographic and Health Survey, 2011
[3]Uganda Malaria Indicator Survey (UMIS), 2009

The major challenges that have affected malaria prevention and control efforts include shortages of ACTs, inadequate expansion of IRS, and inadequate capacity for malaria diagnosis, understaffing and inadequate partner coordination. The percentage of health facilities out of stock of first line anti-malarials improved to13% in 2013/2014, from 17% in 2010/2011 (MoH, 2014).

Acute respiratory infections (ARIs) in children, particularly pneumonia, continue to be a major contributor to under-five mortality—accounting for 13% of deaths (MoH, 2014). Little progress has been made in tackling pneumonia and other respiratory infections. Pneumonia kills up to 24,000 children before their fifth birthday[3]. Some of the key factors associated with acute respiratory infections in Uganda include poor breastfeeding practices[4], housing conditions, and type of cooking fuel used - with those exposed to smoke at more risk. The high rates of pneumonia deaths have also been attributed to low caregiver awareness about the symptoms of pneumonia, delayed care-seeking for pneumonia, (Tuhebwe et al., 2014), as well as misdiagnosis and wrong treatment of the disease with anti-malarials. Only 31% of children with suspected pneumonia receive antibiotics (MoH, 2013). These gaps in diagnosis and treatment are largely rooted in overlapping symptoms of pneumonia and malaria, and the lack of health worker skills and competencies in differentiating the two diseases (Källander et al., 2005).

Anemia is the third leading cause of death in children, causing almost 12% of all inpatient deaths of children under five and 4.6% of all in hospital morbidity (MoH, 2014).

[3] www.UNICEF.org/health/Uganda

[4] Optimal breastfeeding practices, including exclusive breastfeeding during the first six months of life and continued breastfeeding until 24 months of age, are known to reducing the burden of pneumonia among infants and young children. The protective effect of human milk against respiratory infection is attributed to its numerous immunobiological components (Lamberti et al., 2013)

Diarrhea accounts for 2.4% of inpatient deaths among children aged below five. The UDHS 2011 reported that 23% of all children under-five had suffered from diarrhea and 4% had diarrhea with blood in the weeks preceding the survey. The prevalence of diarrhea among children between six and 11 months is the highest at 43%, followed by households with non-improved toilet facilities. Rural children suffer more from diarrhea than urban children. Eastern region has the highest prevalence rate at 32.5% compared to other regions. Yet, only 35% of children with diarrhea receive ORS and 2% receive Zinc tablets. One of the major challenges in the management of diarrhea is caregiver non-compliance to use ORS, as well as strong rooted cultural and traditional beliefs on causes and treatment of diarrhea compounded by low perception of ORS efficacy (MoH, 2013).

The proportion of children under-five with pneumonia and diarrhea who receive appropriate treatment remains below the set target of ensuring that at least 80% of such children receive treatment.

The other causes of under-five deaths are multiple, and include meningitis, and several conditions associated with neonatal and perinatal conditions.

2.3 Nutrition

Adequate nutrition is a prerequisite for human development and socioeconomic well-being. Proper and healthy human growth and development requires adequate nutrition, especially during the first 1,000 days of a child's life (i.e. from conception to the age of 2 years). Yet under-nutrition in all its forms – stunting, underweight, wasting, micronutrient deficiencies and over nutrition – remain major public health challenges in Uganda, hindering sustainable development and the realization of the Uganda Vision 2040 (Government of Uganda (GoU), 2015). Uganda is one of the top 37 countries globally with high levels of chronic malnutrition. Nutrition is an outcome of health status and human and economic development, and affects functional consequences related to morbidity and quality of life, survival, productivity and educability. Child malnutrition greatly increases the risks of mortality and morbidity and as well as adversely affecting intellectual and physical development of the child. In Uganda, malnutrition remains largely a "hidden problem" since a majority of children affected are moderately malnourished and identifying malnutrition in these children without regular assessments is difficult (FANTA, 2010).

2.3.1 Prevalence of malnutrition in children under five years

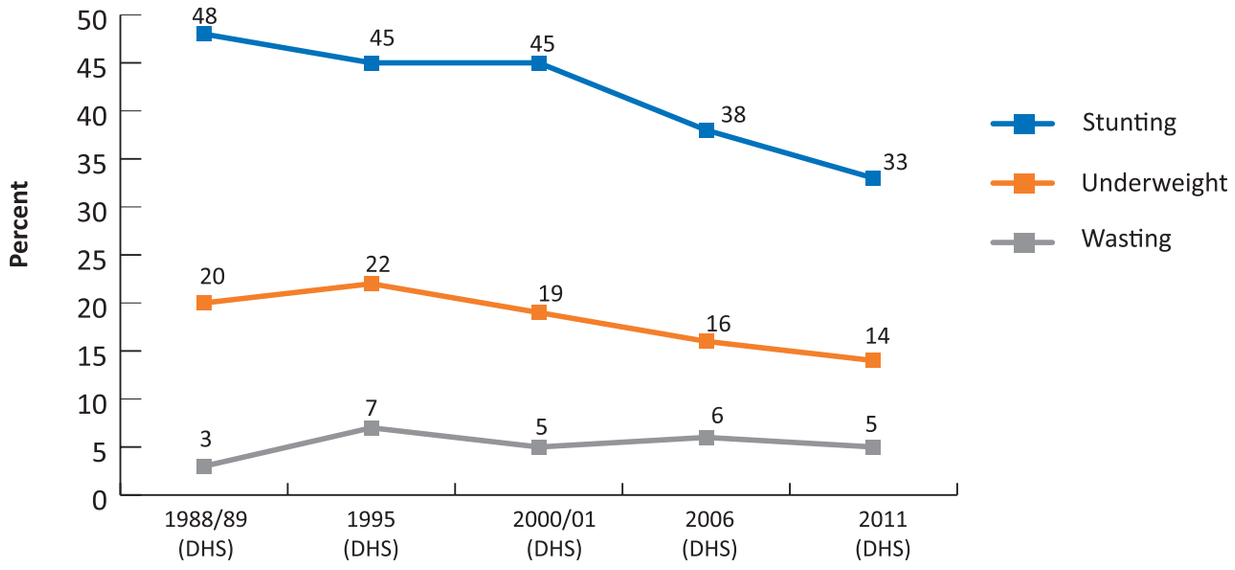
Nationally, 33 out of 100 children below five years are stunted, 14% are underweight and 5% are severely emaciated. In terms of absolute numbers, about 2 million under-five children are stunted and 801,000 are under weight. According to the WHO classification of the nutrition situation in Uganda, stunting levels remain serious and numbers of children wasting and underweight is significant, despite the general improvement in the nutrition indicators. With an estimated population of 34.1 million, of which 19% are children under five, it can be estimated that around 97,185 children (1.5 %) are at increased risk of death due to severe acute malnutrition (SAM), and up to 304,513 in total (4.7%) suffer from either severe or moderate acute malnutrition (MAM) (FANTA 2014; UBOS, 2012). The trends in the prevalence of stunting, underweight and wasting over the past 20 years are shown in Figure 3.

As shown in Figure 3, stunting has only reduced from 48% to 33% in more than 10 years. Similarly, the prevalence of underweight children has only reduced from 20% to 14% over the same period. Wasting shows the least improvement, from 3% in 1988/89 to 5% in 2011. Although the prevalence in these anthropometric indices shows a decline, the rate of change for stunting between 2006 and 2011 was only one percentage point per year, which is too slow to meet the MDG target or the Uganda Nutrition Action Plan target of 32%. The absolute population of children below five years of age that are stunted has also increased by 0.9% per year over the period; translating into 1.96 million in 1995 to 2.18 million in

> *"Adequate nutrition is a prerequisite for human development and socioeconomic well-being. Proper and healthy human growth and development requires adequate nutrition, especially during the first 1,000 days of a child's life."*

2013. This is however attributed to the growing population. Stunting affects cognition, educability and productivity, with irreversible consequences if nothing is done to address it within 24 months of life. Boys are more likely to be stunted and underweight compared to girls–37.7% vs 29.9% and 14.9% vs 12.7% respectively.

FIGURE 3: TRENDS IN PREVALENCE OF MALNUTRITION AMONG UNDER-FIVE



Source: Analysis of the Uganda Demographic and Health Survey (UDHS) 1988/89, 1995, 2001, 2006, 2011.

Regional prevalence and trends in malnutrition

The prevalence of malnutrition among children under-five varies significantly by region in Uganda. Table 6 provides a summary of the trends in stunting, underweight and wasting in 2006 and 2011.

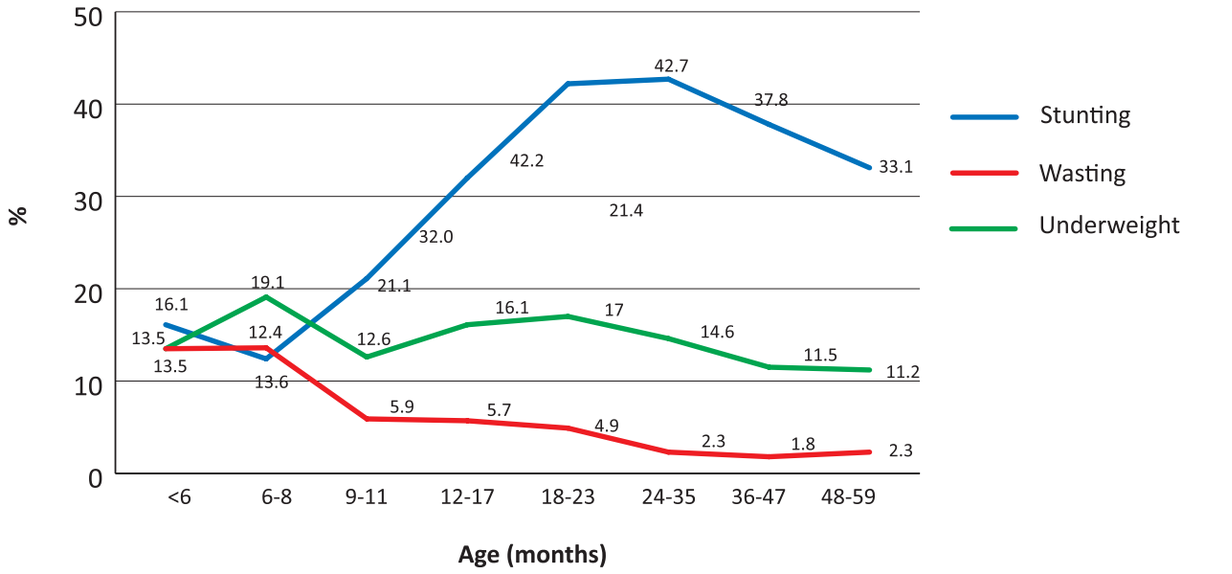
TABLE 6: PREVALENCE OF STUNTING, UNDERWEIGHT AND WASTING BY REGION 2006 AND 2011 UDHS

Region	Stunting		Underweight		Wasting	
	Severe 2006 (2011)	Severe and Moderate 2006 (2011)	Severe 2006 (2011)	Severe and Moderate 2006 (2011)	Severe 2006 (2011)	Severe and Moderate 2006 (2011)
Central 1	15 (14.2)	39 (32.5)	4 (2.5)	13 (12.9)	3 (0.4)	5 (5.8)
Central 2	8 (14.8)	30 (36.1)	2 (1.4)	8 (11.4)	1 (2.1)	3 (5.3)
Kampala	8 (3.1)	22 (13.5)	3 (2.0)	10 (5.7)	4 (1.6)	7 (4.4)
East central	11 (12.9)	38 (33.5)	6 (3.3)	23 (16.7)	5 (1.7)	10 (5.0)
Eastern	13 (7.9)	36 (25.3)	2 (1.3)	11 (10)	1 (0.6)	3 (4.8)
North	17 (9.9)	40 (24.7)	7 (3.2)	22 (12.3)	2 (0.7)	7 (3.4)
West Nile	15 (18.6)	38 (37.8)	5 (5.2)	17 (17.9)	2 (2.4)	8 (6.2)
Western	18 (18.9)	38 (43.9)	3 (4.6)	15 (15.2)	0 (1.4)	5 (2.7)
South-west	23 (18.6)	50 (41.7)	5 (5.2)	19 (14.9)	3 (2.8)	9 (4.9)
Karamoja	25 (23.5)	54 (45.0)	14 (13.4)	14 (31.9)	4 (2.6)	4 (7.1)
National	15 (13.7)	38 (33.4)	4 (3.4)	16 (13.8)	2 (1.5)	6 (4.7)

Source: Uganda Demographic and Health Survey (UDHS) 2006 & 2011

The prevalence of stunting was highest in Karamoja followed by the western and south-west regions; underweight rates are highest in Karamoja and west Nile regions; and wasting is highest in Karamoja, west Nile and central 1 regions. In Karamoja, the reasons explaining this situation include the effects of conflict and insecurity related to cattle raiding, dry climatic conditions, poverty and poor nutrition awareness (WFP, 2009). In other regions, the reasons for poor nutritional status include domestic violence, commercialization of agriculture–resulting into sale of all food crops–and changes in staples grown for food from nutritious to less nutritious foods such as bananas. Cultural factors are also at play, including food taboos and feeding practices. The northern region had an improvement in stunting, underweight and wasting over the period probably because of increased food production following the stability experienced since the end of the conflict. Figure 4 indicates the prevalence of stunting, underweight and wasting through children's life cycle.

FIGURE 4: DISTRIBUTION OF STUNTING, UNDERWEIGHT AND WASTING AMONG CHILDREN BELOW FIVE YEARS



Source: Uganda Demographic and Health Survey (UDHS) 2011

The figures show that stunting, underweight and wasting start early in childhood and steadily increase, especially for stunting from 6 months of age reaching a peak at 24 months of life. This highlights the importance of strong interventions within the first 1,000 days of life.

2.3.2 Low birth weight in children

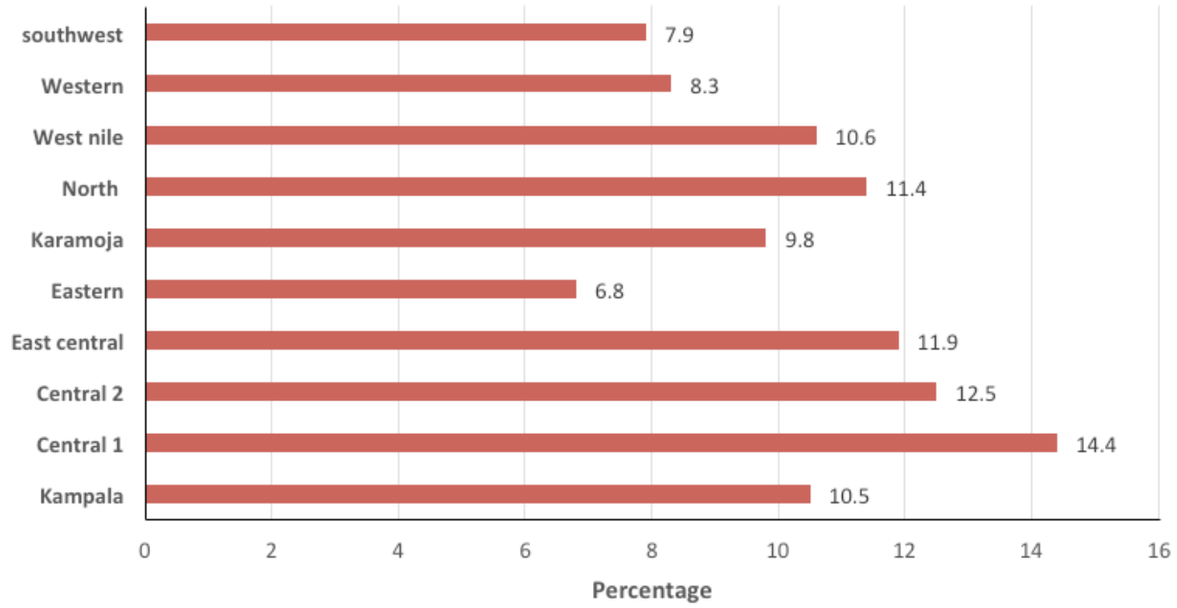
Children with low birth weight are four times more likely to die within the first month of life compared to other children. The World Health Organization (WHO) estimates that low birth weight babies have a three to four times greater risk of dying from diarrhea and acute respiratory infections as well as measles if they are not immunized; they are also more likely to be malnourished by the time they reach their third birthday. According to the 2011 UDHS report, the prevalence of low birth weight (less than 2.5 kg) was 10% compared to 11% in 2006. The birth weight of a child varies by mother's region of residence. The Central 1 region has consistently had the highest prevalence of low birth weight children (14.4%) over the past decade while the eastern region reported the lowest percentage (7%) (Table 7 and Figure 5). Reasons for these regional variations are not well known. Low birth weight tends to decrease with mother's age at birth.

TABLE 7: DISTRIBUTION OF LOW BIRTH WEIGHT BY BACKGROUND CHARACTERISTICS

Background characteristics	Percentage of all births reported	Percentage distribution of low birth weight	
		less than 2.5 kg	2.5 kg or more
Mother's age at birth			
<20	57.9	13.5	86.5
20-34	50.1	9.7	90.3
35-49	43.3	7.9	92.1
Birth order			
1	64.4	13	87
2-3	55.3	10.4	89.6
4-5	45.1	9.5	90.5
6+	40.9	8	92
Residence			
Urban	86.4	11.3	88.7
Rural	44.5	9.9	90.1

Source: Uganda Demographic and Health Survey (UDHS) 2011

FIGURE 5: PREVALENCE OF LOW BIRTH WEIGHT IN UGANDA BY REGION, 2011



Source: Uganda Demographic and Health Survey (UDHS) 2011

"According to a global school based Students' Health Survey 2003 Report, 5.3% of Ugandan school children aged 13-18 years were identified as at risk of being overweight, particularly girls (BMI >25kg/m²)²."

2.3.3 Overweight

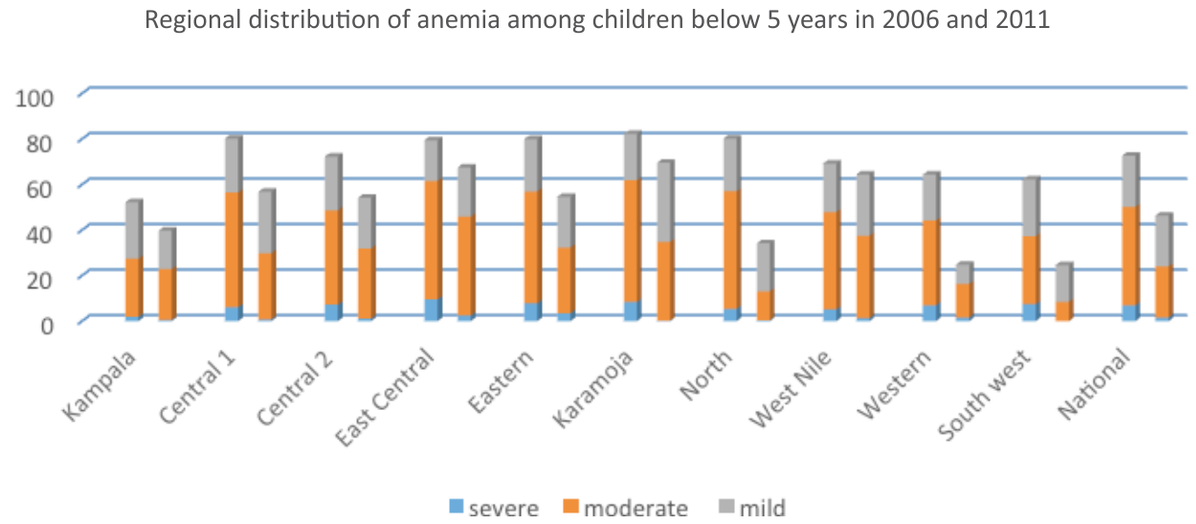
Few studies have documented overweight issues in Uganda, even though it is increasingly becoming a health problem among children on a national level. According to a global school based Students' Health Survey 2003 Report, 5.3% of Ugandan school children aged 13-18 years were identified as at risk of being overweight, particularly girls (BMI >25kg/m²)[2]. Being overweight increases a child's risk for a number of diseases and conditions, including asthma, diabetes, gallstones, heart disease, high blood pressure, menstrual problems among girls, sleep problems, metabolic syndrome, and the risk of being overweight for life.

2.3.4 Prevalence of micronutrient deficiencies

Anemia, Iodine deficiency, zinc deficiency and Vitamin A deficiency are the most common micronutrient deficiencies in Uganda. According to the 2011 UDHS report, 49% of children aged 6-59 months are anemic, this is a decrease from 73% in 2006–implying that one out of two children within this age group is anemic: 22% are mildly anemic, 26% are moderately anemic, and 2% are severely anemic. Anemia results in impaired neurocognitive function in children, contributes to child mortality and decreased work capacity during child growth. There was a significant reduction in the prevalence of any anemia among children by 24% and by 18% for moderate anemia between 2006 and 2011(UBOS and ICF International, 2012).

The prevalence of anemia is highest in east central (67.5 %), Karamoja (69.5 %), and west Nile (64.4 %) regions, while south-west has the lowest prevalence at 24.6%. 51% of children in rural areas have anemia, compared with 38% of children in urban areas. Figure 6 provides the regional distribution of anemia in children below five in 2006 and 2011. The majority of the anemia in children is moderate or mild, which is a major underlying cause of childhood morbidity and mortality. The prevalence of anemia is highest among children aged 6-23 months with approximately nine out of ten children and six out of ten children having any form of anemia (<11.0g/dl) in 2006 and 2011 respectively. Anemia and iron deficiency reduce individuals' well-being, cause fatigue and lethargy, and impair physical capacity and work performance.

FIGURE 6: REGIONAL DISTRIBUTION OF ANEMIA IN CHILDREN BELOW FIVE YEARS



**First bar is for 2006 and the second is for 2011 (MoH, UDHS 2006, 2011)

Vitamin A deficiencies (VAD), RBP <0.825 µmol/L, among children aged 6-59 months in Uganda generally increased from 20% in 2006 to 33% in 2011. This increase is difficult to explain given that vitamin A supplementation in children and postpartum women as well as consumption of vitamin A-rich foods in children increased slightly since the 2006 UDHS. At 42%, the eastern region has the highest rate of VAD, followed by the east central region (40%) while entral 2 region has the lowest VAD prevalence among children 6-59 months old (22 %). VAD is highest among children 2-4 years of age, and boys are more likely to be vitamin A deficient than girls (34.4% compared to 30.9% in 2011).

2.3.5 The cost of malnutrition

According to the 2013 Cost of Hunger in Uganda Report, approximately 54% of the current working age population were stunted while children. Investing in nutrition now would lead to economic gains in the future through increased productivity exceeding 4.3 trillion Ugandan Shillings (US$1.7 billion) by 2025 (OPM, 2014). Table 8 provides a summary of the cost of malnutrition among children in Uganda.

TABLE 8: DEATHS ATTRIBUTABLE TO VARIOUS NUTRITION PROBLEMS AND LIVES SAVED THROUGH IMPROVED NUTRITION

Nutrition problem	Number of deaths that would result if the current situation continues Status quo scenario 2013–2025	Number of lives that would be saved if nutrition situation improves Improved scenario 2013-2015
Anthropometric Indicators		
Deaths/lives saved attributable to **stunting** (severe, moderate, and mild) among children < 5 years of age	422,000	88,000
Deaths/lives saved attributable to **wasting** (severe, moderate, and mild) among children < 5 years of age	232,000	31,000
Low Birth Weight		
Infant deaths/lives saved	196,000	25,800
Iron-Deficiency Anemia		
Maternal deaths/lives saved	9,800	4,400
Perinatal deaths/lives saved	70,900	19,800
Vitamin A Deficiency		
Child deaths/lives saved	221,000	60,900

Source: Namugumya et al., 2014

Malnutrition among children is an underlying cause of 15% of childhood mortality in Uganda (WFP, 2013). Death from malnutrition-induced causes is attributable to the fact that almost 82% of childhood cases of malnutrition and related pathologies go untreated. The annual costs associated with childhood under nutrition are estimated at 1.8 trillion Uganda shillings - equivalent to 5.6% of the country's Gross Domestic Product (GDP). There were improved economic productivity gains of about US$1,700 million (4,257 billion Ugandan Shillings) related to reduction in stunting levels and about US$108.8 million (272 billion Ugandan Shillings) related to improvements in iron deficiency anemia by 2025 (Namugumya et al., 2014).

2.3.6 Causes of poor nutrition status among children in Uganda

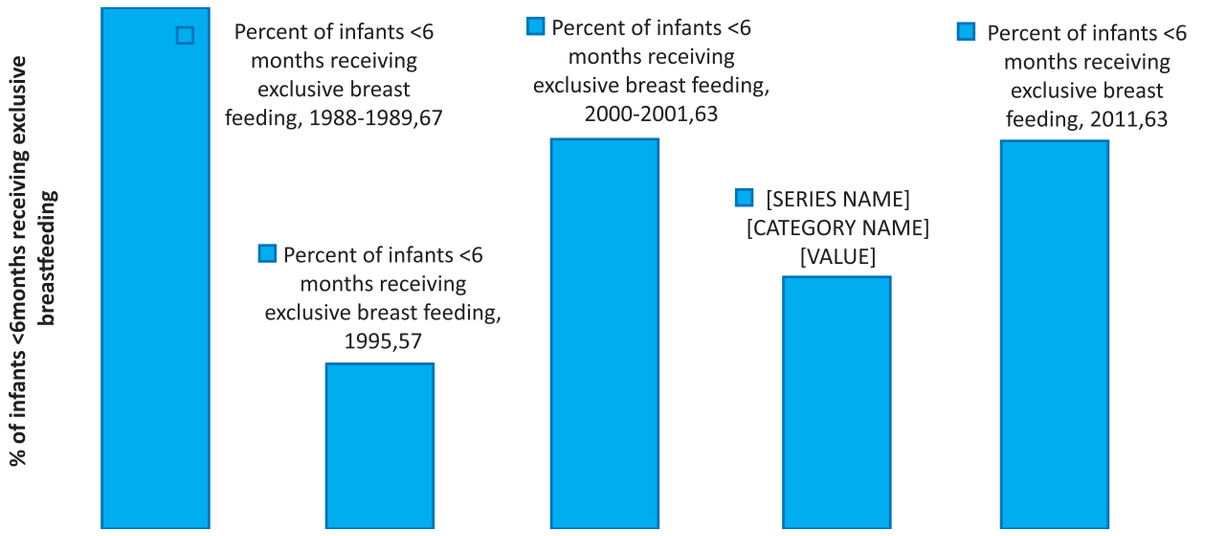
Poor nutrition status among Ugandan children is a result of multiple immediate and underlying causes. The immediate causes of child malnutrition in Uganda are two-fold: (i) inadequate dietary intake resulting from sub-optimal maternal and infant feeding practices and (ii) the high disease burden resulting from malaria, diarrheal diseases, and acute respiratory infections. The underlying causes of inadequate dietary intake and the high disease burden include household food insecurity, inadequate maternal and childcare, and poor access to health care and a healthy environment. They also include early marriage and early childbearing, short birth intervals, gender-based-violence (GBV) and women's low education status (GoU 2011; EPRC, 2012).

Infant and Young Child Feeding Practices

Sub-optimal infant and young child feeding (IYCF) practices are common in Uganda. According to the 2011 UDHS report, almost all children (98%) were breastfed at some point, but only slightly more than half (53.8%) were breastfed within an hour of birth and only 63% of children who were 0–5 months were exclusively breastfed. By 4–5 months of age, the percent of exclusively breastfed children dropped to only 41%. The prevalence of exclusive breastfeeding is slightly higher in rural than in urban areas (19.7% vs 16.3%), but regional disparities are far greater, ranging from 13.6% in Kampala to 23% in the Karamoja region. This is an indication that many children miss out on essential nutrients because of early weaning

by their mothers. The early introduction of foods by mothers also aggravates diarrheal diseases and acute respiratory infections. The median duration of breastfeeding has increased from 3.1 months in 2006 to 3.4 months in 2011. However, this is short of the WHO recommendation of 6 months.

FIGURE 7: EXCLUSIVE BREASTFEEDING OF CHILDREN 1988/89–2011 (%)



Source: MoH, Uganda Demographic and Health Surveys; 1988/89, 1995, 2001, 2006 and 2011

It is also noted that there are various discrepancies between knowledge and practice. For example, the UDHS (MoH, 2011) further reveals that among breastfed children 6–23 months, only 44% were fed the minimum number of times in the previous 24 hours (minimum meal frequency) and only 6% were given foods from four or more groups and fed the minimum times per day (minimum acceptable diet). Amongst children between 6-23 months of age only 61% consumed food rich in iron in the last 24 hours before the study, and only 50% were dewormed. Worm infestation reduces the ability of one's body to absorb needed nutrients from food. Only 57% of children 6-59 months of age received a Vitamin A supplement in the last 6 months before study in spite of the existence of a biannual supplementation program.

Food taboos are also a contributing factor to malnutrition. Qualitative data show that, for example, the Bahima ethnic group in the Kiruhura district, do not culturally eat foods such as fish and pork. On the other hand they are experiencing some cases of obesity, which could be linked to the overconsumption of milk.

Disease prevalence

Malaria, diarrhea, HIV/AIDS, tuberculosis and acute respiratory tract infections (ARIs) contribute to malnutrition among the populace. Illnesses such as diarrhea interrupt the body's ability to absorb and use nutrients from food thereby contributing to malnutrition.

Health seeking behavior and child spacing

Poor health seeking behaviors and short childbirth intervals are predisposing factors of malnutrition in Uganda. For example, while Antenatal care (ANC) provides an opportunity for pregnant women to receive health and nutrition information as well as supplementation, only 48% of pregnant women make the four or more recommended antenatal visits. Generally, the first ANC visit happens at 5 months gestation.

Further, short birth intervals are associated with an increased risk of small birth weight, child mortality and malnutrition. The prevalence of stunting and underweight was higher among children born less than 24 months after the previous birth - at 41.2% and 18.1% respectively. In addition, children born less than 24 months after the previous birth are 93% more likely to die before their fifth year. Child mortality rates are highest among children of first (45%) and seventh or higher birth order (59%) (MoH [UDHS], 2011).

Gender considerations

Violence against women (VAW), women's workload and unequal access to productive resources affect the childcare practices. Six out of ten women (60.7%) in West Nile and slightly over one half in eastern were physically abused by their partners (MOH [UDHS] 2006). Women's workload prevents women from providing proper care to their children, especially in households with a single parent. Women are involved in farm work, household chores and reproductive and community roles which often leave them with little time to care for their children, prepare food and ensure hygiene and sanitation within their homes. As one key informant observed:

Women leave early in the morning and return late in the evening and yet they are the ones to come back and start the cooking and do the rest of the household chores, so you find the child can even stay for the whole day without eating (Program Coordinator, GWEDG, Gulu District).

Food insecurity

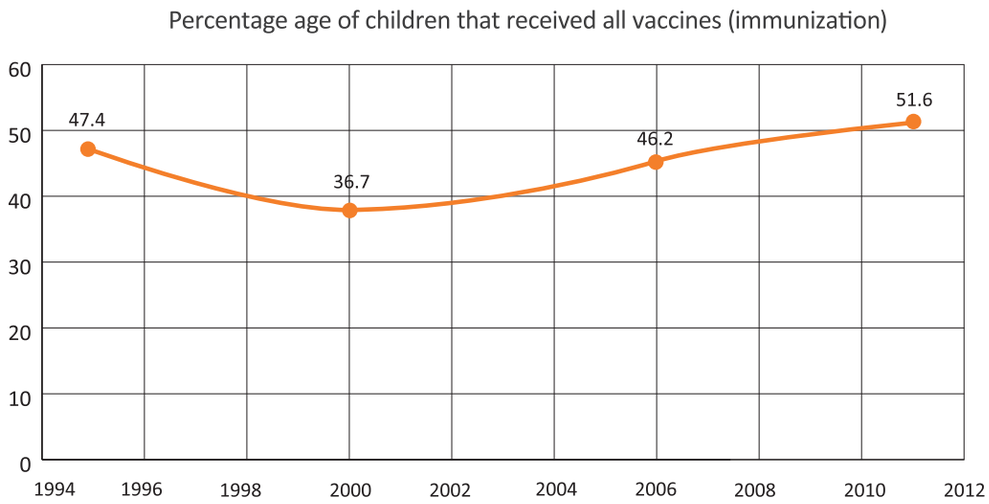
Food insecurity remains a major cause of inadequate dietary intake and malnutrition in Uganda. More than 20.3% of Ugandans have 'unacceptable' food consumption (4.7% poor and 15.6% borderline). Diets are extremely unbalanced, energy-deficient, devoid of protein and chiefly comprised of starchy maize or matooke (plantain) flavored with some vegetables. FGD data from caregivers of children indicated that children in most homes are simply fed on what is available and at the same interval as adults. In many homes this means feeding on one type of food twice a day for many days.

Other factors for poor child nutrition include poor hygiene and sanitation despite the general improvement in access to safe water and sanitation facilities, which affects the utilization of food.

2.4 Immunization Coverage

World Health Organization (WHO) guidelines state that a child is considered fully immunized when he or she has received vaccines against tuberculosis (BCG), three doses of diphtheria, pertussis and tetanus (DPT) and polio vaccines by the age of 12 months. By 2011, the coverage of full immunization was 51.6%, meaning that close to half of children in Uganda had not received full immunization. This rate is far below the national target of 80% coverage of all vaccines. The Uganda National Expanded Program for Immunization (UNEPI 2010-2014) has raised immunization coverage rates from 36.7% in 2000 to the 2011 status of 51.6% (UNEPI, Promotion of routine immunization report).

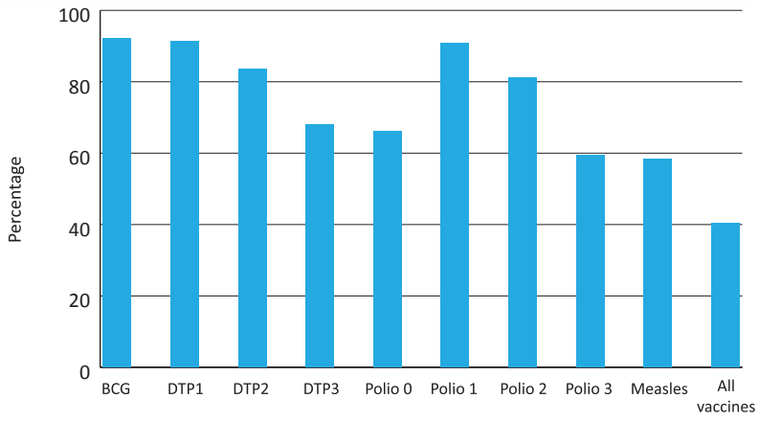
FIGURE 8: TRENDS IN IMMUNIZATION COVERAGE OVER TIME



Source: Uganda Demographic and Health Survey (UDHS) 2001, 2006 & 2011

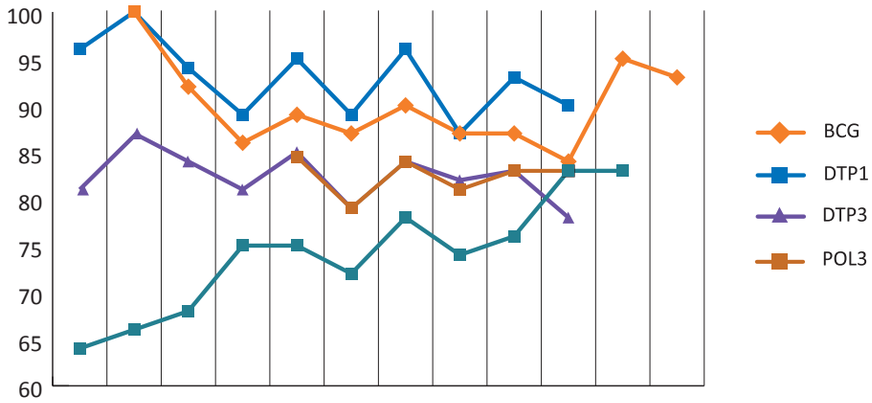
Despite improvement in immunization, there is variation in performance of immunization programs in relation to different vaccines as shown in Figure 9. In the last five years, coverage declined for some of the major vaccines (Figure 9).

FIGURE 9: STATUS OF VACCINATION (12-23 MONTHS) IN 2011



Source: UDHS 2011: Notes: children between 12-23 months that had received vaccines in last 12 months before the survey

FIGURE 10: TRENDS IN SELECTED VACCINE COVERAGE OVER TIME



Source: WHO & UNICEF estimates immunization coverage 2014

In 2012, DTP3 coverage rate was estimated at 78%, meaning 22% of children had not received the third dose of DT, thus falling below the HSSIP target of 85%. A similar trend is noticeable for the DTP1 vaccine.

TABLE 9: PERCENTAGE OF CHILDREN (12-23 MONTHS) THAT HAD RECEIVED ALL VACCINES BY BACKGROUND CHARACTERISTICS

	Overall	Residence		Gender		Mother's Education attainment		
		Urban	Rural	Male	Female	No education	Primary	Secondary or higher
2011	51.6	60.8	50.2	51.6	51.7	45	49.2	61.7
2006	46.2	51.1	45.7	45.5	47	39	46	57.9
2000-01	36.7	42.1	36	36.4	37	28.3	37.2	51.1
1995	47.4	56.1	46.3	48.3	46.6	38.3	48.4	68.1

Source: UDHS 1995, 2000/1, 2006, 2011. Notes: Percentage of children 12-23 months who had received specific vaccines by the time of the survey according to the vaccination card or the mother's report

The data shows that children residing in urban areas are more likely to complete immunization compared to their rural counterparts. Similarly, children whose mothers have secondary education or higher are more likely to complete their immunization compared to those whose mothers have only primary education or no education at all. There are major differences in completion of immunization by gender. The major challenges with regard to immunization outreach services have been the declining funding for operational costs, logistical challenges, irregularities of outreaches, and lack of supportive supervision (MoH, 2010).

2.5 HIV and AIDS in Children

The number of children 0-14 years living with HIV declined from 150,000 in 2014 (UAC, 2015) to around 147,394 in June 2015 (MoH, 2015). In 2014 alone, there was an estimated 5,200 new cases of HIV among children - representing a 66% decline compared to the incidence levels recorded in 2012. The majority of children with HIV are infected during pregnancy, birth or breastfeeding. While mother to child transmission of HIV is preventable, the service up-take has not yet reached all women in need. In 2014, up to 94% of pregnant women living with HIV and AIDS in Uganda received appropriate ART regimes for preventing mother to child transmission of HIV, an increase from 71.7% in 2013 (UAC, 2015). Table 10 below shows key data for pediatric HIV in Uganda.

TABLE 10: PEDIATRIC HIV RATES IN UGANDA

	2009	2010	2011	2012	2013	2014
Number of children 0-14 living with HIV	150,000 [80,000 –210,000]			190,000 [160,000-230,000]		150,000[1] [130,000- 170,000]
Number of new HIV infections (incidence) in children 0-14)	27,300	27,139[2]	31,000[1]	15,411[2]	15,000[1]	5,200[1]
Percentage of infants born to HIV-infected mothers who are infected	9.9%[5]			8.6%[3]	11.2%[3]	4.9[3]
Mother to child transmission rate (including through breastfeeding)	31%[4]	30%[6]	21%[4]	15%[6]		

Sources: Uganda AIDS Commission (2015)[1]; Uganda AIDS Commission (2014)[2]; HMIS, Ministry of Health[3]; UNICEF (2012)[4],; Government of Uganda (GoU), (2010)[5]; UNAIDS (2013)[6]

2.5.1 Mother-to-child transmission of HIV/AIDS

There is a reduction in the number of newly born children turning positive from between 7.5% to 8.6% in 2012 to 4.9% by August 2015 - slightly below the national target of five percent. This reduction could be attributed to the Elimination of Mother to Child Transmission (EMTCT) program that MoH and other USAID and CDC partners are implementing. According to UNAIDS (2013) Uganda's progress towards eliminating new HIV infections among children can be advanced through increasing the availability and uptake of ARV medicines during breastfeeding to reduce the number of new HIV infections among women, and improving access to family planning services.

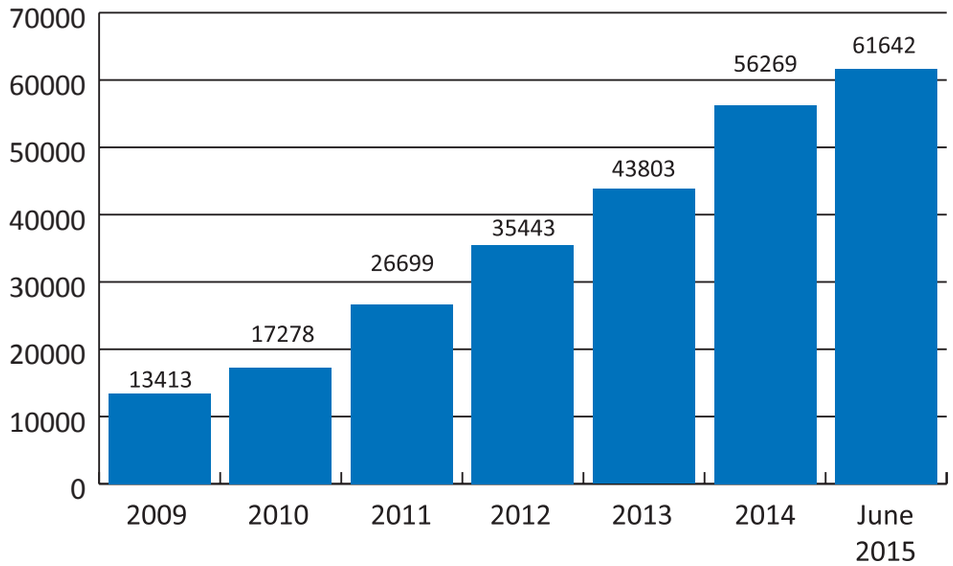
2.5.2 HIV testing for infants born to HIV positive mothers

According to MoH/WHO guidelines, all children born to HIV positive mothers should be given septrine (CPT) and have a DNA/PCR test taken with the first six weeks of birth. This enables early detection of positive children and facilitates enrollment to immediate ART services. Despite this policy, HIV testing for newborns does not happen in the majority of cases. In 2014, only 33% of babies born to HIV positive mothers received a virological test within 2 months after birth (DHIS2, 2014). Qualitative data revealed that HIV testing for infants is affected by several factors. These include the inability of parents to bring back the child to the health facility after two weeks and non-disclosure of mothers' HIV status to their partners during pregnancy, especially if it is a new relationship. The non-disclosure was attributed to the dependency of women on partners' finances, fear of violence at home and lack of knowledge of health effects on children by the mother's health seeking behavior.

2.5.3 ART coverage among children

Scaling up antiretroviral treatment (ART) services is a cornerstone to HIV/AIDS treatment globally and a key element of HIV prevention. Figure 11 shows ART coverage among children in Uganda between 2008 and June 2015.

FIGURE 11: NUMBER OF CHILDREN 0-14 ON ART 2009–JUNE 2015



Source: Ministry of Health (MoH), 2012, 2015; MoH and ORC Macro (2006); UBOS and Macro International (2007); UAC 2015.

ART coverage among children 0-14 increased to about 42% by June 2015 compared to 21% in 2011 (UNICEF, 2012a; UAC, 2015, MoH 2015). The number of children aged 0-14 years on ART was 61,642 by June 2015, continuing the steady increase between 2009 and 2015. The increase in ART coverage for children was attributed to an increase in the number of accredited ART sites countrywide and accellerated efforts towards improving pediatric ART. The latter included training mentors for pediatric HIV care and quality improvement across the country. The increase in ART coverage for

children is also attributed to the MoH guidelines of starting every child aged 14 years and below on ART once diagnosed to be HIV positive. However, these increases have not completely closed the gap in accessing ART services. Out of the estimated 147,394 children aged 0-14 living with HIV by June 2015 85,752 (58%) were not identified and therefore not on treatment (MoH 2015).

2.6 Adolescent Sexual and Reproductive Health

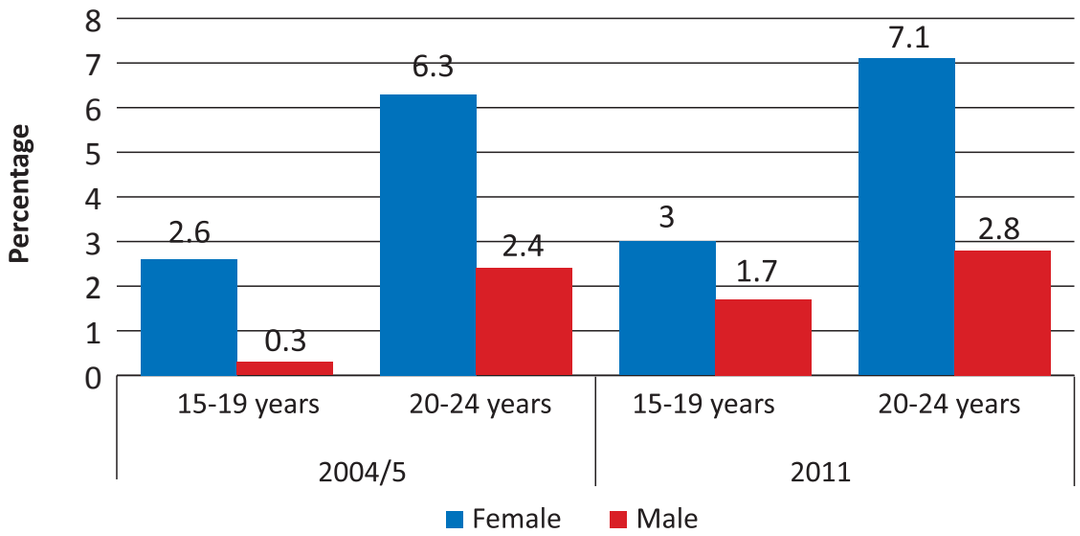
2.6.1 HIV/AIDS among teenagers (10-14)

There is scanty information about the HIV situation among young people aged 10 to 14. Nonetheless, data from the adolescent survey conducted in 2013 indicate that the HIV prevalence rates among this age group in 2013 were 1.9 percent for males and 2.3 percent for females (MoH, 2015b).

2.6.2 HIV prevalence among young people (15-24)

The HIV prevalence among young people aged 15-24 is reported at 3.7% (MoH, 2012), translating into an estimated 214,886 young people living with HIV as per population estimates in 2014 (UBOS 2014a). The overall prevalence of HIV among this age group increased from 2.9% in 2004/5 to 3.7% in 2011.

FIGURE 12: HIV PREVALENCE AMONG YOUNG PEOPLE AGED 15-19 2004/5 AND 2011



Source: Ministry of Health (MoH), 2012; Uganda Demographic Health Survey (UDHS, 2006); MoH and ORC Macro (2006); Uganda Bureau of Statistics (UBOS) and Macro International (2007)

The increase in HIV prevalence amongst young people aged 15-24 has been attributed to high-risk sexual behaviors, low knowledge of one's HIV sero-status and low use of condoms during sexual intercourse. Cross-generational sex has also been identified as a key factor in the spread of HIV among young people, especially among girls. In all districts visited, young people explained that girls enter into sexual relations with older men – lured by money and material gifts, these girls report being unable to negotiate for safer sex.

Other factors highlighted include the existence of surviving adolescents born with HIV, yet many do not disclose their sero-status to their sexual partners for fear of being shunned, isolated and stigmatized, and low condom use due to fear of losing relationships, unplanned sexual encounters that allow no time to obtain condoms, myths and misconceptions about condoms, and the fear of asking for condoms from providers. Some of the young people's voices on these issues are shown in the text box below.

Reasons why girls do not initiate or suggest use of condoms with their sexual partners

- *Girls fear to express their views, as they think in case they said what their partner does not like, they would be pushed out of the relationship and lose their boyfriends (FGD, Young Males, Old Mulago, Kampala).*
- *Sometimes the time you have is so limited to even think about a condom, for example if you met a boy in a corridor and that is the only opportunity, where do you get the condom from? (FGD, Young Females, Old Mulago, Kampala)*
- *Some girls fear to use condoms because they think condoms are dangerous to their health. Some think that they can put it on badly and it remains inside the Vagina (FGD, Young Males, Karangura Sub-county, Kabarole District).*
- *Most men lie before entering the room that they are going use a condom, but when you enter the room, sex is without protection, girls have little 'say' on condom use (FGD, Young Females, Bushikoro -Sub County, Mbale district).*
- *Most people fear being seen picking condoms (FGD, Young Males, Bushikoro Sub County, Mbale district).*
- *Girls fear pregnancy more than HIV, with pregnancy you will be chased out of school (FGD, Young Males, Nakisunga Sub-county, Mukono District).*
- *Girls are too shy to ask boys to use condoms (FGD, Young Males, Katebwa Sub-county, Kabarole District).*

The voices quoted above highlight barriers to accessing and using condoms, such as a lack of adequate information about condoms, lack of confidence and low self-efficacy. As a result of such barriers, young people continue to engage in unprotected sexual intercourse exposing them to high risks of HIV infection, STIs, and early and unwanted pregnancies. These problems in turn lead to unwanted situations such as dropping out of school, abortion, early marriage and high fertility, sometimes putting individuals at further risk of ill-health or even death. Therefore there is need for more proactive approaches that empower young girls to be in charge of their lives by feeling confident to make decisions and choices that can keep them safe.

Some key informants also recognize that political and other leaders as well as health service providers have not agreed on a clear message to give to young people. Some condemn condom use while others promote it, often confusing the youth, and stigmatizing condom use.

Kiruhura is a very religious district but our children might be having sex. However, we have a lot of trouble trying to educate our children about sex education. We think that we will tell our children to abstain, but they may not. There is a gap in providing sex education by the different people –by the parents, religious leaders or other people in the community. There are a lot of messages relating to abstinence and being faithful, but little is done to tell young people about using condoms. There is a lot of stigma in relation to providing HIV information regarding to condom use. Even for me as the DHO to go to the radio and preach about condom use would be very tricky (DHO, Kiruhura)

However, it is also possible that improved access to HIV and AIDS treatment has indirectly contributed to greater longevity for those living with HIV thus the rise in the prevalence in this age group (MoH, 2013). Yet young people with HIV may not easily disclose their HIV status to their intended and current sexual partners for fear of being rejected, stigmatized or losing the relationship altogether as qualitative data shows.

Table 11 below shows the distribution of HIV prevalence among young people aged 15-24 by residence and level of education.

TABLE 11: TRENDS IN HIV PREVALENCE AMONG YOUNG PEOPLE AGED 15-24 BY SELECTED DEMOGRAPHIC CHARACTERISTICS

	2004/5		2011	
	Percentage HIV positive		Percentage HIV positive	
	Male	Female	Male	Female
Residence				
Urban	1.8	6.9	1.6	5.9
Rural	0.9	3.8	2.3	4.6
Education				
None	4.8	4.3	0.0	3.2
Primary	1.1	4.5	2.3	5.5
Secondary and higher	0.8	4.0	1.9	4.0

Source: Ministry of Health (MoH), 2012; MoH and ORC Macro (2006); UBOS and Macro International (2007)

The HIV epidemic continues to affect more young girls than young boys. In Uganda, as in many parts of the world, this is partly attributed to socio economic inequities and the low status of girls (and women) within a predominantly masculine society. This increases the young girls' risks of exposure to HIV infection especially when sex is a result of economic insecurity and where negotiation for safe sex is almost out of the question. The promise of gifts and other financial and social benefits to economically vulnerable girls is associated with an increase in cross-generational sexual relationships, or marriage at a young age. The limited knowledge about HIV and low risk perception exacerbates their risk to HIV infection (UNICEF, 2013).

HIV prevalence is much higher among young people living in urban areas as compared to the rural areas across the two surveys (6.9% vs. 3.8% in 2004/5 and 5.9% vs. 4.6% in 2011). Among both the male and female adolescents, the prevalence continued to rise among those with primary education. However, the prevalence has continued to rise overall in all education categories.

2.6.3 Access to ART for adolescents

Uganda currently faces an unprecedented HIV/AIDS burden among adolescents, a significant proportion of them were vertically infected, and have survived and grown into their teenage years (UAC, 2014a). These continue to need ART and other forms of care. Yet by 2015, only 29 percent of the estimated ART-eligible adolescents are receiving ART (MoH, 2015). Access to cotrimoxazole among adolescent is at 80% but only 40% had accessed CD4 count services. If nothing is done to enable this big number of HIV positive young people to access ART, they face the risk of quickly developing AIDS, infecting their partners, and ultimately dying at a young age. Measures to ensure that young people are enrolled onto ART and adhere to recommended treatment are therefore urgently needed.

2.6.4 HIV related knowledge and practices among people aged 15-24

TABLE 12: HIV-RELATED COMPREHENSIVE KNOWLEDGE[5] AND PRACTICES AMONG PEOPLE AGED 15-24

	2004-05			2011		
	15-19	20-24	15-24	15-19	20-24	15-24
Proportion of young people aged 15-24 years with comprehensive knowledge about AIDS						
Male	32.5	39.9	35.3	36.1	44.0	39.3
Female	29.0	30.1	29.5	36.3	41.3	38.6
Higher risk sex among 15-24						
Male	-	-	74.3	-	-	70.7
Female	-	-	25.9	-	-	30.8
Condom use at higher risk sex among 15-24 year olds						
Male	-	-	55.1	-	-	46.2
Female	-	-	52.9	-	-	41.3

Source: Ministry of Health (MoH), 2012; MoH and ORC Macro (2006)

Data from the AIS 2011 show that only 39.3% of young males and 38.6% of young females aged 15-24 had comprehensive knowledge about HIV prevention (MoH, 2012). This means that almost 60% of both male and female young people in this age group continue to lack accurate knowledge about how they can protect themselves from acquiring HIV. These figures had only increased slightly from the 2004/5 levels. These low levels of knowledge about HIV/AIDS are of great concern given the efforts of government and its partners to disseminate information about HIV/AIDS over the past 20 years.

The low levels of knowledge are also consistent with the high levels of high-risk sexual behavior and low condom use, the latter having gone down by almost 10 percentage points for both males and females between 2004/5 and 2011.

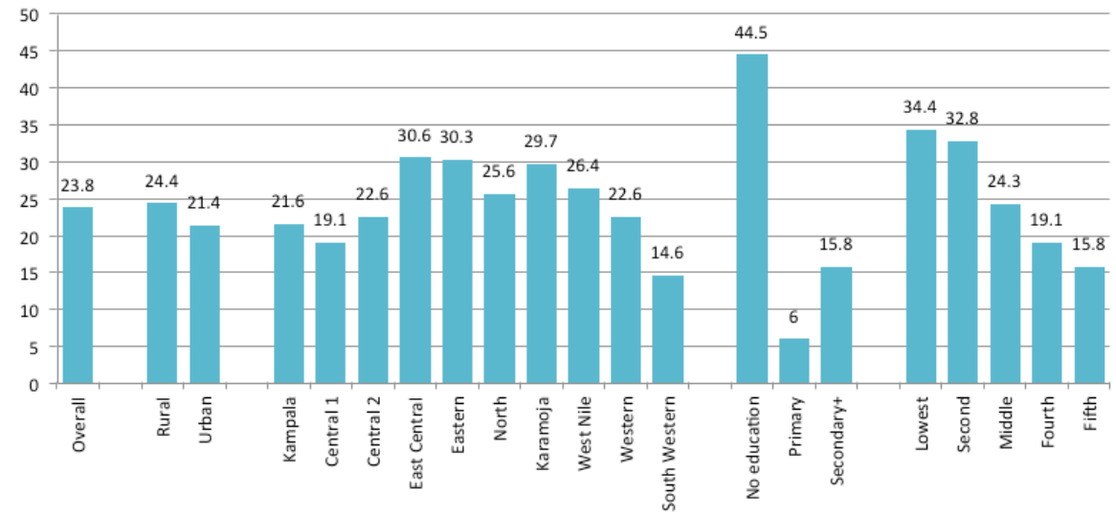
> *"The HIV epidemic continues to affect more young girls than young boys. In Uganda, as in many parts of the world, this is partly attributed to socio economic inequities and the low status of girls (and women) within a predominantly masculine society."*

2.6.5 Adolescent pregnancy and adolescent birth rate

According to the 2011 UDHS one in every four girls aged 15–19 years has begun childbearing (is pregnant with their first child or has had a live birth) (UBOS and Macro International Inc., 2012). Teenagers with no education are three times more likely to start childbearing than those with secondary education. Teenagers from households in the lowest wealth quintile are twice as likely to start childbearing than those from households in the highest quintile. In addition, teenagers in east central, eastern and Karamoja regions are twice as likely to begin childbearing than teenagers in south-west region (see Figure 13).

[5] Comprehensive knowledge about HIV combines several individual indicators - it is the percentage of respondents who say: (1) that people can reduce the chances of getting the AIDS virus by using a condom every time they have sex, and (2) that people can reduce the chances of getting the AIDS virus by having sex with just one partner who is not infected and who has no other partners, and (3) that people cannot get the AIDS virus from mosquito bites, and (4) that people cannot get the AIDS virus from sharing food with a person who has AIDS, and (5) that a healthy-looking person can have the AIDS virus.
Higher risk sex: The percent of respondents who have had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activity in the last 12 months.

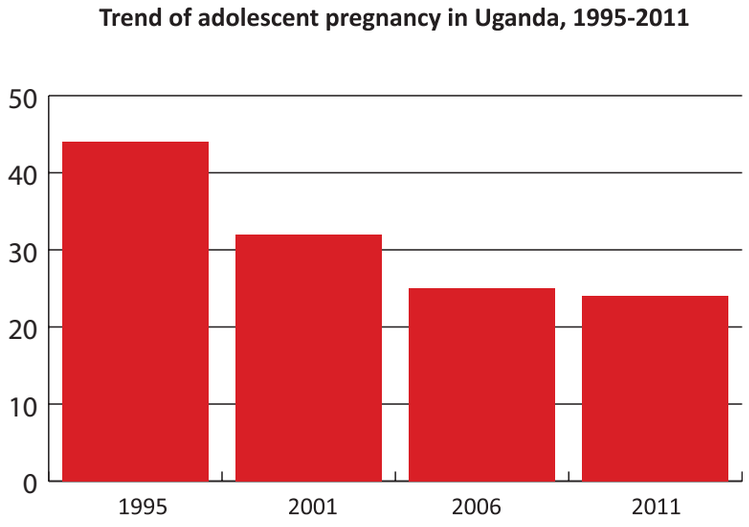
FIGURE 13: WOMEN AGED 15-19 WHO HAVE HAD A LIVE BIRTH OR WHO ARE PREGNANT WITH THEIR FIRST CHILD (BEGUN CHILDBEARING) BY BACKGROUND CHARACTERISTICS



Source: UDHS 2011

Figure 14 shows the overall national trend in teenage pregnancy rate in Uganda over a 15 year period. Overall teenage pregnancy rates have been persistently high over time with a slight decline from 43% in 1995 to 31% in 2001, to 25% in 2006 and to 24% in 2011 (UBOS 1995; 2001; 2006, 2011).

FIGURE 14: TRENDS IN TEENAGE PREGNANCY 1995-2011



Source: UBOS 1995; 2001; 2006, 2011

There are several factors that contribute to teenage pregnancy. These include early initiation of sexual intercourse (early sexual debut), high rates of child marriage, lack of access to accurate SRH information and effective sexual and reproductive health services and low contraceptive use.

- Several myths and misconceptions exist among teenagers: 54% of young people think a girl cannot get pregnant the first time she has sex. (Straight Talk Foundation, 2013)
- Only 5% of public health facilities in Uganda provide Youth Friendly Sexual and Reproductive Health services. (Ministry of Health, 2011)
- Only 14% of girls age 15-19 use a contraceptive method (UBOS and Macro International Inc. 2012)
- About 14% of young women in the age group 15-24 had their first sex early in life, i.e., before the age of 15.
- Nearly six in ten young women age 15-24 years (58%) had had sex before age 18

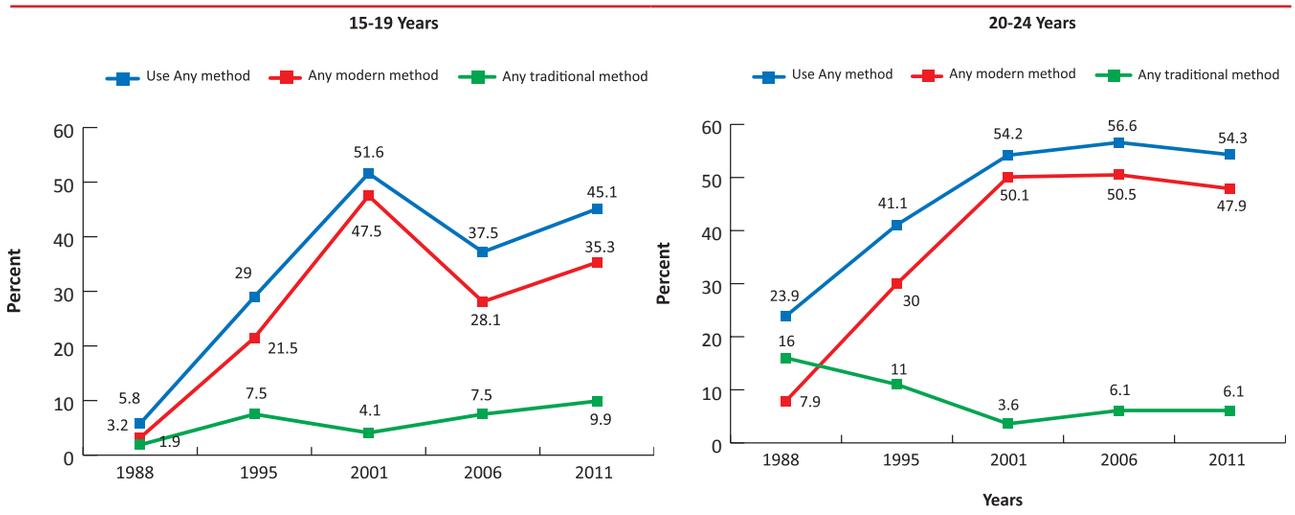
Teenage pregnancy has consequences on girls' lives. Compared to women, many teenage girls are less likely to give birth with a skilled attendant. A girl in this age group is therefore twice as likely to die during pregnancy or childbirth than a woman in her 20s (UNFPA, 2013). Teenage mothers are also more at risk of complications and disabilities, including obstetric fistula. Stillbirth and newborn deaths are 50% higher among infants of teenage mothers than among infants of mothers between the age of 20 and 29 (UNFPA 2013). Teenage pregnancy can lead to school drop-out and loss of education and lack of acquisition of productive or employable skills (Ahikire & Madanda, 2011; Grant & Hallman, 2008; Kyomuhendo-Bantebya, Muhanguzi, & Watson, 2014; Mbabazi-Mpyangu, Ochen, Olowo, & Lubaale, 2014; Stoebenau, Warner, Edmeades, & Sexton, 2015). This in turn leads to low productivity which in the long-term contributes to poverty.

Early marriages and early pregnancies lead to dropping out of school, for example in Bufumbu sub-county girls are married so early. Last year in a primary school called Bumadada by the end of the year about 4 girls had dropped out of school (KII, Inspector of schools, Mbale district).

2.6.6 Contraceptive prevalence among people aged 15-24

Contraceptive use allows young women to delay childbearing and to avoid unintended pregnancy. Figure 15 shows the contraceptive prevalence rate among unmarried sexually active young women 15-24 years based on UDHS data. According to the 2011 UDHS, only five in ten unmarried sexually active young women aged 15-19 reported using a method of contraception, with most women using a modern method (35%).

FIGURE 15: USE OF FAMILY PLANNING METHODS AMONG UNMARRIED BUT SEXUALLY ACTIVE GIRLS



Source: Analysis based on Uganda Demographic and Health survey 1988-2011

Contraceptive use among married and sexually active young women is even lower (Figure 16 and 17). For example, among currently married women age 15-19 years, only 14% reported current use of any contraceptive method. This is expected since young couples would be looking forward to having children and therefore have limited incentive to use family planning devices.

FIGURE 16: UTILIZATION OF FAMILY PLANNING AMONG MARRIEDS AGED 15-19 YEARS

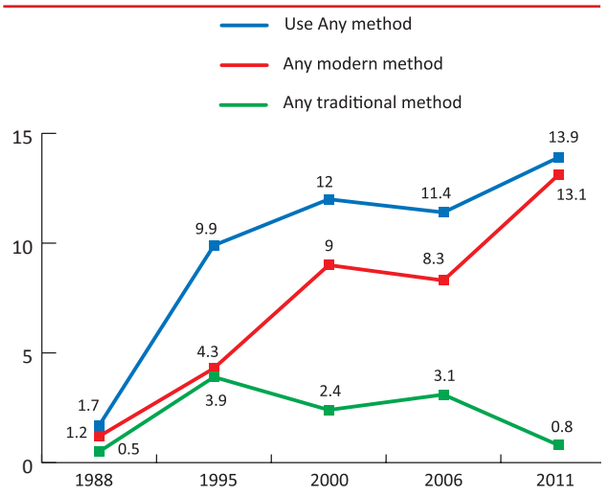
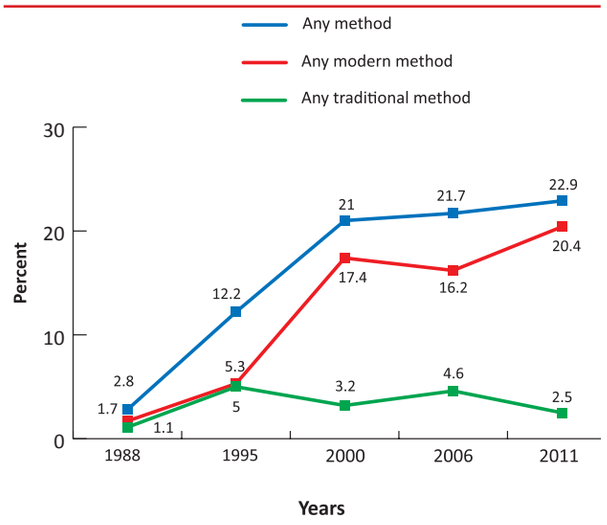


FIGURE 17: UTILIZATION OF FAMILY PLANNING AMONG MARRIEDS AGED 20-24 YEARS



Available evidence indicates that contraceptive use among young women, whether married or unmarried, involves a lot of experimentation and is inconsistent (Blanc, Tsui, Croft, & Trevitt, 2009). Additionally, young women face many obstacles to contraceptive use, which include misconceptions and fears related to contraception, gender power relations, accessibility and affordability of modern contraceptives, socio-cultural expectations and contradictions.

"Well, one of the challenges is the cost in accessing because most of them are self-sponsored. Then services are limited and also when these girls go to the health centers they do not find the services there and there is limited access to most especially information. Girls here do not normally get such information." (KII with Principal Hope ECD, Kumi district)

"They think it's unheard of for a girl to buy a condom so when they're relating with the boys it's up to the boy to use or not use condoms." (Senior program officer, Raising Voices)

"Girls don't have the confidence of seeking health care services because they don't have enough privacy at health centers and they feel shy to open up to health workers. Most girls don't have the courage to tell their boyfriends to use condoms and they cannot even go to health centers and ask for contraceptives or STI services because they fear to be judged by the health workers." (Program Officer, ANPPCAN)

"For me I cannot use condoms because there was a girl in Kumi town who died because of using a condom. I hear that the man used a condom and it remained in the girl and they kept quiet and the thing got rotten in the girl and she died, so for me I cannot use that at all. You see, when you, a young person, goes to ask for a condom, they suspected that you, a young person, has started doing "bad things" and yet you may not want other people to know." (FGD with young people in Pallisa)

"Girls also say that a sweet cannot be eaten in a Kaveera (polythene bag – meaning condom), that it is not sweet, so they prefer it live." (FGD with young girls in Oseera sub-county, Kumi District)

Source: Primary data

2.6.7 Child marriage

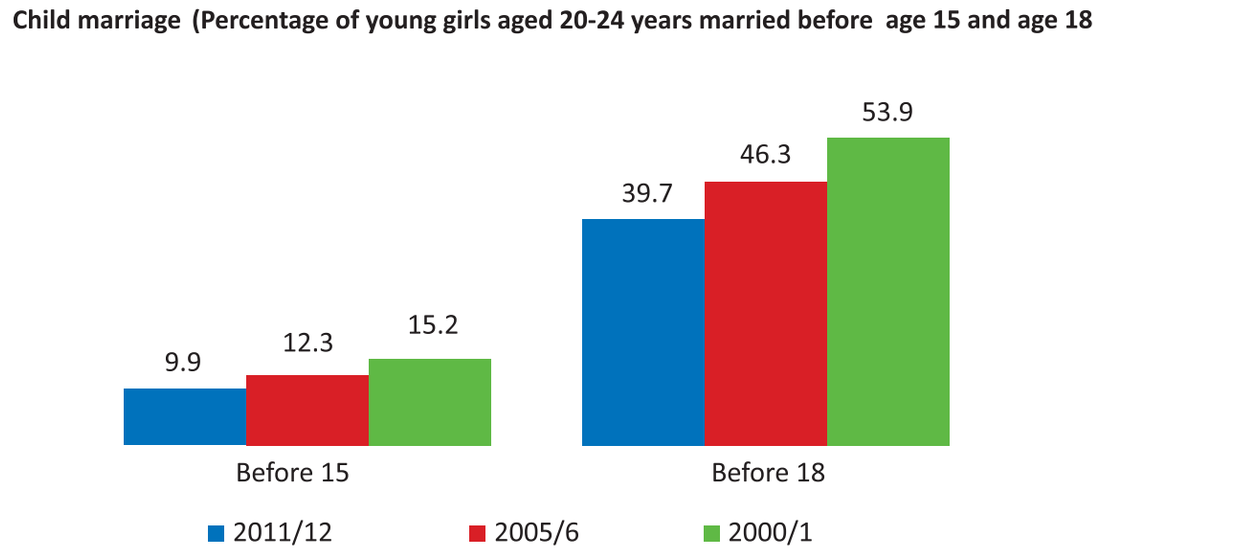
Uganda adopted the UN Convention on the Elimination of All Forms of Discrimination against Women in 1985, providing a legal framework for actions against forced marriages. The Convention states that the marriage of a child shall have no 'legal effect, and that all necessary action, including legislation, shall be taken to specify a minimum age for marriage' (Walakira and Ddumba-Nyanzi, 2012: 16). Nonetheless, the prevalence of child marriage in Uganda remains unacceptably high. While boys can be affected, the practice predominantly impacts girls.

According to the 2011 UDHS, up to 40% of women aged 20-24 were married/in union before age 18 (see Table 13). Compared to data from the 2005/6 UDHs, the 2011 UDHS reveals a six percent decline in the prevalence of child marriage. Child marriage occurs more frequently among girls who are the least educated, poorest and living in rural areas.

TABLE 13: CHILD MARRIAGES

	2011/12 DHS	2005/6 DHS	2000/1 DHS	1995 DHS
Percentage of women age 20-24 years married before age 15	9.9	12.3	15.2	15.1
Percentage of women age 20-24 years married before age 18	39.7	46.3	53.9	54.1
Married adolescents: Percentage of adolescents (15-19year olds) married or in union.	20.0	19.6	28.9	

FIGURE 18: UNDER AGE MARRIAGES 2000/1 – 2011/12



Source: UDHS 1995, 2000/1, 2005/6, 2011/12

Rural girls are twice as likely as their urban counterparts to marry as children. Girls with no education are more than three times as likely to marry young than girls who have completed secondary school. Regional differentials in trends by age at time of first marriage between 2006 and 2011 indicate that while some regions (Kampala, northern and western) showed a decline in very early marriages (below age 15), others showed either no change or an actual rise in the percentages of women who marry below age 15. In east central region for instance the percentage of women who married below age 15 rose slightly from 25% in 2006 to 26% in 2011. There was slightly more consistent downward regional trend in percentages of women marrying between age 15-17 with the exception of northern region where there was an increase from 40% to 45% of women marrying between age 15 -17.

> *A study by Refugee Law Project conducted in four refugee settlements in Uganda reveals that many parents perceived early marriage as the best and often, the only, means of safeguarding their daughters from the high levels of SGBV prevailing in Uganda's refugee settlements"*
>
> *(Refugee Law Project (RLP), 2007).*

Studies have identified a number of social and economic drivers for child marriage, ranging from poverty to gendered social norms that place high value on girls' reproductive capabilities. For example, poverty-stricken families see early marriage as a way to offload themselves of the responsibility of bringing up girls, or an opportunity to receive bride wealth (Yiga, Kagaha, Enst, & Akera, 2008). Girls may also seek early marriages to escape from poverty within their own families. Further, some parents encourage early marriages because it is what they expect for their daughters, or they have the expectation that it will contribute to the care and protection of the girl. For example, a study by Refugee Law Project conducted in four refugee settlements in Uganda reveals that many parents perceived early marriage as the best and often, the only, means of safeguarding their daughters from the high levels of SGBV prevailing in Uganda's refugee settlements (Refugee Law Project (RLP), 2007). Qualitative data from the present study also confirms these factors. See Box below:

Factors that affect child marriages

Poverty

"The main reason why girls are getting married before the age of 18 is that parents lack money for school fees, and to buy food for the family. When the child drops out of school that becomes the beginning of marriage" **FGD care givers, Bushenyi**

"For me I have seen a scenario of the mother of the girl selling her girl off, it happened here near goa, where some army men live, this young girl, not yet 18 years, barely 17, the mother would receive money from that army guy, then after, he came picked the girl and left with her, off to marriage" **FGD, formerly abducted mothers, Gulu district**

Poor Parenting

"…Most parents do not want to educate their girl children because they believe that they are just liabilities in a home because they will go away to other families hence they just force them into early marriage." **FGD 17-19 years, Mbale**

'Poor parenting styles have escalated child marriages since parents cannot engage with their child freely." **Childcare Coordinator, Bushkori Christian Center (Mbale)**

Gendered Social Norms

"'There are still people with that kind of mindsets, they see a girl as source of wealth so when she starts developing breasts the parents is only thinking about bride price."**Senior education officer, Ministry of Education, Science, Technology and Sports (MoESTS special needs department).**

"You know in Buganda they say that a girl should not stay for long in the compound, meaning a girl should be married off early if not she can easily get pregnant from home which is an embarrassment to her family." **FGD with caretakers, Mukono**

"Culture, this does not value women, they believe girls are supposed to learn household activities like cooking, fetching water, firewood and cleaning compounds and educating them is a waste of time."HIV/AIDS youth coordinator, **Mildmay Medical Center**

School drop out

"These girls get pregnant quite early in their lives and when she keeps home your friends keep on telling you that you are keeping a woman home that you never impregnated, you also decide that she goes and lives with the man who impregnated her." **FGD with caregivers, Kampala**

Child marriage has devastating consequences. Recently published global reviews have documented that young women who marry early are more likely than their peers to drop out of school and have lower earning capacity, earlier and more frequent childbearing and complications in pregnancy, higher maternal mortality, increased risk of HIV infection, and higher infant mortality (International Center for Research on Women, 2007; UNICEF, 2005). In addition, girls who marry before the age of 18 are more likely to suffer domestic violence (UNICEF, 2011, p. 9), including sexual violence at the hands of their partners. Married girls also tend to be more isolated, exacerbating their vulnerability. They are also the most likely to extend vulnerability to their children, by perpetuating intergenerational cycles of poverty and gender discrimination (Walakira & Ddumba-Nyanzi, 2012).

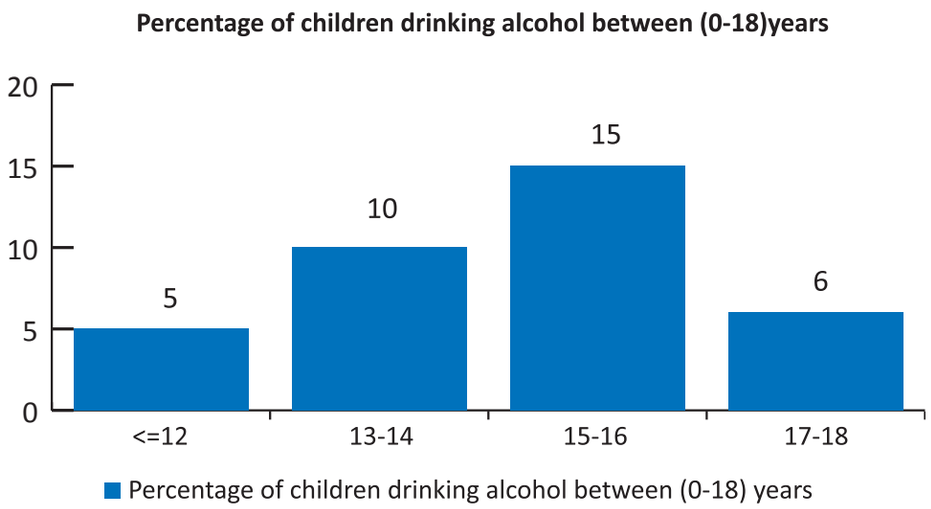
2.7 Mental Health

Data on mental health in Uganda is generally scarce. Nonetheless, available evidence suggests that 35% of Ugandans (approximately 9,574,915 people) have some form of psychiatric (mental) disorder (Basangwa, 2004) of which at least 15% require treatment. In 2006, it was estimated that 7% of households in Uganda had at least one person with a disability. Out of these, 58% had at least one person with a mental disorder (UBOS, 2006). The number of Ugandan children with mental health disorders is not known. Overall, it is feared that the incidence of mental disorders in Uganda is on the increase.

Mental illness in children has also been associated with several factors and conditions, including civil wars, displacement and refugee status, disability and HIV/AIDS. An estimated 10,421 children with disability out of 250,804 (4.2%) have mental illness, many with epilepsy. Similarly, physical and psychological war-related trauma accounts for major depressive disorders among 71% of refugees and Internally Displaced Persons. Individuals living with HIV/AIDS may face physical and psychological stresses that negatively impact their well-being.

Mental illness is also associated with drug abuse. Drug and substance abuse affects children's mental health. It is estimated that nearly one in four (18%) people with mental illness engages in substance abuse.

FIGURE 19: SUBSTANCE ABUSE AMONG YOUNG PEOPLE AND MENTAL HEALTH IN KAMPALA SLUMS

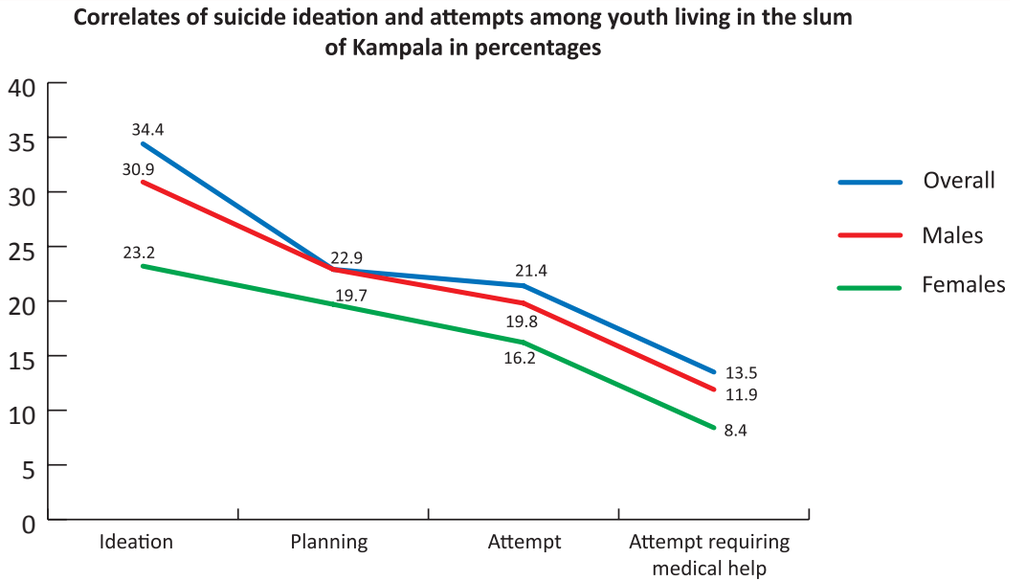


Source: Swahn et al., 2012a

Figure 20 shows that alcohol consumption is higher in the age category of 15-16 and 13-14, at 15% and 10% respectively, compared to other age categories. These age categories encompass the transition from child to adolescent, a time often associated with a lot of experimentation with alcohol and other substances.

Mental ill-health can have a profound effect on children's development and well-being. In one study, it was reported that 67% of persons with mental health conditions aged from 6-24 had their school attendance either fully or partially affected by their disability (Riche & Anyimuzala, 2014). In extreme cases, mental ill-health can be manifested in suicidal tendencies. At least one in five people (approximately 23%) with mental health problems have suicidal tendencies.

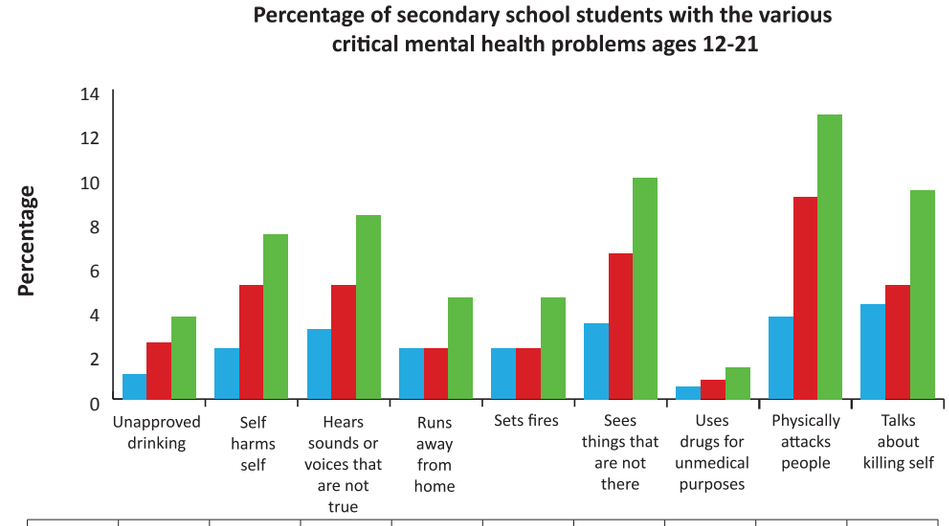
FIGURE 20: PREVALENCE OF SUICIDAL IDEATION AND SUICIDAL BEHAVIORS FOR BOYS AND GIRLS AGED 12-18 LIVING IN THE SLUMS OF KAMPALA (N=457)



Source: Swahn et al., 2012b

Mental health problems are more prevalent in females as compared to males (see Fig 21). From Figure 21, we observe girls are more likely to attempt suicide as compared to their male counterparts in all categories of ideation (34.4%), planning (22.9%), attempt (21.4%) and attempt requiring medical help (13.5%).

FIGURE 21: PERCENTAGE OF SCHOOL CHILDREN AGED 12-21 WITH SELECTED BEHAVIORS



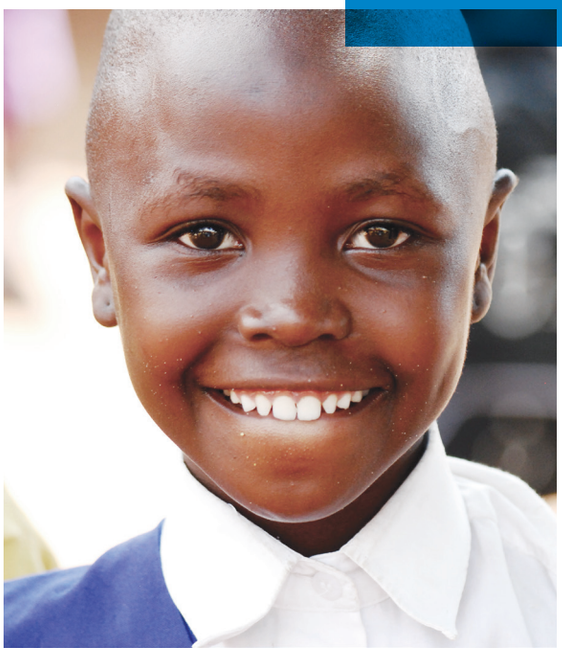
	Unapproved drinking	Self harms self	Hears sounds or voices that are not true	Runs away from home	Sets fires	Sees things that are not there	Uses drugs for unmedical purposes	Physically attacks people	Talks about killing self
Males	1.14	2.29	3.14	2.29	2.29	3.43	0.57	3.71	4.29
Females	2.57	5.14	5.14	2.29	2.29	6.57	0.86	9.14	5.14
Overall	3.71	7.43	8.29	4.57	4.57	10	1.43	12.86	9.43

Source: PADA, Uganda (2015)

2.8 Conclusion

The health and nutrition of children in Uganda is still in a dire state and renewed efforts and investments are needed to make real headway in guaranteeing the survival and healthy development of children. Mortality rates among children are still unacceptably high, and progress in the previous years has been slow, necessitating protracted action especially to save newborn babies during the first month of life. Malnutrition remains a real but hidden problem, which requires more attention, advocacy, and mainstreaming into diverse sectors. Concerted action during the first 1,000 days of life are needed and these must address mothers' knowledge and feeding practices, food security and other underlying factors that affect children's nutrition. In areas where tremendous achievements have been realized such as in the use of ITNs to protect children from mosquitoes that cause malaria, there is opportunity to do even more. Young people should be empowered with life skills to enable them to make informed decisions concerning sexual activities and safe practices around HIV, STIs and early pregnancy. In other areas such as ART coverage for children a lot of progress has been made, but the remaining unmet need for ART is still too large, thus calls for corrective measures. Since most of the causes of child morbidity and mortality are clearly preventable, there is every opportunity for the country to do more to protect its children from dying too soon.

3 CHILDREN AND EDUCATION



This section discusses some of the progress made in access to education in Uganda and the remaining barriers to achieving high-quality education for all children throughout the country. It focuses on all levels of education relevant to children and young people, namely, early childhood development (including pre-primary education), primary, secondary and vocational education.

HIGHLIGHTS

- The GoU ECD policy has been in place since 2007. Most ECD programs are limited in coverage and are run by NGOs, multinational organizations and the private sector
- Enrollment in pre-primary schools remains low and concentrated in urban areas, offered by the private sector
- Three percent of all children aged 6-12 years in Uganda are not attending primary education
- There is gender parity in enrollment at primary level but girl child enrollment rates at secondary level is six percent points lower than boys
- Seven in ten children who started primary one never made it to primary seven
- Literacy and numeracy rates in northern and eastern are lower than National averages. Less than four out of ten pupils in these regions are proficient in English and/or Local languages at respective grade levels
- Only four in ten of students who start senior one complete senior 4, depicting a high drop-out rate with girls being more affected (34%) compared to boys (45%)
- Over half of girls enrolled in senior one do not complete senior four
- Only three in ten of those who completed senior four got enrolled into senior five
- Each additional year of schooling increases lifetime earnings by at least five percent making investment in education worthwhile

3.1 Policy Context

Enhancing human capital development (including education and skills development) is one of the four strategic objectives of the National Development Plan 2015/16-2019/20 (NDP II). It is also a core objective of the Uganda Vision 2040. The Education Sector Strategic Plan (2007-2015) provides the guiding framework for provision of education services in Uganda and operationalizes the different education policies, including the Universal Primary Education (UPE) policy and Universal Secondary Education (USE) policy.

Recently, the government formulated the National Integrated ECD policy (2013). The policy seeks to increase access to ECD centers, to improve quality and to develop relevant integrated and multi-sectoral ECD services.

3.2 Early Childhood Development

3.2.1 Infant stimulation

A major ingredient in this developmental process of brain architecture is the serve and return interaction between children and their parents and other caregivers in the family or community. In the absence of responsive caregiving—or if responses are unreliable or inappropriate—the brain's architecture does not form as expected, which can lead to disparities in learning and behavior. Ultimately, genes and experiences work together to construct brain architecture (Center on the Developing Child, 2007).

Established and emerging evidence about brain development indicates the early years of life are crucial not only for individual health and physical development, but also for cognitive and socio-emotional development (World Bank, 2011). Scientists have also shown definitively that brain development is experience-based and has long-lasting effects[6]. A child's environment and experiences—beginning in utero—not only affects brain development, but also physical and mental health, learning and behavior over time. For example, when the quality of stimulation, support and nurturance is deficient, child development is seriously affected. In addition good early childhood care is associated with higher levels of physical, cognitive, emotional well-being and increased lifetime learning and earnings (Lusk and O'Gara 2002). Conversely, stress and adversity in the first years of life can permanently affect the development of physical and mental capacities throughout adulthood[7] (Shonkoff et al, 2012)

Parenting practices contribute significantly to the course of early child development, because they constitute the majority of child-environment interactions and affect child adaptation (Bornstein, 2006). For example, the quality of parenting and stimulation in infancy plays a critical role in enhancing child development. Stimulation occurs through responsive and developmentally appropriate interactions between caregivers and children. Responsiveness in the parent-child relationship not only promotes healthy socio-emotional development, but also leads to improved physical and cognitive growth (Zaff et al., 2003). Walker et al. (2007) summarized seven causal studies on the effects of cognitive stimulation interventions from developing countries, and found significantly higher cognitive functioning in young children, from birth to five years of age, given additional cognitive stimulation or learning opportunities than non-stimulated controls. Interventions included teaching mothers the techniques for educational play and play materials, verbal stimulation, developing children's motor skills and cognitive skills, increasing responsiveness, etc.

In Uganda, there is very limited data on ECD in the context of parenting, early learning and stimulation in the early years. The little data available indicates that the provision of psychosocial stimulation to children remains low, and one stimulation study (Britto, Engle, & Alderman, 2013) found that 75–80% of children between 3 and 6 years old did not have toys or were not engaged in learning activities (e.g. counting or naming objects). Consequently, child stimulation interventions have been implemented in Uganda, including community-based parenting intervention aimed at improving mother–child interaction and maternal psychological well-being (Boivin et al., 2013; Britto, Engle, & Alderman, 2013; Morris et al., 2012; Singla, Kumbakumba, & Aboud, 2015). Evaluation of these interventions revealed significant improvements in psychosocial stimulation (Boivin et al., 2013; Morris et al., 2012; Singla et al., 2015), infant cognitive and language development (Boivin et al., 2013; Singla et al., 2015), improved maternal emotional well-being and better mother-child interaction (Singla et al., 2015). In addition, a longitudinal study of a Nutrition and Early Child Development program in Uganda showed that exposure to ECD intervention with nutritional interventions resulted in a significant increase in weight for children less than one year of age (Alderman, 2006).

Qualitative data from the present study indicates some of the major forms of early childhood development going on as shown in the figure below.

[6] Supportive relationships and positive learning experiences begin at home but can also be provided through a range of services with proven effectiveness factors. Babies' brains require stable, caring, interactive relationships with adults — any way or any place they can be provided will benefit healthy brain development.

[7] There is also evidence to the effect that children from disadvantaged families are less likely to receive proper support and guidance from responsive caregivers and also likely to have had less opportunity to develop the critical skills, such as controlling their impulses, relating with people from different backgrounds and focusing attention. These skills are important for engaging effectively with teachers and other children, paying attention in class, completing assignments, and behaving appropriately (World Bank, 2015).

FIGURE 22: FORMS OF PARENTS'/CAREGIVERS' ENGAGEMENT IN ECD IN A NON-FORMAL SETTING

Community based childcare arrangements
Home schools facilitated by a community volunteer
Encouraging reading a local language at early stages
Life skills training e.g. courtesy, table manners
Send children for immunization

Source: KII and FGDs conducted as part of the second phase of the study

A balanced approach to emotional, social, cognitive, and language development will best prepare all children for success in school and later in the workplace and community. This type of engagement can take place in a formal or informal setting, including the home or community. Early childhood development through parenting, at family level, and in an informal manner as part of the socialization process is part and parcel of African child upbringing. This type of engagement can be provided by parents but also other members of the extended family and in many cases, neighbors and other community members. There is need to document more systematically the good practices in community and family based early childhood development services.

3.2.2 Pre-primary education

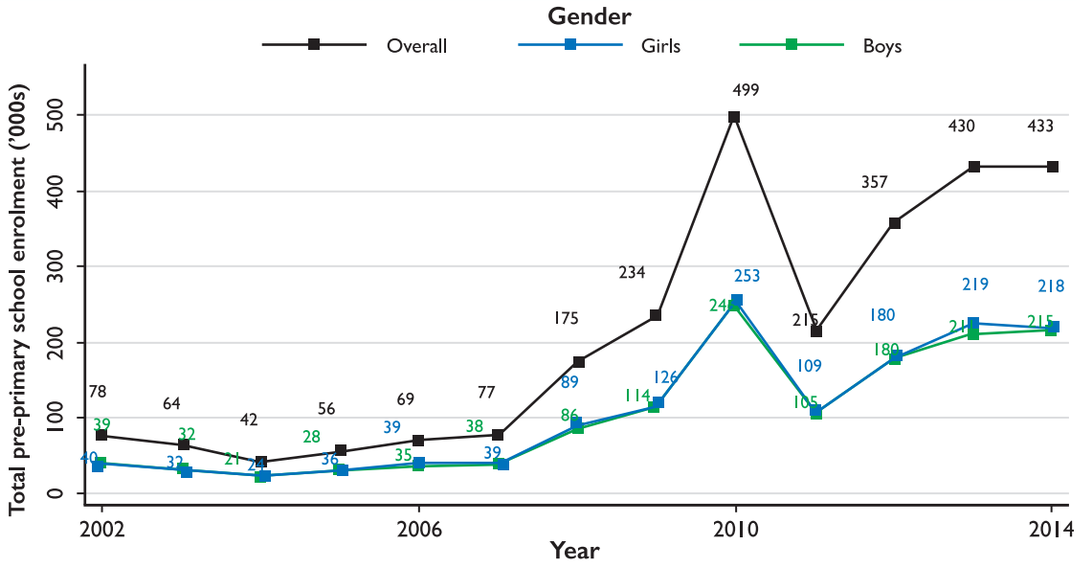
Estimates show that net enrollment at pre-primary level stands at 10.1% (EMIS, 2014). This implies that close to nine out of ten children aged 0–5 years[8] in Uganda are not enrolled in pre-primary schools. According to data from the Ministry of Education, Science, Technology and Sports (MoESTS), a total of 433,258 children were enrolled into pre-primary schools in 2014. Majority (91.5%) of these were enrolled into nursery schools. Other enrolling school categories included community-based schools (7.8%), day care (0.5%) and home-based schools (0.2%). By 2013, about six out of ten ECD centers were located in the central and eastern regions; and over 80% of ECD centers are privately owned, making them out of the financial reach of most Ugandans (MGLSD & UNICEF 2015).

[8] This should refer to only those aged 3-5 since children aged less than 3 are not meant to be in school. However, EMIS data is reported for 0-5.

Figures 23 and 24 show that, overall, there has been a surge in pre-primary enrollment between 2006 and 2011, partly as result of licensing new facilities.[9]

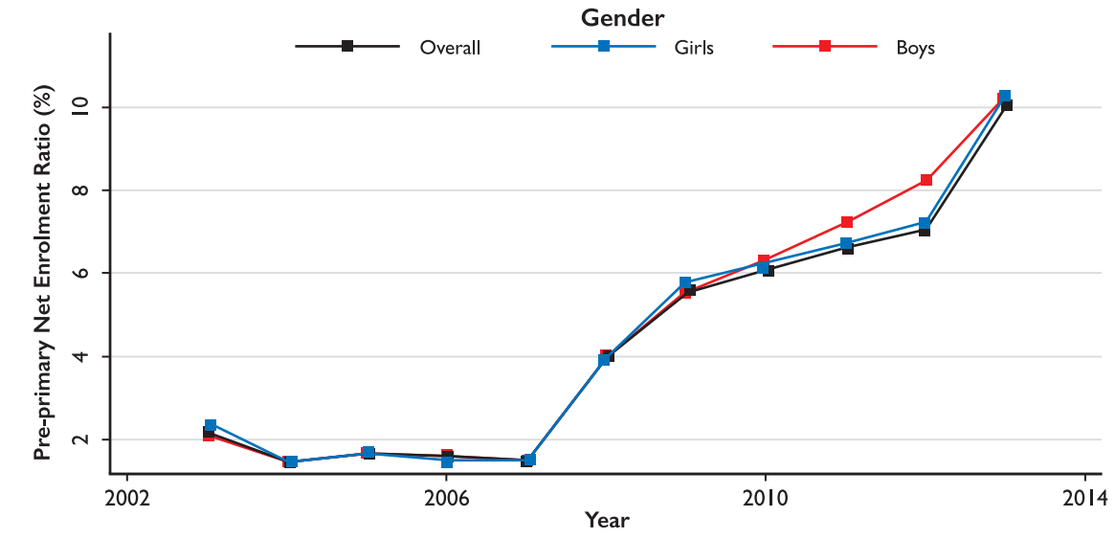
There were no major gender differences in pre-primary enrollments over time. The pre-primary NER rose steadily over the time period, from about one percent in 2003 to ten percent by 2013. Despite this increase, major gaps remain and these include: inadequate government support; inadequate policy and regulatory framework and lack of qualified providers (Government of Uganda (GoU), 2015).

FIGURE 23: TRENDS OF TOTAL ENROLLMENT IN PRE-PRIMARY SCHOOLS BETWEEN 2002 AND 2014



Source: EMIS, UBOS, 2014

FIGURE 24: TRENDS OF PRE-PRIMARY NET ENROLLMENT RATIO BETWEEN 2002 AND 2013



Source: EMIS, UBOS, 2014

Enrollment in ECD centers has remained low in the relatively poor regions of Uganda. Table 14 shows that the share of ECD enrollments has generally been low in the north-eastern (Karamoja) region.

[9] The 2012 Education and Sports sector report reveals that at least 130 new ECD were licensed during 2011/2012 (MoES, 2012).

TABLE 14: PERCENTAGE SHARE OF ENROLLMENT INTO PRE-PRIMARY SCHOOLS BY REGION 2009-2011

	Total Enrolled	Regional Percentage Share of total enrollment					
Year		East	Central	North	South-west	West	North-east
2009	234,482	16.0	28.8	26.7	15.4	11.8	1.4
2010	498,644	20.3	36.4	13.6	10.3	13.3	6.1
2011	214,797	19.7	33.0	19.9	5.8	14.7	6.9

Source: Authors' compilations based on MoES Education Statistical Abstracts, 2009-2011

Children who go through pre-primary learning tend to perform better once they enroll in primary school. The National Assessment for Progress in Education (MoES-NAPE), 2013 study by the Uganda National Examinations Board (UNEB), showed that children who have attended pre-primary education on average score 30% higher on literacy tests compared to those who missed pre-primary education. Similarly, children attending ECD have better chances to learn socializing with peers, learning different languages, and have improved stimulation and cognitive functioning at an early stage. There is also evidence that each additional year of education results in at least 5% increase in future potential income earnings (Cuaresma, et al., 2014).

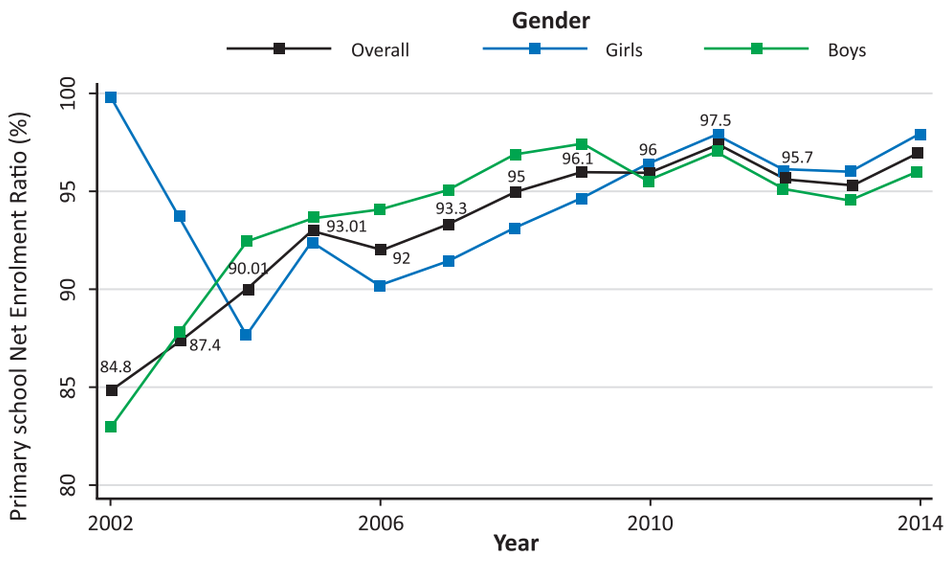
This evidence implies that the large number of children not enrolling in ECD programs, mostly from poorer households and in rural areas, will most likely not achieve their full productive potential. There is a need to ensure children receive early childhood services such as stimulation and comprehensive care and to prioritize and invest in exploring various options of formal and informal pre-primary education and ECD programs.

3.3 Primary Education

3.3.1 Primary education enrollment rates

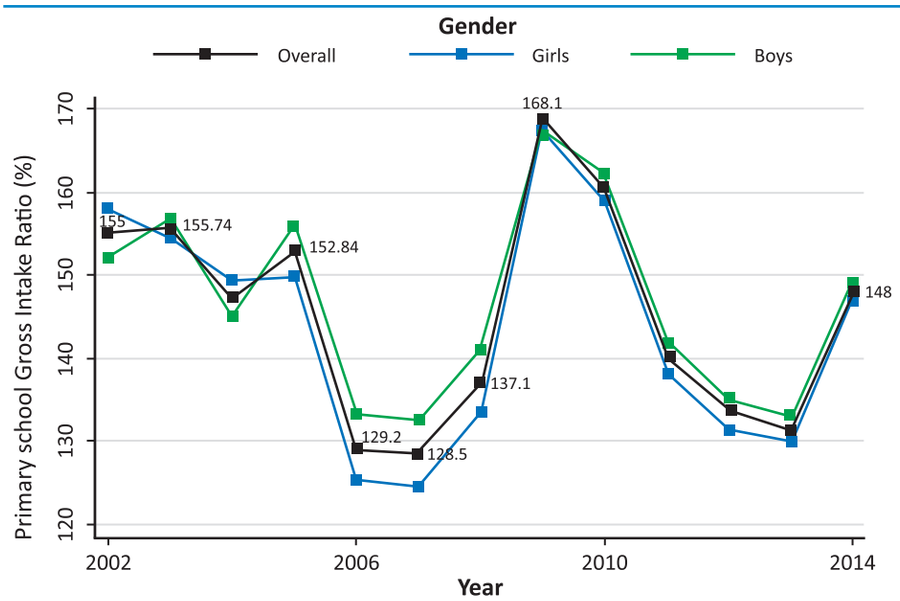
Since the introduction of Universal Primary Education (UPE) in 1997, there has been a drastic increase in primary school enrollment. Primary school enrollment increased from 7.3 million pupils in 2002 to 8.8 million pupils in 2014 (Annex B, Figure B1.0). The Net Enrollment Ratio (NER) increased from 84.8% in 2002 to 97% by 2014. However the Gross Intake Ratio (GIR) has been varied, increasing to a peak of 168% in 2010 but dropped drastically to 124% by 2013, suggesting a high drop-out rate (Figures 25 and 26). By 2014 only 3 out of 100 children aged 6-12 years in Uganda were not attending primary education.

FIGURE 25: TRENDS IN PRIMARY SCHOOL GROSS INTAKE RATIO BETWEEN 2002 AND 2014



Source: EMIS, UBOS 2014

FIGURE 26: TRENDS IN PRIMARY SCHOOL NET ENROLLMENT RATIO BETWEEN 2002 AND 2014



Source: EMIS, UBOS 2014

Over the past two decades, the enrollment rate for girls into primary schools has generally lagged behind compared to that of boys, but the gap has narrowed since 2010. Likewise gross intake ratio remains relatively lower for girls. At the regional level, the eastern and central region account for more than 50% of the children enrolled into primary schools. Enrollment proportions are lowest for north-eastern (Karamoja) region (see Table 15). This finding may be linked to the persistent food insecurity, drought, cattle wrestling and other cultural practices in this area. The higher share of enrollment in eastern and central region depict the high population within these regions.

TABLE 15: PERCENTAGE SHARE OF ENROLLMENT INTO PRIMARY SCHOOLS BY REGION

Year	Total enrolled	Regional percentage share of total enrollment					
		East	Central	North	South-west	West	North-east
2008	7,963,969	27.8	22.4	22.4	10.2	15.6	1.7
2009	8,297,780	28.1	22.9	21.4	10.6	15.4	1.7
2010	8,374,648	29.3	23.8	20.0	13.2	12.0	1.6
2011	8,098,177	30.1	22.2	21.1	12.8	12.2	1.6
2012	8,337,069	30.5	22.7	20.8	12.3	12.0	1.7

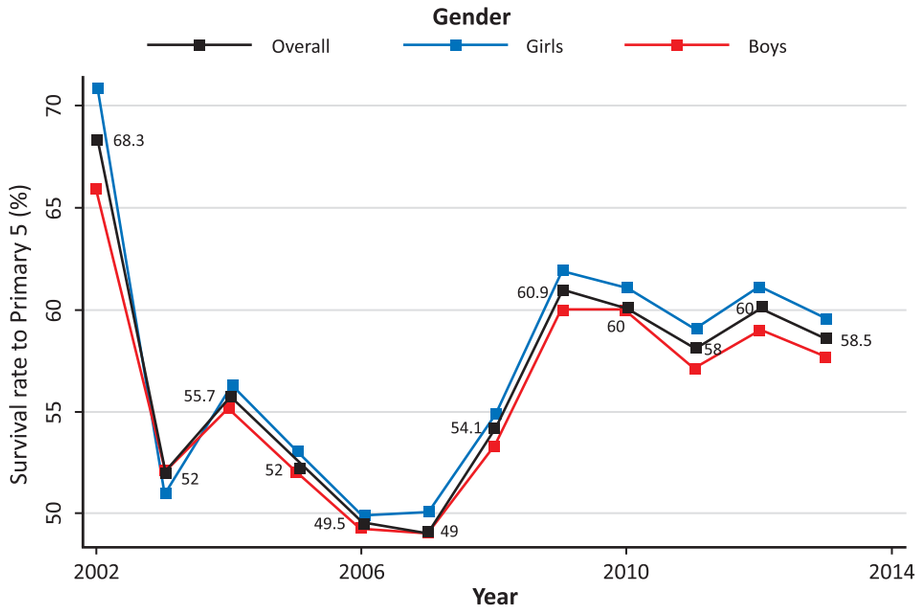
Source: Authors' compilations based on Education Statistical Abstracts (2008-2012)

Given the strong association between educational attainment to economic opportunities such as employment and income earning potential, regions with lower enrollment rates like north-eastern are prone to intergenerational poverty and are likely to be perpetually economically disadvantaged. This implies that interventions to improve enrollment and retention of children in the education system beyond primary levels are important for turning around the poor economic situation in these regions.

3.3.2 Survival and drop-out rates at primary level

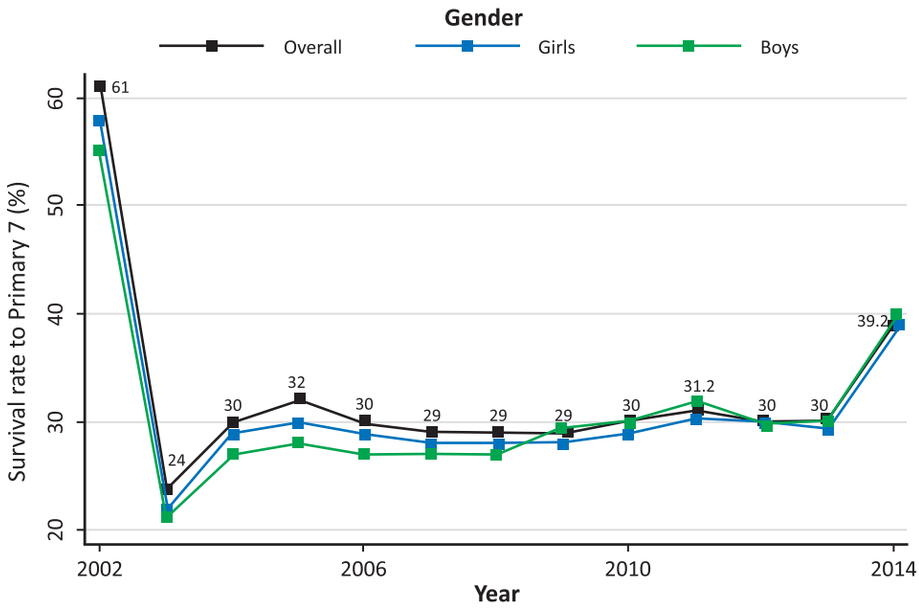
While enrollment levels have improved over the years, survival rates in primary remain poor. Figure 27 and 28 indicate that in 2013, about six out of ten pupils who joined primary one made it to primary five, whereas only four in ten of them survived until primary seven in 2014. Gender differences for survival rates to primary seven in 2014 were marginal (boys: 39.2%, girls: 38.7%). This data shows a low level of survival, and thus suggest a high level of drop-out rates and serious leakage of resources invested in primary education in Uganda.

FIGURE 27: TRENDS OF SURVIVAL RATES TO PRIMARY 5 BETWEEN 2002 AND 2013



Source: EMIS, 2014

FIGURE 28: TRENDS OF SURVIVAL RATES TO PRIMARY 7 BETWEEN 2002 AND 2014



Source: EMIS, 2015

The regional and gender breakdown of survival rates to primary seven in 2014 is presented in Table 16. Generally, survival rates were lowest among pupils from West Nile, Karamoja and Kigezi regions, where less than three in ten pupils who started primary one in 2008 made it to primary seven in 2014. On the other hand, at least half of the pupils from the Elgon and Buganda regions who commenced primary one in 2008 survived until primary seven by 2014.

Table 16 also shows that the gender differences in primary school survival rates are only marginal, with girls reporting slightly higher rates within the Elgon and Buganda regions, and lower rates within the West Nile region.

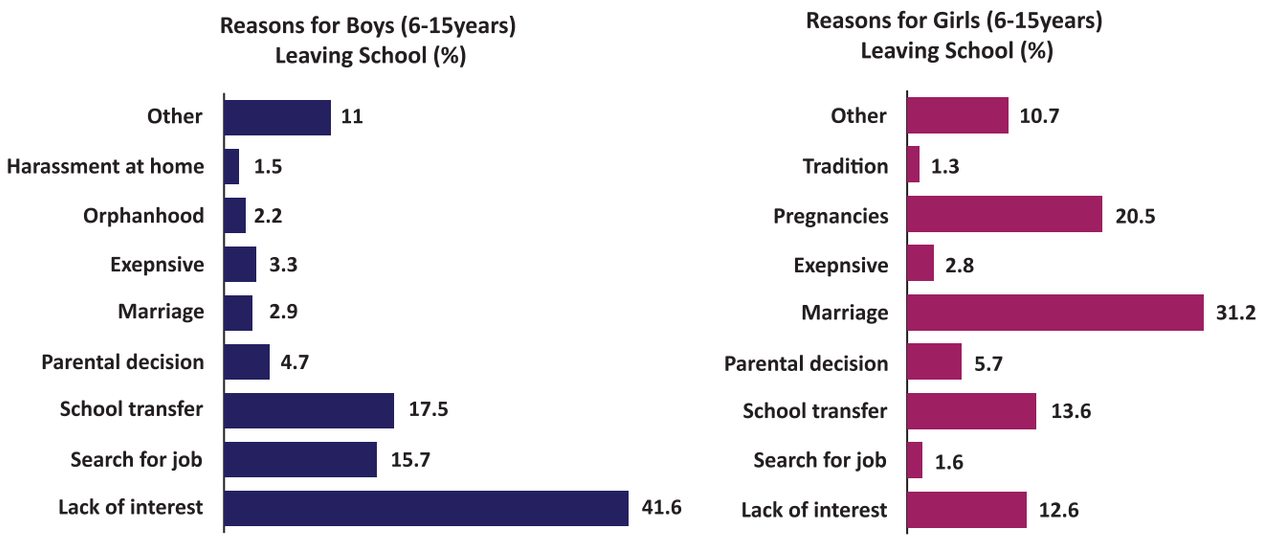
TABLE 16: A REGIONAL AND GENDER BREAKDOWN OF SURVIVAL RATES UNTIL PRIMARY 7 IN 2014

Region	Boys	Girls	Total
West Nile	20.3%	13.2%	16.8%
Karamoja	26.9%	19.5%	23.5%
Kigezi	27.3%	32.4%	29.8%
Bukedi	36.7%	32.7%	34.7%
Ankole	34.5%	37.2%	35.9%
Teso	38.5%	38.5%	37.1%
Lango	43.8%	32.9%	38.4%
Bunyoro	41.9%	40.6%	41.3%
Acholi	30.5%	34.2%	42.5%
Busoga	45.0%	44.4%	44.7%
Elgon	48.1%	52.9%	50.5%
Buganda	47.9%	55.5%	51.7%
Overall	39.2%	38.7%	38.9%

Source: EMIS, 2015

The reasons for dropping out of school are multiple and tend to vary between boys and girls. The Uganda National Household Survey 2013/2014 shows that the major reasons for boys dropping out of school were lack of interest, followed by transfer of school and search for a job. Lack of interest may indicate both the school-based factors such as uninteresting school routine or very strict school rules, but it could also indicate better attractions outside of school. For girls, the major reasons for leaving school were marriage and pregnancy. As shown in other parts of this report, these findings (See Figure 29) confirm that early pregnancy and early marriage are closely related with girls' failure to complete the primary school cycle.

FIGURE 29: REASONS FOR SCHOOL DROPOUT

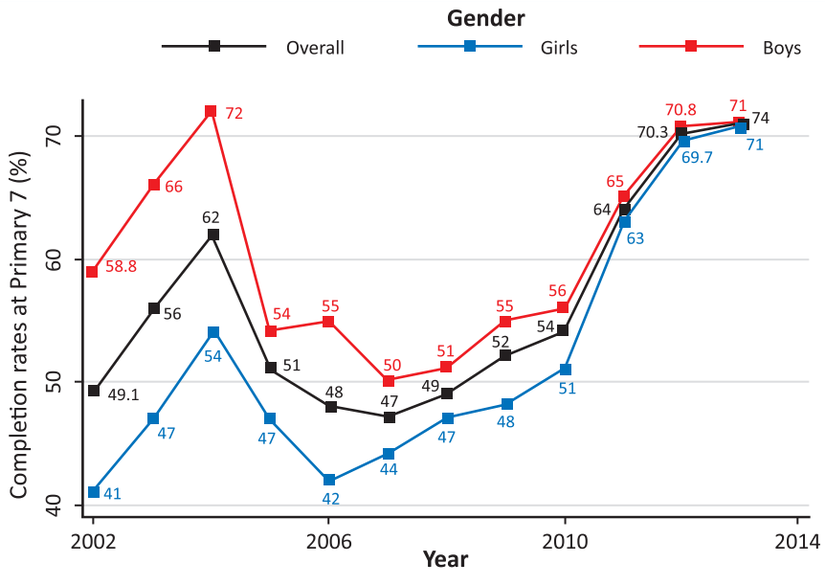


Source: Uganda National Household Survey 2012/201

3.3.3 Primary completion and transition to secondary level

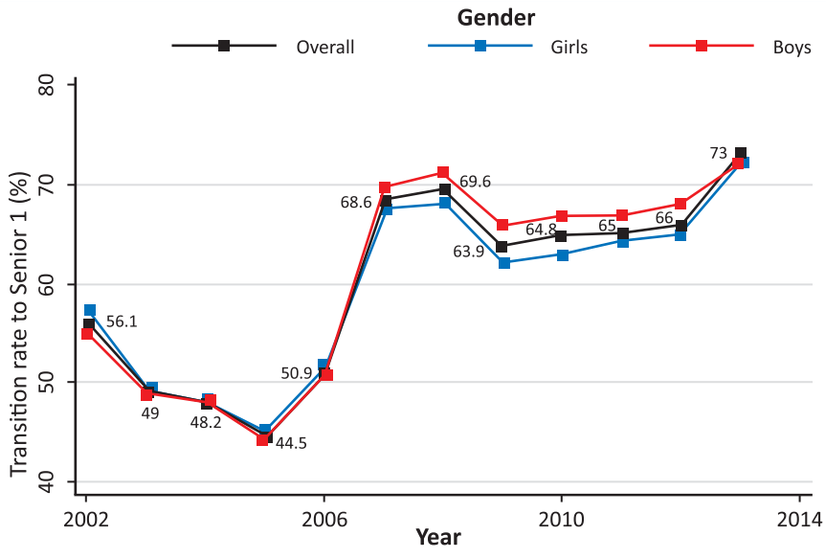
Primary school completion rates and transition to secondary level are important as they indicate the extent of the efficiency of the primary education system. Figures 30 and 31 show that a large number of children are still not able to progress from primary to secondary level. Transition to secondary level by those who completed P7 in 2013 was relatively high (73%).

FIGURE 30: TRENDS OF COMPLETION RATES AT PRIMARY 7 BETWEEN 2002 AND 2013



Source: UNEB, 2014

FIGURE 31: TRENDS OF TRANSITION RATES TO SENIOR 1 BETWEEN 2002 AND 2013



Source: EMIS, 2014

> *The low primary level completion rates and the very low progression to post-primary education imply that a large number of children leave school with limited ability to be productive in the labor market."*

While seven in ten of the pupils completing primary seven progress to senior one, completion rates at secondary level are disappointingly low. Only four in ten students complete secondary level as shown in Figure 39 (Section 3.4).

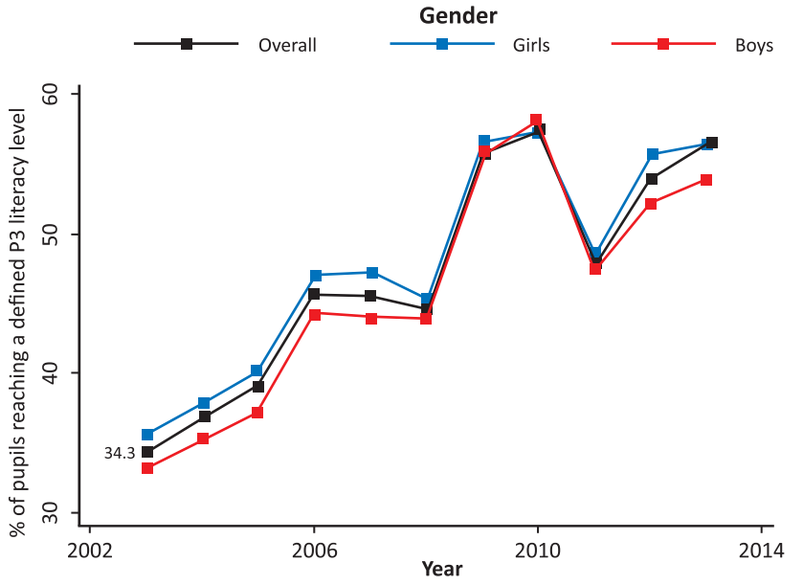
The low primary level completion rates and the very low progression to post-primary education imply that a large number of children leave school with limited ability to be productive in the labor market. It also represents a form of leakage of financial resources invested by government and parents to keep children for the few years in school.

3.3.4 Quality of primary education

Literacy and numeracy rates

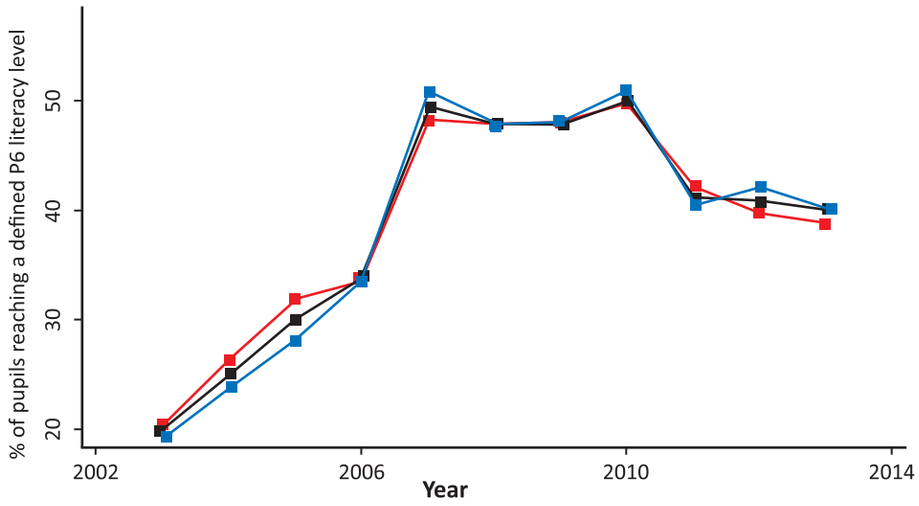
Available data for primary-going pupils generally depict low levels of numeracy and literacy rates, with only 56.2% and 40.1% pupils reaching a defined literacy level at primary three and six respectively (Figures 32 and 33).

FIGURE 32: TRENDS OF THE PROPORTION OF PRIMARY PUPILS REACHING A DEFINED LEVEL OF LITERACY AT GRADE 3 BETWEEN 2002 AND 2013



Source: NAPE 2014, UNEB 2014

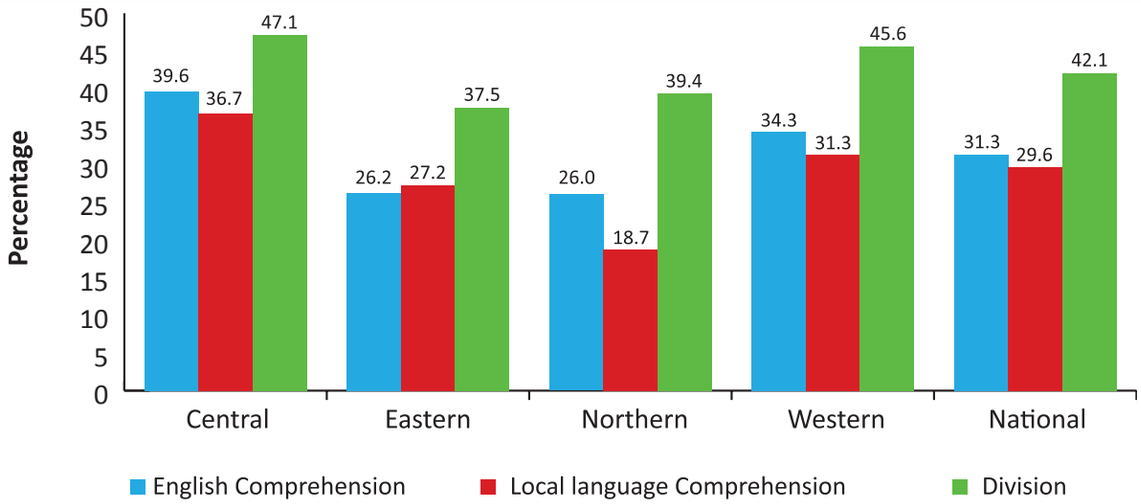
FIGURE 33: TRENDS OF THE PROPORTION OF PRIMARY PUPILS REACHING A DEFINED LEVEL OF LITERACY AT GRADE 6 BETWEEN 2002 AND 2013



Source: NAPE 2014, UNEB 2014

Across regions, children in central region are better than other regions in primary 2 level English comprehension and local language stories and primary 2 level mathematical divisions (Figure 34). Overall, comprehension and division performance is lowest among children in the eastern region compared to other regions.

FIGURE 34: PERCENTAGE OF PUPILS (P3-P7) WHO CAN DO PRIMARY 2 WORK, BY REGION.



Source: (Source: UWEZO, 2012)

Emerging results from the Early Grade Reading Assessment (EGRA) being conducted in 2,800 government schools[10] indicate that reading fluency in local languages and literacy in local languages improves better with targeted interventions (Table 17). These results further supplement the MoESTS recommendations of promoting the use of local language during earlier years of learning.

TABLE 17: ORAL READING FLUENCY BY LANGUAGE

Local Language	Percentage of pupils who could read at least 20 words per minute by the end of P2		Percentage of local language reading questions answered		Percentage of pupils reading English at the end of P2	
	SHRP school	Control school	SHRP school	Control school	SHRP school	Control school
Ateso	2.8	0	20	0	1.3	0
LebLango	4	1.5	20	0	1.3	0
Luganda	18	9	60	30	27.8	14.3
Runyankole-Rukiga	16.4	5.5	60	40	9.3	8
	Percentage of Learners answering at least one comprehension question by the end of P1		Percentage of Learners who could at least identify one local language letter by sound		Percentage of learners who could at least one story word of a local language story	
	SHRP school	Control school	SHRP school	Control school	SHRP school	Control school
Acholi	81	71	54	33	5	0
Lugbara	92	90	51	49	1	1
Lumasaba	53	37	27	20	0	0
Runyoro-Rutoro	87	71	71	59	13	6

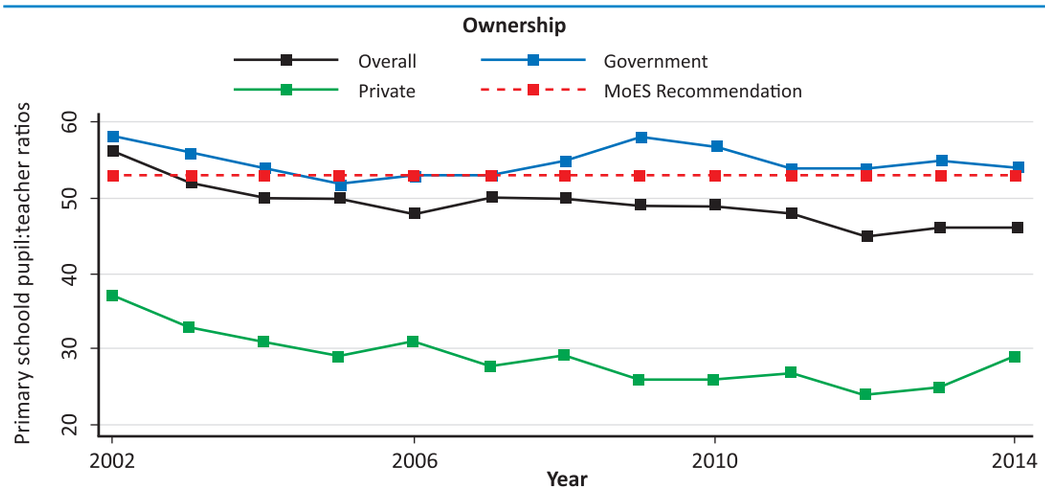
(Source: USAID/RTI, 2015)

[10] This is a randomized controlled trial under the USAID/Uganda School Health and Reading Program (SHPR)

Primary schools' Pupil-Teacher and Pupil-Classroom Ratios

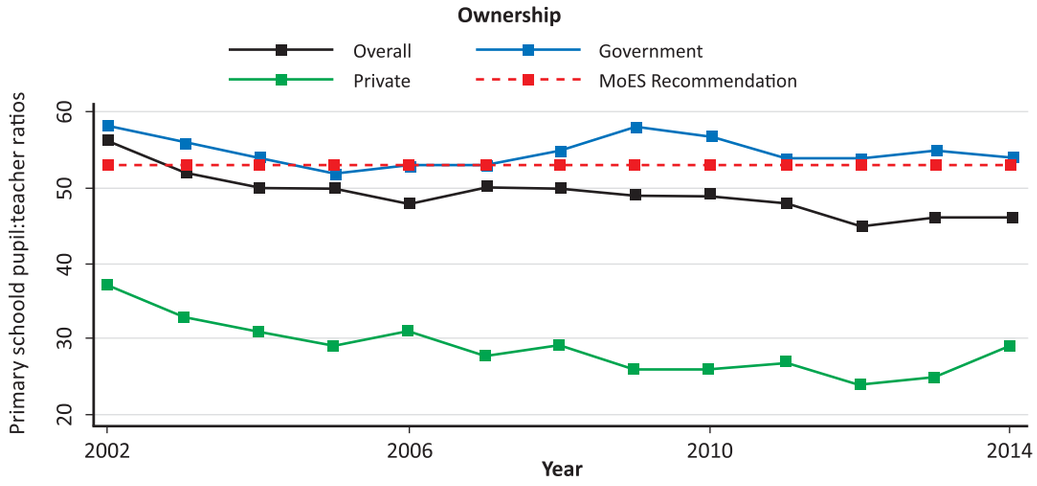
The national primary pupil-classroom-ratio (PCR) has improved from 68:1 in 2009 to 59:1 in 2014 (Figure 36). The pupil-teacher-ratio (PTR) at around 49:1 from 2009 to 2014 at the national level (Figure 35) shows an improvement that meets the national target. Key informant interviews with MoESTS officials revealed that the recommended primary PTR is 53:1 and the recommended PCR is 53:1. A lower number for PTRs imply that there is likely to be greater contact between the pupil and teacher during lessons and outside of class work, thereby leading to better learning. Similarly, fewer pupils per class translates into better learning environment when classrooms are not congested/ over-populated.

FIGURE 35: TRENDS OF PUPIL-TO-TEACHER RATIOS IN PRIMARY SCHOOLS BETWEEN 2002 AND 2014



Source: EMIS, 2014

FIGURE 36: TRENDS OF PUPIL-TO-CLASSROOM RATIOS IN PRIMARY SCHOOLS BETWEEN 2002 AND 2014



Source: EMIS, 2014

Based on PTR and PCR figures, the quality of learning is therefore better in private schools. Given that children from poorer households are more likely to be attending overcrowded primary schools under the UPE program, pupils from lower social economic class are less likely to access high quality education. The lack of opportunity to get quality education could translate into such children failing to realize their full productive potential, thereby perpetuating a poverty cycle - intergenerational poverty.

At regional level, the north-eastern region performed poorest on three education quality indicators pupil-to-teacher Ratios (PTR), pupil-to-classroom ratios (PCR) and pupil-to-stance Ratios (PSR) among pre-primary schools during the years 2010 and 2011 for which data were available (Table 18). The situation in the north-eastern region reflects the persistently poor level of social service delivery and poverty in the region.

TABLE 18: REGIONAL BREAKDOWN OF PUPIL-TO-TEACHER RATIO, PUPIL-TO-CLASSROOM RATIO AND PUPIL-TO-STANCE RATIOS IN PRE-PRIMARY SCHOOLS

	Pupil-to-Teacher Ratio		Pupil-to-Classroom Ratio		Pupil-to-Stance Ratio	
	2010	2011	2010	2011	2010	2011
Central	23	24	43	29	18	13
East	23	21	45	24	22	12
North-east	79	72	1596	292	346	210
North	25	27	67	34	32	18
South-west	27	28	43	27	17	14
West	25	25	50	30	25	15
National	25	25	50	30	25	15

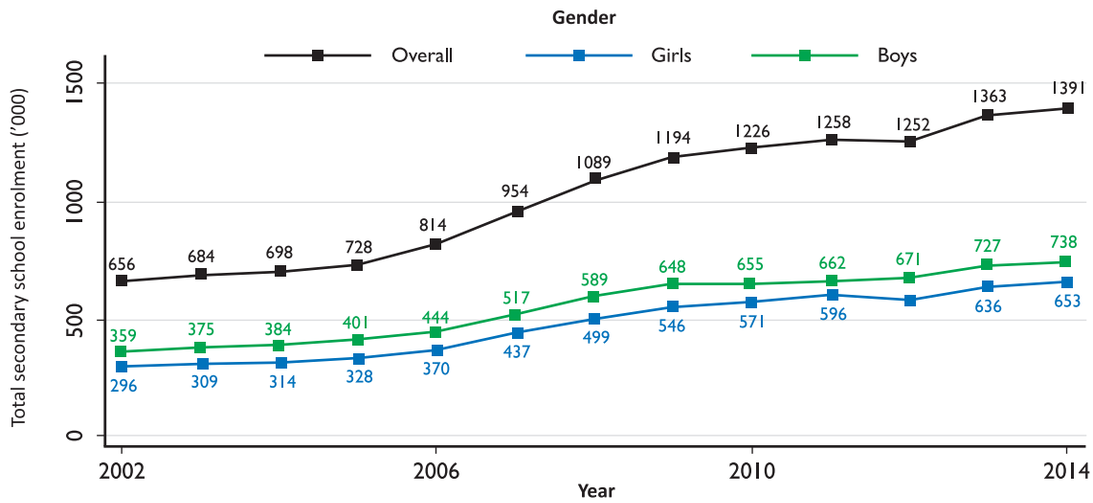
Source: Authors' compilations from Education Statistical Abstracts from MoES -2010-2011

According to analysis done by the National Planning Authority (NPA), the key challenges at primary level include: reduction in the capitation grant from UGX. 8,000 in 1997 to UGX. 6,860 in 2013 per child per annum; shortage of critical infrastructure; high pupil/textbook ratio; high dropout particularly by girls; high head teacher, teacher and pupil absenteeism estimated at 20%; limited community participation; and rapid population growth estimated at 3.5% per annum (GoU, 2015).

3.4 Secondary Education

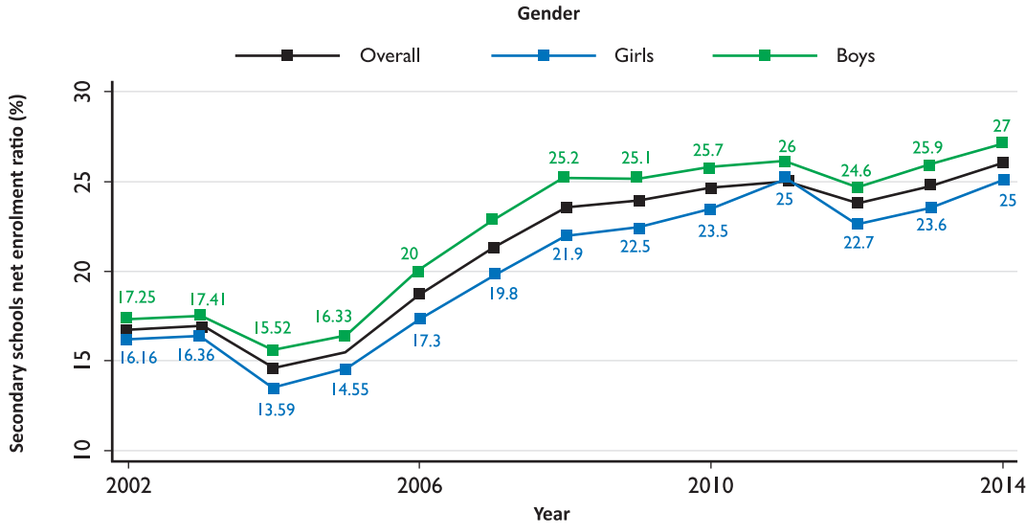
Secondary school enrollments between 2002 and 2014 are presented in Figures 37 and 38. Total enrollments have increased over time, from 0.7 million students in 2002 to 1.4 million students in 2014. Recent data in 2014 however suggests that only 26% of the entire population aged 13-18 years in Uganda is enrolled in secondary schools, implying that 74% of this population are either out of school or attending other vocational education. Enrollments have persistently been higher among boys compared to girls. The trends in secondary school NER show marked increments between 2004 and 2010 following the introduction of Universal Secondary School Education (USE).

FIGURE 37: TRENDS OF TOTAL ENROLLMENT INTO SECONDARY SCHOOLS BETWEEN 2002 AND 2014



Source: EMIS, 2014

FIGURE 38: TRENDS OF SECONDARY SCHOOL NET ENROLLMENT RATIO BETWEEN 2002 AND 2013



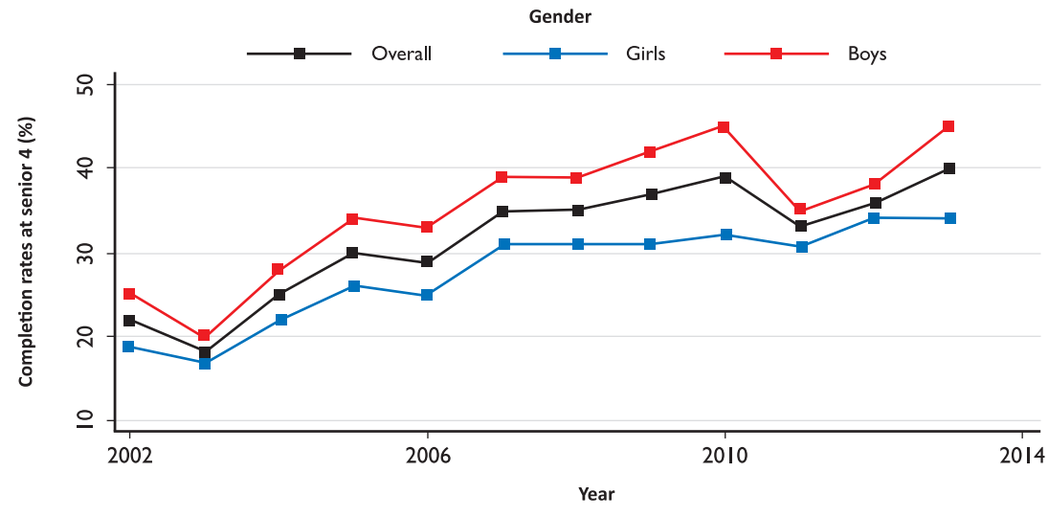
Source: EMIS, UBOS 2014

3.4.1 Completion rate at senior 4 and transition to senior 5

Figure 39 indicates that completion rates at senior 4 remain appallingly low at 40% despite having increased from 18% in 2003. There is a wide disparity in secondary school completion rates for girls (34%) compared to boys (45%). Similar trends are observed in transition rates into advanced secondary, where only three in ten of those who completed senior 4 in 2013 were enrolled into senior 5 (Figure 40). Information on survival rates at secondary level is not readily available from MoESTS. The EMIS data does not report data on survival rates at secondary level, which would be a better indicator to evaluate the status of secondary education. However, given the high drop-out rates, and the low transition rates to senior 5, survival rates at secondary level should be even lower than primary level.

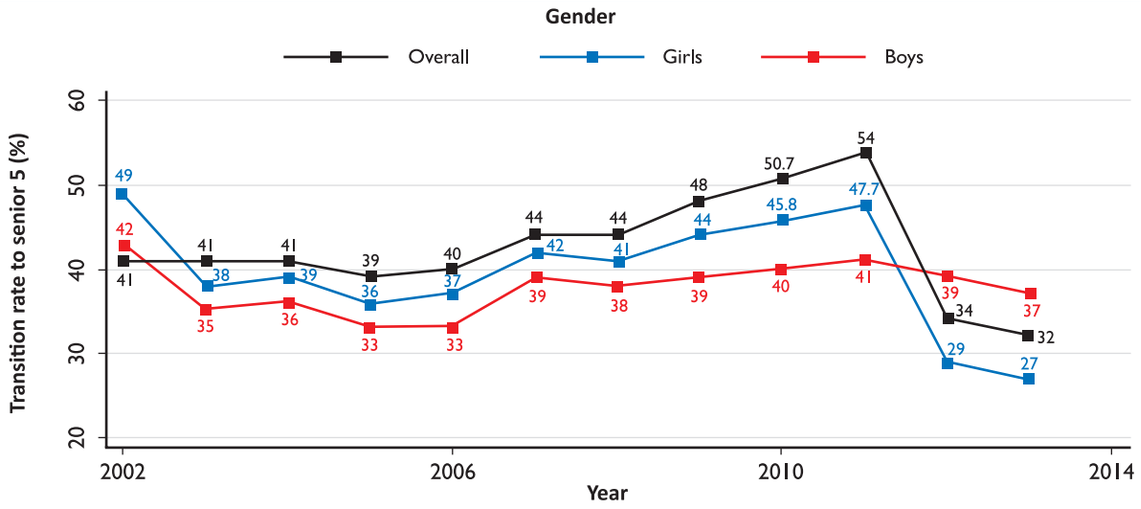
> *"There is a wide disparity in secondary school completion rates for girls (34%) compared to boys (45%). Similar trends are observed in transition rates into advanced secondary, where only three in ten of those who completed senior 4 in 2013 were enrolled into senior 5."*

FIGURE 39: TRENDS OF COMPLETION RATES AT SENIOR 4 BETWEEN 2002 AND 2013



Source: EMIS, 2014

FIGURE 40: TRENDS OF TRANSITION RATES TO SENIOR 5 BETWEEN 2002 AND 2013

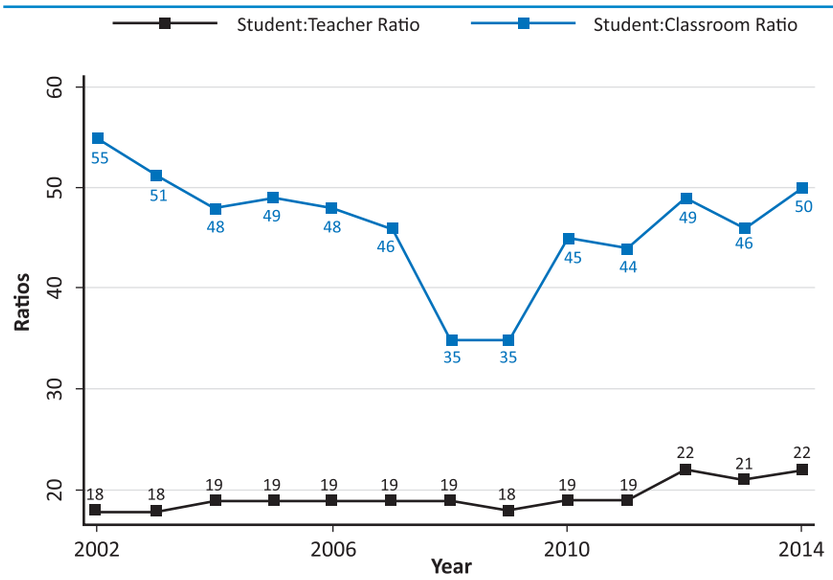


Source: EMIS, UNEB, 2014

3.4.2 Secondary school student-teacher ratios (STR) and student-classroom ratio (SCR)

Figure 41 suggests that there was one teacher for every 22 students in secondary schools in 2014, and that this trend was generally constant between 2002 and 2014, ranging from 18 to 22 students per teacher. The student-to-classroom ratio declined between 2002 and 2008, and currently stands at 50 students per one classroom. The SCR and STR indicators are associated with the quality of learning, with higher ratios being indicators of poor learning conditions that are likely to lead to poor education outcomes. Currently, MoESTS recommends a standard STR of 35:1 and a standard SCR of 60:1, and data presented in Figure 41 indicates that this is being met by most secondary schools in Uganda. It is however likely that the situation regarding these indicators may differ between private and public schools.

FIGURE 41: TRENDS OF SECONDARY STUDENT-TO-TEACHER AND STUDENT-TO-CLASSROOM RATIOS 2002 AND 2014



Source: EMIS, 2014

The regional breakdown of the SCR and STR for the years of 2009 and 2010 show that eastern and north-eastern regions perform poorer than other regions, having the highest ratios of student-teachers and student-classrooms. The poor education quality indicators in these regions partly explain the generally poor education performance in these areas as revealed during the KIIs with Ministry of Education officials.

TABLE 19: REGIONAL BREAKDOWN OF SECONDARY SCHOOLS' STUDENTS-TO-TEACHER AND STUDENT-TO-CLASSROOM RATIOS DURING 2009 AND 2010

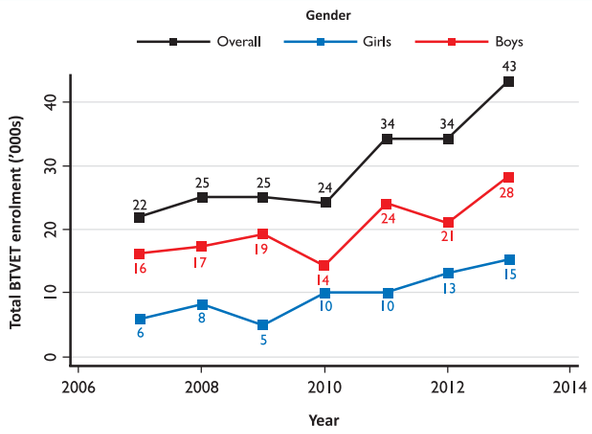
Region	Student-to-Teacher Ratio		Student-to-Classroom Ratio	
	2009	2010	2009	2010
Central	18	18	35	41
East	20	22	37	52
North-east	19	24	32	56
North	18	19	33	44
South-west	19	19	35	43
West	17	21	32	46
National	18	19	35	45

Source: Authors' compilations from Education Statistical Abstracts from MoESTS

3.5 BTVET and Tertiary Institutions

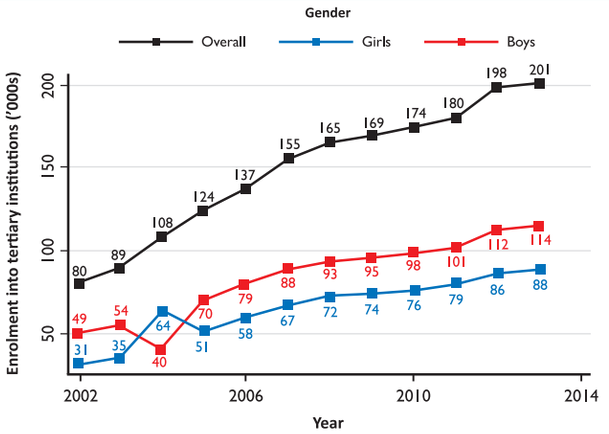
There has been a steady increase in enrollment into Business, Technical and Vocational Educational (BTVET) institutions since (Figure 42). However, more boys than girls enroll in BTVET institutions for all the period under review. Total enrollment into tertiary institutions were steadily increasing between 2002 (79,857 students) and 2013 (201,376 students) (Figure 43). Similarly, the trends of total enrollment into universities was steadily increasing between 2002 (57,144 students) and 2013 (140,403 students) (Figure 44). In all these institutions of higher learning, total enrollments were markedly higher for boys compared to girls.

FIGURE 42: TRENDS OF TOTAL ENROLLMENT INTO BTVET SCHOOLS BETWEEN 2007 AND 2013



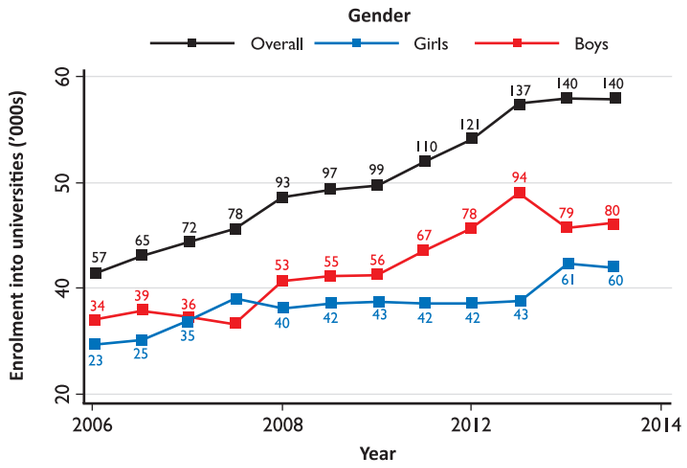
Source: EMIS, 2014

FIGURE 43: TRENDS OF TOTAL ENROLLMENT INTO TERTIARY INSTITUTIONS BETWEEN 2002 AND 2013



Source: EMIS, NCHE, 2014

FIGURE 44: TRENDS OF TOTAL ENROLLMENT INTO UNIVERSITIES BETWEEN 2002 AND 2013

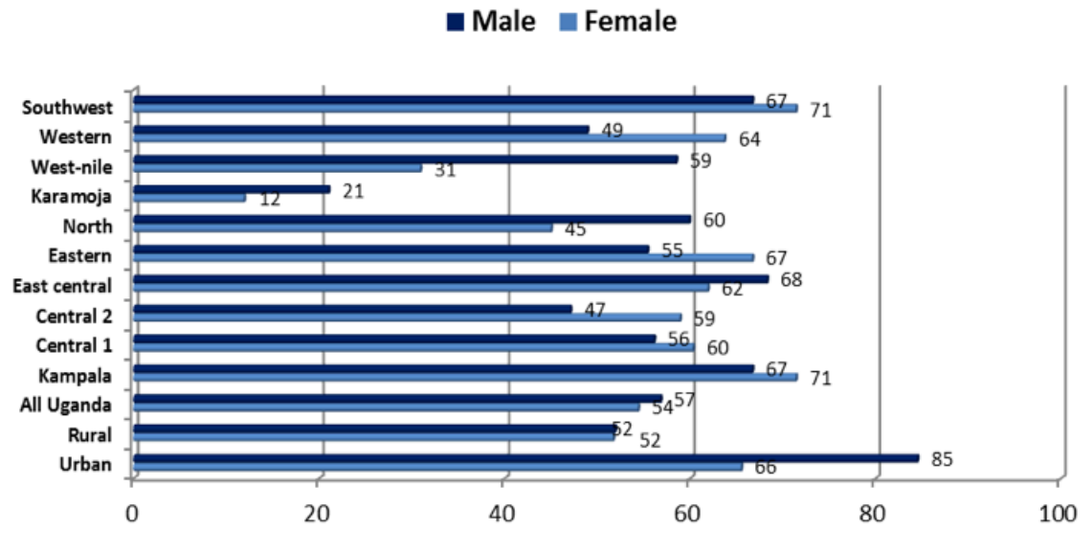


3.6 Disparities in Education

3.6.1 Geographic disparities

A regional analysis using data from the UDHS 2011 shows substantial variation in school completion especially by gender (Figure 45). Only in western, eastern, and Kampala sub-regions, are girls more likely to complete primary schools than boys. The gender gaps in primary completion rates are largest in West Nile (28 percentage points) and Karamoja (about 10 percentage points) as well as urban areas. Girls are more likely to complete school in central Uganda while in northern Uganda, more boys than girls complete primary school.

FIGURE 45: PRIMARY COMPLETION RATE, 2011



Source: Authors' calculations, based on UDHS 2011 data

3.6.2 Wealth disparities

The child poverty report 2014 revealed that there was a positive correlation between secondary school enrollment and increase in household wealth - with enrollment rates rising from 3.3% for the poorest quintile to 32% for the richest quintile (MGLSD, UNICEF, & EPRC, 2015). A similar study using UNHS 2010 data showed that the odds for a child from a poor household attending primary school to completion were 23% lower than those from a non-poor household

(Tamusuza, 2011). These findings suggest that household income is a strong predictor of primary and secondary school enrollment and a determinant of the likelihood of drop-out. Table 20 contains some of the monetary reasons for children dropping out of school documented in the 'Out-of-School' Survey (Mpyangu, Ochen, Olowo, & Lubaale, 2014).

TABLE 20: MONETARY REASONS FOR DROPPING OUT OF SCHOOL BY REGION

Cost	Central	Eastern	Karamoja	Northern	Western	Total
School fees	80.5	13.3	78.4	24.4	62.8	**41.1**
Uniform or clothing	18.4	7.9	48.7	26.5	32.6	**22.5**
Examination fee	20.1	4.2	8.1	31.6	20.9	**21.2**
Building development fund	12.1	3	29.7	30.1	32.6	**20.8**
Books and supplies	16.1	6.7	35.1	18.1	26.7	**17.0**
PTA fees	10.3	2.4	24.3	10.5	18.6	**10.3**
Transportation	4	0.6	16.2	2.7	12.8	**4.3**
Coaching	2.3	0.6	0	0.3	4.7	**1.3**
All costs	12.6	53.3	13.5	27.4	7	**26.7**

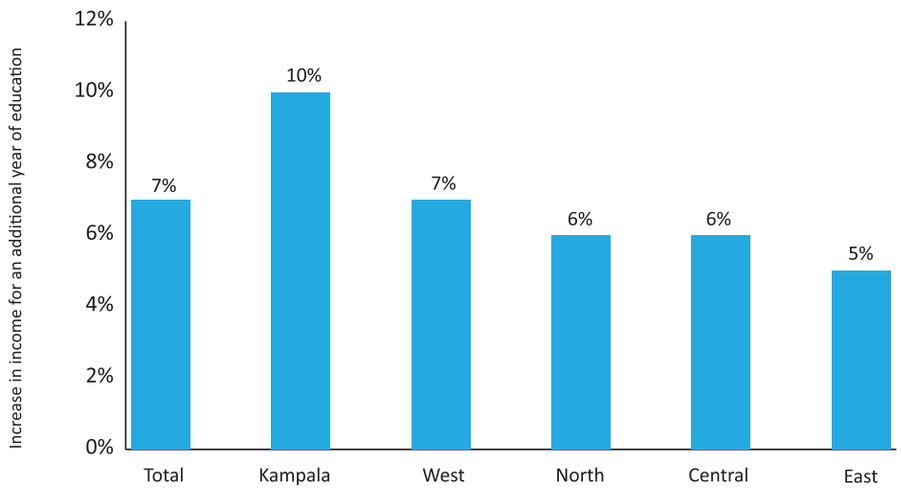
Source: Mpyangu, et al (2014).

Factors emerging from interviews with key informants in selected districts for high drop-out rates include unaffordable school fees and uniform/clothing fees as well as negative attitudes of some parents towards educating girls. Interview participants in the present study also commented on the limited access to proper sanitation for older girls, including access to sanitary pads as reasons forcing girls to drop out of school.

3.7 The Case for Education Investment

In economic terms, there are large and positive private returns to every additional year of education in Uganda. These returns have been mainly estimated in terms of income earnings associated with each additional year of schooling (Cuaresma, and Raggl, 2014) (See Figure 46). There are also positive social returns to investment in education at all levels such as molding socially responsible persons, well-groomed leaders, persons of integrity and good social behavior. Other potential benefits especially for girls include delayed marriages, reduced teenage pregnancies, improved social status and increased access to information, better connectivity and improved decision making.

FIGURE 46: INCREASE IN INCOME PER ONE ADDITIONAL YEAR OF EDUCATION



Source: Cuaresma and Raggl (2014)

Progression to secondary and higher levels including business and technical education is important for further developing human capital with the required skills to spur economic growth and development. From a long-term development perspective, estimates from the demographic dividend model by UBOS suggest that, for Uganda to realize the Vision 2040, average years of education must increase more than threefold from the current level of 4.9 to 16 years (UBOS 2014c). Indeed the models for different scenarios for achieving the Vision 2040 GDP per capita target show that emphasis on education (and family planning - for population control) are key factors for attaining the middle income status by 2040 as shown in Annex B, Figure B2.1. Simulation estimates by UBOS also show that interventions in education and family planning would result in doubling of GDP per capita and a 53% increase in the HDI by 2040 compared to business as usual scenario (Annex B, Figure B2.2)

3.8 Conclusions

Enrollment in ECD/pre-primary education has increased over the past decade but largely remains an urban phenomenon. Majority of the ECD/pre-primary centers are owned by the private sector, making these services expensive and unaffordable for the rural poor. Little is known about ECD services and activities in the early days (0-3 years) of children in terms of parenting skills, nutrition, early stimulation and learning. Enrollment in primary schools has increased especially following the UPE, and is higher for boys than girls, although the disparity has been reducing. However, primary completion rates and transition to secondary education remains unacceptably low. Secondary school enrollment has steadily increased, for both girls and boys. However less than half of children enrolled in Senior 1 complete senior 4. Secondary school completion rates are lower for girls, perhaps as a result of teenage pregnancies and early marriages as reflected in section 6 (girl child section) of this report.

At the regional level enrollment at pre-primary and primary level is lower in the northern and north-eastern (Karamoja) regions. While data on completion rates and quality of education were not readily available at regional level, it is likely that the two regions still perform poorer than other regions.

Further, while UPE and USE policies have increased enrollment in primary and secondary levels, the quality of education in government schools remains low. Since the majority of children from low-income households attend UPE and USE schools, the persistently low quality of education in government schools limits such children reaching their full productive potential and effectively being competitive in the labor market with their counterparts who attended private schools - thus potentially perpetuating intergenerational poverty. There is need to invest in improving the quality of education at all levels.

There is evidence to justify investment in education based on the private and social benefit of each additional year of education. Lifetime personal income could increase by up to 7% for each additional year of education while GDP per capita and Uganda's HDI could double by 2040 with emphasis on interventions in education (Cuaresma and Raggl, 2014).

4 CHILD PROTECTION

This section highlights the underlying causes of children's vulnerability that results in multiple forms of abuse, neglect and exploitation; the children affected; the weaknesses in prevention and response; and makes suggestions on the way forward.

HIGHLIGHTS

- Over 8 million children, 51% of the child population, are either moderately (43%) or critically vulnerable (8 %)
- Over 2.2 million children (11.3% of children under the age of 18) are orphans
- About 2.5 million children live with some form of disability in Uganda— representing 13% of all children in Uganda
- Over 31,000 children between the ages of 10 to 17 are heading households
- About 40,000 children live in residential childcare institutions, and approximately 10,000 live on the streets with no adult care
- On average, 11 per 100,000 juveniles were arrested by police in 2013
- More than half of 15–19-year-old women have experienced physical or sexual violence
- About 26 girls are defiled everyday
- Eight in ten children in primary and secondary school experience sexual violence. Male teachers are the main perpetrators

4.1 Policy Context

The Children's Act Cap 59 provides the overarching legal framework for childcare and protection in Uganda. The Act draws heavily from provisions of the United Nations Convention on the Rights of the Child 1989 and the African Charter on the Rights and Welfare of the Child (ACRWC). In addition, legislative protection of children against all forms of violence in the different settings is contained in The Penal Code Act, Cap 120 (as amended); Constitution of the Republic of Uganda 1995 (as amended); The Sexual Offences Bill, 2011; The Domestic Violence Act, 2010; The Prohibition of Female Genital Mutilation Act, 2010; The Trafficking in Persons Act, 2009; Local Government Act 1997; and The *Witchcraft Act*, 1957.

The Ministry of Gender Labour and Social Development (MGLSD) and the Community Based Services Department (CBSD) under the Ministry of Local Government are mandated to plan, manage and deliver welfare services for children and other vulnerable groups—working in collaboration with other social services sectors. The efforts of the MGLSD and other actors are guided by The National Orphans and Vulnerable Children Policy (NOP) (2004) and The National Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children II (NSPPI II, 2011/12—2015/16), which builds on the first plan (2005/06-2009/10). NSPPI II seeks to improve

and strengthen the response systems for vulnerable children in order to achieve more equitable and sustainable services and outcomes. In addition, several policies and action plans have been developed to respond to specific child protection issues. These include among others the National Child Labour Policy, 2006 at the three corresponding action plans i.e. The National Action Plan on Elimination of the Worst Forms of Child Labour 2012-2016; National Action Plan (NAP) to address child labor (2010-2015); and National Action Plan on Child Sexual Abuse and Exploitation, 2010-2015.

"The need for child protection arises in part because of the multiple forms of vulnerability that children are exposed to. Vulnerability refers to a situation where children and their caregivers are defenseless when exposed to risks and shocks."

4.2 Child Vulnerability

The need for child protection arises in part because of the multiple forms of vulnerability that children are exposed to. Vulnerability refers to a situation where children and their caregivers are defenseless when exposed to risks and shocks. Upon exposure, they are bound to suffer serious consequences due to lack of social protection. Some of the consequences are long term and irreversible. The situational analysis undertaken by Kalibala and Lynne (2010) revealed that nearly all Ugandan children (96%) were vulnerable, of which 43% (7.3 million) suffered from moderate and 8% (1.3 million) from critical vulnerability. Although children's vulnerability is widespread in all regions of Uganda, the magnitude is highest in post conflict areas, especially in northern Uganda (Kalibala & Lynne, 2010).

TABLE 21: REGIONAL DISTRIBUTION OF VULNERABLE CHILDREN IN UGANDA (%)

	Critically Vulnerable	Moderately vulnerable	Generally vulnerable	Total vulnerability
Central	7.8	33.6	52.7	94.1
Eastern	7.5	45.5	43.8	96.8
North	9.3	53.6	35.9	98.8
Western	8.1	41.1	45.1	96.1
Average	8.1	42.9	45.1	96.1

Source: Kalibala and Lynne (2010)

Underlying causes of child vulnerability include material deprivation (child poverty and deprivation), HIV and AIDS and other chronic illness, family breakdown, orphanhood, internal migration, and armed conflict among others (Kalibala & Lynne, 2010; MGLSD, 2011a; Walakira & Ddumba-Nyanzi, 2012).

4.2.1 Child vulnerability due to poverty and deprivation

Poverty in its multifaceted nature is the leading cause of child vulnerability in Uganda and is associated with other forms of child rights violations including violence, exploitation, abuse, and neglect of children; and the phenomena of child labour, child trafficking, and child marriages (MGLSD & UNICEF, 2015).

The Situation Analysis of Child Poverty and Deprivation in Uganda (MGLSD, UNICEF and EPRC, 2014), using the deprivation approach to child poverty[11], established that 55% (3.7 million) of Uganda's under-five children (0-4 years) and 38% of 6–17 year olds live in child poverty (i.e. deprived in at least two poverty dimensions). The most common deprivations for under-fives include: nutrition (38%); health (34%); and access to improved water sources (30%). Child poverty among 0-4 year olds affects 68% of children in West Nile and Karamoja. Even in the south-western region, where rates seem lower (41%) or Kampala where the concentration of poverty is lowest (20%) the levels are still high. Among children 6-17 years, child poverty is highest in Karamoja (82%) and lowest in western and south-western regions (MGLSD, UNICEF, & EPRC, 2015).

[11] Using UDHS 2011 data the report estimates the level of child poverty in Uganda based on child deprivations in 7 critical dimensions: nutrition, access to safe drinking water, sanitation, health, shelter, education and access to information. Child poverty is defined as **children deprived in 2 or more of these dimensions**, and **extreme child poverty** as children extremely deprived in two or more dimensions

Furthermore, about one in four children (24%) aged 0-4 years and about two in five (18%) aged 6-17 years live in extreme poverty (i.e. experience two or more severe deprivation issues or are extremely deprived in at least 2 dimensions). Children 0-4 years under extreme poverty are predominantly in northern and eastern Uganda. Rates of extreme child poverty for children aged 6-17 years are highest in the northern region, compared to other regions.

Rural areas have more deprived children compared to urban areas. Boys suffer more multidimensional deprivation compared to girls. The reasons for this disparity are not known. Male-headed households have more children who suffer severe multi-dimensional deprivation, an indication of poor childcare practices among men. In addition, multiple deprivations are strongly related to household wealth: around 84% of all children in the poorest quintile are extremely deprived in at least one dimension, 52% in at least two dimensions and 5.6% in four or more dimensions (MGLSD et al., 2015) (See Annex C, Table C1).

TABLE 22: CHILD POVERTY RATES BY SELECTED CHARACTERISTICS

	Child poverty (deprived in 2 or more poverty dimensions)		Extreme child poverty (Extremely deprived in two or more poverty dimensions[12])	
	0-4	**6-17 years**	**0-4**	**6-17 years**
National	54.6	37.6	23.8	18
Sex of child				
Male	54.9	38	24.9	17.5
Female	54.4	37.3	22.6	18.4
By region				
Central	49.6	33.1	18.7	11.7
Eastern	58.4	38.9	25.5	19.5
Northern	61.9	54.3	36.5	33.7
Western	49.7	28.2	17.6	10.6
Sub-regions				
Kampala	22.6	15.6	2	26.2
Central 1	60.4	33.9	25.3	49.4
Central 2	56.1	39.1	22.7	46.7
East central	60.6	39.9	22.1	52.3
Eastern	57.1	39.4	27.5	55.3
North	54.6	45.4	27.2	56.2
Karamoja	68	81.6	57.2	88.1
West Nile	68.3	51.2	37.7	57
Western	57.5	29.5	14.7	37.9
South-western	40.9	26.7	20.9	46
Location				
Rural	58.3	39.8	26.7	19.7
Urban	31	21.3	4.8	5.1

Source: MGLSD, UNICEF, & EPRC(2015).

[12] Children experiencing 2 or more severe deprivations.

4.2.2 Categories of vulnerable children

Orphans

According to the 2012/13 Uganda National Household Survey (UNHS), at least 2.2 million children (11.3% of children under the age of 18) have lost one or both parents (UBOS, 2014a). This represents a two percent decline in the proportion of children who have lost one or both parents between 2002/3 and 2012/3 as indicated in the Table 23.

TABLE 23: ORPHANHOOD TRENDS

	UNHS 2002/3	UNHS 2005/6	UNHS 2009/10	UNHS 2012/13
Children under the age of 18) have lost at least one or both parents	**13.4**	**14.6%**	**12.7 %**	**11.3**

Source: UBOS, Uganda National Household Surveys 2002-2013

Of those who are orphaned, about 5 in 10 (46%) have lost their parents to AIDS. According to the 2012/13 UNHS, the rate of orphanhood was more than five times higher among children aged 15-17 compared to those aged 0-4 years (see Annex C, Table C2). Orphanhood has gendered features. Children are two times more likely to report having lost a father than a mother at any given age. In addition, orphanhood is more prominent in female-headed households (25%) compared to male-headed households (6%). Further, there are some notable differences in percentages of orphans across regions. Orphan status is significantly higher in mid-northern Uganda (at least 16% of children in the region have lost a parent) than in the rest of the country (see Annex C, Table C2).

Available evidence indicates that while most orphaned children continue to live in families – typically with a surviving parent or sibling or members of their extended family – a considerable number fall through the cracks of regular familial support networks. This has led to a large number of children outside of protective family care. In a recent survey of 668 children living and/or working on the street aged 11-17, more than half (55.2) reported to be orphans. About 23% of the children were double-orphans i.e. had lost both mother and father, while 21.5% and 10.7% of the children had lost their fathers and mothers respectively (Walakira, 2012).

Available evidence also indicates that orphanhood reduces the network of care and protection available to children (Walakira, Ddumba-Nyanzi, & Kaawa-Mafigiri, 2014). For example, recent studies show that about 63% of orphans live with caregivers who were typically impoverished and/or elderly–many of whom lacked access to basic services (Kalibala & Lynne, 2010). Orphanhood is also associated with multiple deprivations with far reaching implications for child survival, growth and development (Walakira, Ddumba-Nyanzi and Kawa-Mafigiri, 2014). Research also shows that orphans are less likely than non-orphans to be at the age-appropriate grade level, due to the interruption of education caused by parental illness and death (Kasirye and Hisali, 2010). In particular, younger children and double orphans were the most affected groups in terms of schooling gaps (Ainsworth, Beegle and Koda, 2005; Bicego, Rutstein and Johnson, 2003); (Ainsworth, Beegle, & Koda, 2005; Bicego, Rutstein, & Johnson, 2003). In addition, orphans are more likely to be engaged in employment (including hazardous work), at the expense of schooling (Uganda Bureau of Statistics (UBOS), 2013). A recent review also indicates that orphans are more likely than non-orphaned children to engage in sex at an earlier age, and are more likely to be sexually exploited (Walakira, Ddumba-Nyanzi, & Kaawa-Mafigiri, 2014).

Child headed households

Orphanhood in part causes child headed households. According to the 2012/13 UNHS, about 0.4% of the households in Uganda are headed by children. Therefore it is estimated that over 31,000 children are heading households in Uganda (UBOS, 2014a). Child headed households were more prevalent in the urban (0.7%) compared to rural areas (0.3%). In terms of regional distribution, Kampala, mid-west and central 2 have the highest proportion of child headed households, while the south-western region has the lowest (see Annex C, Table C3). This could possibly be a result of child migration to urban areas.

Child headed households (CHHs) are more susceptible to the risk of severe poverty, owing to limited productive abilities to earn sufficient money (UNICEF, 2006); and are more vulnerable to deprivation, abuse, violence and risky sexual behaviors (Wakhweya et al., 2002). A qualitative study of 969 child headed households in one district in Uganda, found that orphans living in CHHs are poorer than other orphans, have lower school attendance and have less access to social services (Luzze & Ssedyabule, 2004).

Children outside of protective family care

There is universal agreement that optimal support for a child comes from a caring and protective family. Protective and permanent family care and positive childhood experiences have beneficial immediate and long-term effects (USAID, 2012). However, a number of children in Uganda continue to live outside of protective families. These include mainly children in residential childcare institutions, and children in street situations (CSS). These children are deprived of their rights to grow up in a nurturing family environment and especially those living in street situations, are unable to access the basic needs thereby undermining their survival, growth and development. They also do not receive the adult care that is critically needed for developing social competencies, and behavior that fosters positive relationships with others.

Children in residential childcare institutions (CCIs)

The ignorance of parents on the negative consequences of institutionalization, the neglect of parental responsibility, and the craftiness of some managers of CCIs are some of the major factors linked to the growing number of children in CCIs in Uganda. Other reasons are linked to poverty, low adoption rate and inadequate attention towards other alternative forms of family-based care. Estimates indicate that between 40,000 to 50,000 children[13] in Uganda live in residential childcare institutions (MGLSD, 2012). Institutional care is often a "first resort" response without consideration for or investment in family-based care options (MGLSD, 2012); contrary to The National Alternative Care Framework for Uganda.

A study by Walakira, Ddumba-Nyanzi, & Bukenya (2015) indicates that more than two-thirds of the children in the childcare institutions (CCIs) have at least one living parent and many more have a contactable relative. The study also revealed that 45% of children were aged 0-3 years at the time they were placed in the institutions while 15% of children were placed into institutions before attaining six months. The main reasons for institutional placement are poverty and child abandonment rather than parental death (MGLSD, 2012; Walakira et al., 2015). Disturbingly, where sponsorship of children in institutions is involved, resettlement is hardly contemplated even where all indications showed that the child's family is able and protective enough to take care of the children.

Further, in many institutions, the standard of care is poor. Many of the CCI staff and managers have minimal knowledge of the guidelines and standards for the operation of childcare institutions as outlined in the Approved Babies' and Children's Homes Regulations (2013). This has implications for the children's safety and protection as well as their social and emotional wellbeing.

Box 1: Detrimental effects of institutionalization

The continued placement of children in childcare institutions has consequences for child growth and development. Childcare institutions are not considered to be an ideal environment in which to raise children (Save the Children, 2009; Walakira et al., 2015). Childcare institutions generally lack the capacity to meet the physical and emotional needs of children, and institutionalization can lead to serious developmental, emotional, and social problems (Walakira et al., 2015; Williamson & Greenberg, 2010). In addition, research shows that growing up in an institution in Uganda can damage and delay children's development and makes them vulnerable to neglect, violence and abuse. The detrimental effects of residential childcare institutions are increased when children are placed at an early age and/or for long periods of time (Browne, 2009) in institutions with large numbers of children and few caregivers (Browne, 2009; Bunkers, Cox, Gesiriech, & Olson, 2014; Csaky, 2009). Studies also show that placing children in protective family care results in better outcomes and is significantly less expensive than institutional care (Whetten et al., 2009; Williamson & Greenberg, 2010).

In light of the above, there is a need to develop effective interventions to prevent children from being separated from their families and to promote family reunification. Efforts should also be directed towards development of high-quality alternative care options such as kinship care, fostering and national and international adoption to expand the range of options for children needing alternative care. The MGLSD should also undertake measures to ensure that all institutions taking care of children are registered to operate as Children's Homes in line with the Approved Babies' and Children's Homes Regulations (2012), and are monitored and inspected regularly, to ensure they meet certain minimum quality care standards.

[13] This number however is considered by many to be a significant underestimate, given that many childcare institutions are not only unregistered but are also unknown (MGLSD, 2012).

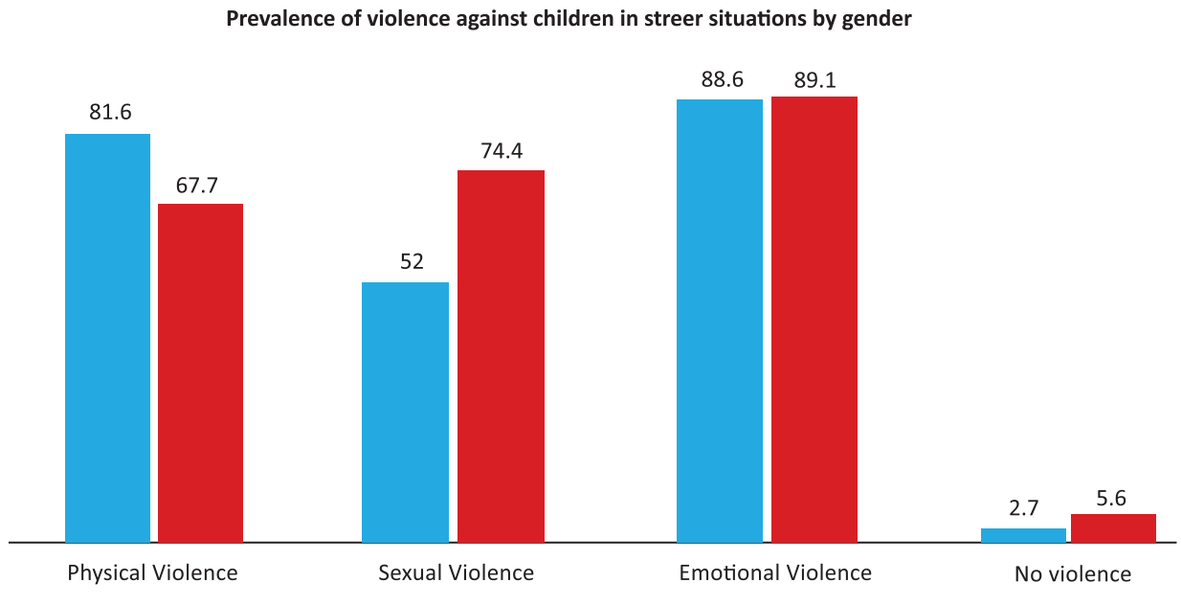
Children in street situations

Children are a visible part of the street-scene in urban areas in Uganda. However, data relating to the number of children in street situations (CSS) is scarce and to some extent unreliable. Estimates made over 10 years ago suggested there were over 10,000 'street children' in Uganda's town (USAID, Undated; Walakira & Ddumba-Nyanzi, 2012; Walakira, Ddumba-Nyanzi, Lishan, & Baizerman, 2014). Currently, the number could be more than four times higher (Walakira & Ddumba-Nyanzi, 2012). To ascertain this, a comprehensive survey to establish the number of street children in the country should be undertaken.

The factors accounting for the presence of children on the streets include material poverty, violence or maltreatment at home, family disintegration due to ill health/death and child trafficking among others (Lugalla & Mbwambo, 1999; Walakira, 2012; Walakira & Ddumba-Nyanzi, 2012; Young, 2004). Other factors are cultural practices that unfairly burden young people on the basis of age, sex and kinship orientation, insecurity (especially in Karamoja region), poor parenting, peer pressure and the processes of rapid urbanization—with children filtering into city centers due to the provision of a variety of informal survival opportunities (Walakira & Ddumba-Nyanzi, 2012).

However, there is limited knowledge about the general welfare of children in street situations in Uganda. Data in other contexts and the little available in Uganda suggests that the children experience multiple deprivations including lack of food, clothes, shelter, and education (Thomas de Benitez, 2011; Walakira, 2012). They are also exposed to extreme risk of violence, abuse and exploitation, including trafficking (Thomas de Benitez, 2011; Walakira, 2012; Human Rights Watch, 2014). This is due in part to the lack of adult supervision, protection and guidance. Exposure to violence can have profound impacts on children's mental, physical health and social development.

FIGURE 47: PREVALENCE OF VIOLENCE AGAINST CHILDREN IN STREET SITUATIONS BY GENDER



Source: Walakira, Ddumba-Nyanzi, Lishan, et al. (2014)

For example, in a 2012 survey of 668 children in street situations (CSS) aged 11-17 years, 76% have experienced at least one or more forms of physical violence, while 61% and 89% of the children reported to have experienced one or more forms of sexual, psychological or emotional violence respectively, in the last 12 months prior to the survey (Walakira, 2012). More girls experienced sexual violence than boys (74% vs. 52%), while boys were subjected to higher levels of physical violence than girls (82% vs. 68%) (Walakira, et al, 2012).

4.2.3 Children in conflict with the law

More children are getting into conflict with the law in Uganda as Table 24 shows. The growing number of children in conflict with the law has been attributed to violence in the homes, pressures of chronic poverty, and poor socialization. There are also an increasing number of reported crimes by juveniles linked to alcohol and substance abuse. However, the magnitude remains to be ascertained.

In 2013, the number of crimes committed by juveniles accounted for about one percent of all reported crimes in Uganda; with the Uganda Police Force arresting on average, 11 per 100,000 juveniles (Government of Uganda, (GOU) Justice, Law and Order Sector (JLOS), 2014). Children are arrested and detained for allegedly committing capital offences such as defilement, robbery, murder and other offences such as theft, assault, child-to-child sex (Justice Law and Order Sector (JLOS), 2014; Moore, 2010; Walakira & Ddumba-Nyanzi, 2012).

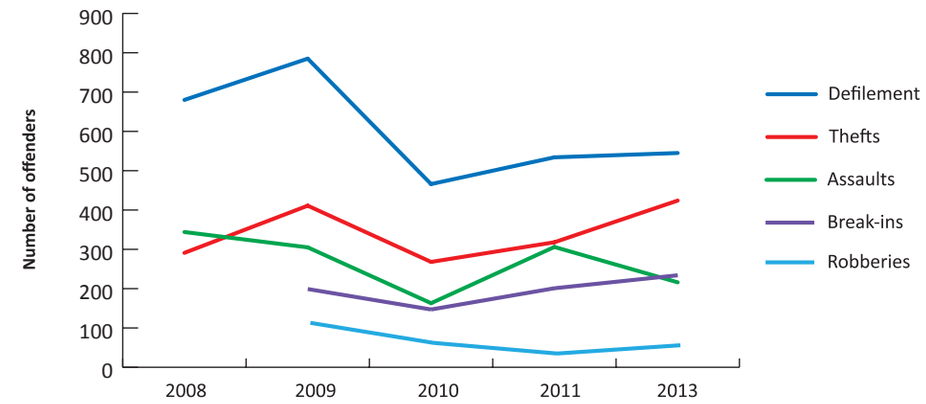
> *"In 2013, the number of crimes committed by juveniles accounted for about one percent of all reported crimes in Uganda; with the Uganda Police Force arresting on average, 11 per 100,000 juveniles.."*
>
> *(Government of Uganda, (GOU) Justice, Law and Order Sector (JLOS), 2014).*

TABLE 24: CHILDREN IN CONFLICT WITH THE LAW

	2008	2009	2010	2011	2012	2013
	Juveniles as suspects in crimes, 2008-2013					
Defilement (%)	28.1	35.0	25.0	30.1	n.a	24.3
Thefts (%)	12.0	18.3	14.4	17.9	n.a	18.9
Assaults (%)	14.2	13.6	8.8	17.2	n.a	9.6
Breakings (%)	0.0	8.9	7.9	11.3	n.a	10.4
Robberies (%)	0.0	5.0	3.3	2.0	n.a	2.5
Other crimes* (%)	45.7	19.2	40.6	21.4	n.a	34.2
Number of crime cases (n)	**2421**	**2245**	**1861**	**1774**	**1851**	**2240**

Source: Uganda Police Annual Crime and Traffic Road Safety Reports, 2008, 2009, 2010 , 2011, 2013
*Other crimes are not defined in the police reports—they could however include drug use, homicide, child to child sex, arson, false pretense etc.

FIGURE 48: TRENDS OF CRIMES COMMITTED BY JUVENILES



Defilement	680	785	466	534	545
Theft	291	411	268	268	424
Assaults	344	305	163	306	216
Break-ins		199	147	201	234
Robberies		113	62	35	56

Source: Uganda Police Annual Crime and Traffic Road Safety Reports, 2008- 2013

Considerable progress has been made in ensuring that juvenile offenders are handled in accordance with the juvenile justice legal framework. For example, the proportion of juveniles diverted from formal judicial proceedings increased from 41% in 2012 to 85% in 2013. In addition, the time spent in detention by juveniles before sentencing has declined from an average of five to three months. This is partly attributed to efforts by justice for children (J4C) programs to ensure that juvenile cases are fast tracked in the system, in collaboration with police, the Directorate of Public Prosecutions (DPP), and courts through the District Chain Linked Committees (DCC) and the J4C subcommittees. Prior to sentencing, however, children continue to be held with adults because of a lack of separate holding facilities at police stations (JLOS, 2014); putting them at risk of physical, emotional and sexual violence.

The MGLSD runs four remand homes (Naguru, Mbale, Gulu, and Fort Portal) and one National Rehabilitation Center (Kampiringisa National Rehabilitation Centers)—for children who are charged with or convicted of crimes and there are ongoing plans for two others.[14] However, there are concerns about deplorable conditions in juvenile detention facilities and remand homes (Human Rights Watch, 2014; Moore, 2010). For example the 2013 Auditor General report deemed several centers "unsuitable" for juveniles, citing understaffing and poor infrastructure (OAG, 2013). Children in the remand homes and the rehabilitation center also have limited access to meaningful activities and programs for their rehabilitation and reintegration into society (Walakira and Ddumba-Nyanzi, 2012). More efforts are therefore needed to ensure adequate rehabilitation of juvenile offenders to reduce the levels of recidivism.

TABLE 25: SELECTED JUVENILE JUSTICE INDICATORS

	2011/12	2012/3	2013/14
Number juveniles arrested per 100,000 of the child population	10.1	5.62	10.7
% Of juveniles diverted from formal judicial proceedings	52.6%	41.2%	85.4%
Proportion of juveniles receiving non-custodial sentences	75%	78.3%	47%
Number of children on remand per 100,000 child population	1.5	2.6%	2.78%

Source: (Justice Law and Order Sector (JLOS), 2013, 2014)

4.2.4 Children with disability

There is an estimated 2.5 million children in Uganda, comprising 13% of the child population, who live with some form of disability (Riche & Anyimuzala, 2014). (The child disability prevalence varies across the country: the northern region has the highest rate while the eastern and central regions have the lowest rates (Riche & Anyimuzala, 2014:26). Children with disabilities face stigmatization, increased violence, low enrollment in primary school (9% compared to 92% of the national average for all school going children) and face extreme discrimination (Uganda Society for Disabled Children (USDC) & National Council for Children (NCC), 2011).

TABLE 26: PREVALENCE OF CHILD DISABILITY

Prevalence of child disability		Data source
Proportion of children between age five to nine with disability	12%	DHS 2011
Disability rate for people aged between five and 29 years	13%	DHS 2011
Proportion of children aged between five and 19 live with some form of disability.	10%	UNHS 2009/10
Proportion of children with disability aged five to nineteen years is slightly below 10%	>10%	UNHS 2005/6
Proportion of children with disability aged five to nine years.	>5%	UNHS 2005/6

[14] Construction of two new remand homes in Kabale and Arua were ongoing as of a 2013 Auditor General report.

4.2.5 Children living in areas affected by armed conflict

The armed conflict in northern Uganda, which lasted over two-decades, has had an enormous impact on the lives of children. During the insurgence, a countless number of children were abducted, mutilated, tortured, beaten, raped, and enslaved for sexual purposes[15]. Many of the children previously abducted remain unaccounted for. In addition, thousands of families were displaced in the affected districts and were often relocated, sometimes in a chaotic manner, to internally displaced people's camps (IDPs), eroding the capacity of families and communities to take care of vulnerable children.

Nearly 8 years later, the effects of the conflict still linger. Compared to other parts of the country, the northern region has the highest proportion of vulnerable children, including orphans, children with adult responsibilities (heading households, children who are married), children with disabilities, and children multi-dimensionally deprived; with figures in most cases far above the national average. In addition, growing up amid violence, and experiencing displacement and family separation continues to have adverse effects on the psychosocial well-being of children. Further, the reintegration of formerly abducted children (FAC) back into their communities has been slow and difficult, and many children face persistent stigmatization and rejection (Awich, 2012; Corbin, 2008).

4.2.6 Child exposure to violence and abuse

Exposure to violence

Currently, there is no national representative population-based study on violence against children (VaC) in Uganda.[16] Nonetheless, several studies provide an indication of the extent of violence, abuse and exploitation in Uganda. Violence against children is pervasive, particularly in settings where children should be safe and protected, including homes and schools (USAID, 2012; Walakira & Ddumba-Nyanzi, 2012). Violence against children at home or in school–whether physical, emotional or sexual–is a major violation of their right to protection.

Physical violence

Physical violence against children in Uganda is wide spread and mostly takes place in the context of disciplining children or child-to-child violence (Walakira and Ddumba-Nyanzi, 2012). Corporal punishment for children is nearly universal (98%), with children mainly experiencing punishment at home (39%), or both at school and home (32%) (Naker, 2005). Recent studies show some decline in physical violence albeit on a limited scale. A study in post war northern Uganda undertaken

[15] The extent of the problem and the numbers of children affected is very difficult to assess, as official data is very scarce.

[16] The Uganda VAC study funded by PEPFAR/USAID will be ready in late 2016.

by Makerere University in collaboration with War Child Holland and Evaluation Challenge Fund puts prevalence of physical violence at 75% (Walakira et al, 2015). Another study based on a randomized controlled trial of 42 primary schools in Luweero puts prevalence at 52% (Devries, Child, Allen, Walakira, Parkes and Naker, 2013), while the one of UNICEF puts prevalence in schools at 74% (UNICEF, 2013). Prevalence according to regions is not well known. Boys are more susceptible to physical violence than girls. The reasons for this are not well known.

> *"The high prevalence of child marriages points to sexual violence. Up to 40% of the women aged 20-24 were married before the age of 18, and 15% before the age of 15 years."*
>
> *(UBOS and ICF International, 2012).*

Sexual violence

The risk of sexual abuse is pervasive in Uganda, with gender as a major risk factor (MGLSD & UNICEF., 2015). For example, 58% of 15-19 year old women had experienced sexual or physical violence and 25% and 23% of women in eastern and west Nile regions respectively had experienced violence during their pregnancies (UBOS and ICF International, 2012). The high prevalence of child marriages points to sexual violence. Up to 40% of the women aged 20-24 were married before the age of 18, and 15% before the age of 15 years (UBOS and ICF International, 2012).

In addition, defilement remains an immense risk to the safety of children in Uganda with defilement cases accounting for nearly 10% of the crimes reported in Uganda in 2013 (Uganda Police Report, 2013). The number of defilement cases reported to the police increased from 7,360 in 2009 to 9,588 in 2013, representing a 30% increase and translating to an estimated 26 girls being defiled every day – and these are only the cases reported to the police (Uganda Police Force, 2013). Up to 90% of the perpetrators of defilement are persons known to these children. They include close relatives, teachers, uncles, step-parents, biological parents, aunties, etc., who take advantage of the vulnerable state of these children to defile them, instead of protecting them (ANPPCAN, 2013).

TABLE 27: NUMBER OF DEFILEMENT CASES REPORTED TO POLICE 20007-2013

Year	Number of Defilement cases reported to police
2007	12,230
2008	12,463
2009	7,360
2010	7,564
2011	7,690
2012	8076
2013	9,588

Source: Annual Police report, 2007-2013.

Out of the 9,588 cases of defilement reported and investigated by police in 2013, only 4,931 cases were taken to court (51%), of which 359 led to convictions, 38 led to acquittals, 248 were thrown out, and 4,288 were still pending trial. Similarly, the 2012 annual crime report indicates that only half of the cases of defilement received at police stations made it to court.

The bigger tragedy perhaps is that there are several cases of defilement that go unreported. For example, out of the 34 sampled cases of defilement in Tororo district in 2014, only two had been reported to police in a timely manner (although they were both later withdrawn[17]). Underreporting of defilement cases has been attributed to widespread ignorance of existing laws (with many people unaware that defilement was a capital offence); corruption (occasionally involving buying off the parents especially where there is fear of shame by those involved) and the social norms that promote a culture of silence, especially in cases of incest. One child commented, "How are you going to come out and say, my relative has defiled me?" Often children do not disclose incidents of defilement due to guilt, shame, fear of not being believed, or even being reprimanded for what has occurred (Walakira & Ddumba-Nyanzi, 2012).

[17] Interview with Deputy Police Commissioner for the Child and Family Protection Department, Uganda Police [September 2015]

Further, many cases of defilement are never prosecuted and investigations of such instances are hampered by systemic failures. One of the causes of systems failure is the financial settlements between the parents of the victim, the defiler, and his family, if he is young. Where the parties reach a financial settlement, the defilement typically does not get reported to the police. Where the defilement is reported, it is reported late after negotiations for a financial resolution have failed and then with serious and negative ramifications for the prosecution of such cases. Even where a timely report is made, it is often withdrawn or not pursued because of such financial settlements[18]. As one informant asserted: "some families only use the threat of reporting to the police to intimidate the defiler into giving them money."[19]

Successful prosectution of defilement cases is hampered by the lack of birth certificates for some children, which makes it hard for one to ascertain the age of the victim; limited police surgeon services; and limations in protection of victims and witnesses. In some instances the victim chooses not to cooperate with the Police and instead shields the offender.

Child sexual abuse in Kalangala District

On 30th November 2013, Mr. Bernhard Glaser Berry a German national and proprietor of Ssese Humanitarian Service and caretaker of 21 girls aged between 10-17 years was arrested and charged after two children under his care accused him of sexual abuse. The minors, aged between 12 and 14, claimed that Glaser had repeatedly defiled them since 2007. The police rescued the victims. When they were examined, they were found to have been sexually abused. Fourteen of the victims were found to have implants for family planning.

Source: Annual Crime and Traffic/Road Safety Report, 2013

Similar to physical violence, sexual violence takes place in Ugandan homes, schools and communities. For example in a survey by Raising Voices and Save the Children, 32% of the children interviewed had experienced sexual violence mainly at home, 24% mainly at school, and 34.3% had experienced sexual violence both in a home and at school (Naker, 2005).

A recent survey however reveals a high prevalence of sexual violence in schools, with up to 78% of primary school children and 82% of secondary school students reporting that they had experienced sexual abuse at school. More than half (51%) of victims were aged between 10 and 13 years and 40.6% between 14 and 17 (UNICEF, 2013). Among children who experienced sexual abuse at school, 67% of them said the perpetrators were male teachers, 22% fellow students, 5% female teachers and 6% non-teaching staff.

Emotional violence

Available evidence suggests that emotional violence often co-exists with other forms of violence. Children experiencing sexual or physical violence are also likely to experience various levels of emotional violence. For example children exposed to sexual abuse may also be threatened, manipulated, or coerced into silence, which creates a kind of relationship or rather complicity between the child and perpetrator (Walakira & Ddumba-Nyanzi, 2012, p.15).

Emotional violence is far more common than any other violent disciplinary practices in families and schools. Up to 98% of children report experiencing emotional violence expressed in the form of shouting, insulting and threatening harm, mainly at home (42.6%) and both at home and school (35.5%) (Naker,2005). Within the school setting, children experience emotional violence from both teachers and students. For example, in a recent survey by Ministry of Education, Science, Technology and Sports (MoESTS) and UNICEF Uganda, some 46% of children reported experiencing emotional abuse by a teacher (UNICEF, 2013). Bullying is also wide spread in schools and is symbolized with a wide range of threats such as name calling, false accusations to make trouble for the victim with authority figures, damaging or stealing belongings, threats, and intimidation (Walakira & Ddumba-Nyanzi, 2012, p. 32)

Emotional violence is associated with a range of psychological and/or behavioral problems: it can lead to poor self-esteem, emotional distress, insecurity, difficulty in forming relationships, lack of attachment, reduced capacity to communicate and form emotional bonds, and suicide ideation among others (Walakira & Ddumba-Nyanzi, 2012).

[18] KII with Senior Community Development Officer(CDO), Kabarole district [September 2015]

[19] Interview with Deputy Police Commissioner for the Child and Family Protection Department, Uganda Police [September 2015]

Child labor

Child labor remains a serious issue in Uganda, negatively impacting on child health and education and impairing their opportunities for normal growth and development. According to the *National Labour Force and Child Activities Survey* 2011/12 (NLF&CAS 2011/12) up to 2 million children aged 5-17 are engaged in some form of work, of which 1.7 million are below 14 years of age. This constitutes 16.3% of all children nationally, with males (16.9%) having slightly higher rates than females (15.6%) (ILO/IPEC & UBOS, 2013). Compared to data from the 2009/10 UNHS, the proportion of children engaged in work declined by 9% (ILO/IPEC & UBOS, 2013; UBOS, 2010).

TABLE 28: PREVALENCE OF CHILD LABOUR IN UGANDA

	UNHS 2005/6	UNHS 2009/10	NLF&CAS 2011/12
Working children (children aged 5-17)	**32.4%**	50.6%	**38.8%**
Child labor	15.6 %	25.4%	**16.3%**
Child laborers, by sex			
Male	17.1	26.9	16.9
Female	14.1	23.7	15.6

The central region has the highest proportion of children at work (24%) followed by Karamoja region (23%) (See Annex C, Table C4).

Out of the 2 million engaged in work, up to 507,000 are involved in hazardous work. This constitutes 25% of the working children. The proportion was higher for males (28%) than females (22%). The proportion of children in hazardous work was more than twice (61%) in urban areas compared to the rural areas (23%). It is worth noting that by regional disaggregation, Kampala City had the highest proportion of children in hazardous work (88%) compared to all other regions (ILO/IPEC & UBOS, 2013).

Hazardous forms of child labor

Some of the categories of children in hazardous work include children working in the agriculture sectors, children in domestic services, and children in commercial sex work (CSW).

Child labor in the Agricultural sector

Commercial and subsistence agriculture has been identified as one of the sectors where children are involved in some of the most dangerous and exploitive forms of labor. It is also one of the most dangerous sectors in terms of work-related fatalities, non-fatal accidents and occupational diseases (ILO/IPEC & UBOS, 2013). Ironically, it is the sector where by far the largest share of working children in Uganda is found – approximately 93%. Children in the agriculture sector undertake activities including land tilling, sowing, weeding and harvesting in sugar cane, tobacco and rice plantations, picking coffee beans and tea leaves, and/or fishing among others.

The children in plantation agriculture are exposed to toxic pesticides and other chemicals, dangerous machinery or tools (like knives), heavy loads, heat, extra hours and harsh conditions, and long hours that interfere with schooling. For example, manual harvesting of sugar cane involves chopping thick stalks of cane with a blade, often for more than eight hours per day throughout the harvest season. Therefore, injuries such as cut fingers or legs caused by the use of machetes and sickles are common, as is muscular-skeletal damage resulting from the hours of repetitious striking and bending over.

Furthermore, many children are still not enrolled in school, or go to school once in a while, to work in the agriculture sector. For example, during primary data collection, it was established that in Bugiri district, some children are withdrawn from schools to attend to rice fields. Work on the rice field range from transplanting rice to acting as scarecrows (to scare away birds). This is most common in eastern Uganda. Similarly, key informants in west Nile reported an increasing number of children working on tobacco farms, during school days:

Child labor is there e.g. you take the Nile belt children are ever in the boats instead of going to school, the existence of the tobacco industry especially when it comes to plucking the leaves, parents retain children to do that one and in dry season children are at home laying bricks and people know that they can exploit their labor cheaply and instead of using adults, they use children (Key Informant – District).

Children in the extractive industry

A growing number of children in Uganda are involved in Artisanal and Small-Scale mining (ASM) and stone quarrying, although the number remains to be ascertained. Mining is considered a form of hazardous labor unfit for children under any circumstances. Work for child miners includes digging shafts, crushing rocks, carrying ore in gold mines and digging, scraping and lifting in salt mines, carrying and crushing large stones in quarries. Child miners face many potential health consequences due to the nature of their work including: over-exertion, respiratory ailments, headaches, joint problems, as well as hearing and vision loss. In addition to the risks faced by all child miners, children gold miners are potentially at risk of side effects from mercury, a highly toxic substance used to extract gold. However, because of the relatively small number of child miners, compared to child laborers in agriculture, child mining has not received the attention it deserves. This is probably because it takes place in temporary, remote, small-scale locations making it difficult to regulate and monitor.

Children in domestic servitude

Children in domestic service (i.e., child domestic workers, or CWDs) are singled out in the Child Labour Policy, 2006 and the National Guidelines on Child Labour as one of the categories of children in worst forms of child labour (WFCL). The use of children for domestic work is a widespread practice, especially in urban areas (Kasirye, 2007). Children in domestic service constitute the largest proportion of children trafficked internally.[20] However the magnitude remains to be ascertained. In addition, it is not clear what the best intervention options are for such children bearing in mind that the government and other actors have not experimented far reaching implications for the protection and wellbeing of these children.

[20] CWDs lack clear terms of service, often work long hours, are not paid or paid very low wages. They are also prone to verbal, physical and sexual violence.

Commercial and sexual exploitation

Commercial sexual exploitation of children is one of the worst forms of child labor, according to the National Child Labour Policy 2006. Data based on two separate surveys[21] show that the number of children affected by CSEC increased from an estimated 12,000 children in 2004 to 18,000 in 2010 and that girls were more impacted than boys. Most cases of CSEC occurred among children aged between 14 and 18 (ILO/IPEC, 2004; UYDEL & Acting for Life, 2011). CSEC is more prevalent in urban settings and the major risk factors for becoming involved in CSEC were lack of parental care, school dropout (mainly primary school) and poverty (UYDEL & Acting for Life, 2011). Commercial sexual exploitation of children is particularly on an upward trend in fishing communities, densely populated urban informal settlements, and truck stops along major transport corridors. The case below from Naluwerere, one of the truck stops along the Kampala-Malaba/ Busia exemplifies this problem.

Child prostitution in Naluwerere truck stop, Bugiri District

The UN defines child prostitution as the sexual exploitation of a child for remuneration in cash or in kind, usually, but not always, organized by an intermediary. Child prostitution is a growing problem in Uganda, especially in truck drivers' stopover towns such as Naluwerere in Bugiri District. The majority of children involved in commercial sex are between 12-18 years. Most of them are school drop-outs. Some young girls are trafficked from various sub-counties to trading centers under the disguise of being given jobs but are instead forced into prostitution. According to the Senior Probation and Social Welfare Officer in Bugiri District: young girls between the age of 13 and 17 are picked from villages, after convincing their parents that they are going to get them jobs. They (girls) instead end up in small rooms of various lodges in trading centers along the Jinja-Bugiri where they are forced to sell their bodies to long-distance truck drivers… "One day, I was doing my investigations in Naluwerere trading center about trafficking of girls and I could not believe with what I saw. I saw girls as young as 13 years old doing prostitution at about 9.00pm" he says. He attributes the vice to existence of poverty, lack of access to basic needs by guardians and parents at household level, bad cultural practices, illiteracy and ignorance on the laws governing human trafficking.

Narrating her journey to prostitution, Fausa (not real name), a 17 year old prostitute in Naluwerere observed: *I started prostitution when I was 13 years old. I didn't have money to go to school so I decided to start doing this work. I studied up to Senior 2, we were many at home and I had no school fees my parents couldn't afford they told me to stop. We were five in our family, three girls and two boys. After staying home for some time I had my needs and I needed money to address these needs. I needed money for pads, clothes, shoes, oil and others. I decided to do this kind of work because it didn't need any academic papers and there is nothing demanded for. I used to have friends who used to do this work and they were making money while I was sited at home these are the ones who convinced me and initiated me in this work. I get my clients through phone calls and reference or old customers (my customers) who already know me. Sometimes customers call me to go where they are I make money between UGX 35,000-30,000 on a good day. I charge a fee ranging from UGX 5,000 shillings for young person, and between UGX. 10,000–15,000 for adults.*

Children involved in commercial sex are at risk of contracting HIV and other sexually transmitted infections (STIs), and unwanted pregnancies (Walakira & Ddumba-Nyanzi, 2012). Commercial sexual exploitation is further associated with increased involvement in delinquent activities, and increased rates of alcohol and substance abuse. In addition, it exposes children to other forms of abuse and violence at the hands of their clients, such as rape, physical assault, and use of 'objects' for sexual satisfaction (Walakira & Ddumba-Nyanzi, 2012). There is however very little data on services accessible to these children to protect them against sexually transmitted diseases and unwanted pregnancies.

4.2.7 Child trafficking

Child trafficking is a serious problem in Uganda (Walakira & Ddumba-Nyanzi, 2012). Internal trafficking is estimated to be the most significant form of trafficking in the country; typically characterized by trafficking of children, especially girls, from poor rural areas to urban areas (Mukuye & Ddumba-Nyanzi, 2009). Trafficking takes place for various exploitive purposes, including sexual and labor exploitation. For example, children are internally trafficked for work in domestic servitude, bars,

[21] The approaches used to arrive at these estimates in both studies may not have been rigorous enough to suggest that the estimates were realistic; with researchers in the more recent study cautioning that further investigations are needed to "generate evidence and country wide picture of the problem of CSEC."(UYDEL & Acting for Life, 2011:6)

restaurant, night clubs, and as street vendors, or even commercial sex workers, 'with no access to education, no freedom of movement and working long hours in poor conditions for little or no pay' (Walakira & Ddumba-Nyanzi, 2012, p. 69).

TABLE 29: REGISTERED VICTIMS OF INTERNAL AND TRANSNATIONAL TRAFFICKING IN 2013

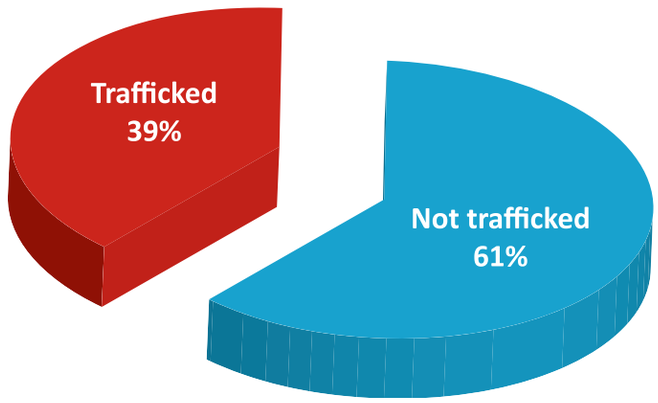
	Male Adults	Female Adults	Male Children	Female children	Total
Internal trafficking	4	5	192	207	408
Transnational trafficking	163	186	44	36	429

Source: COCTIP, 2014 (The Coordination Office to Combat Trafficking in Persons (COCTIP)

A survey conducted by Makerere University (See Walakira, Bukenya, and Ddumba-Nyanzi, 2015) provides some indication of the prevalence of child trafficking among children in poor urban settlements: with about four out of ten working children reporting being trafficked. In rural communities in Karamoja (Moroto district) and eastern (Iganga district); child trafficking stood at 34% within the surveyed households (n =819), suggesting that three in ten of the households experienced child trafficking (see figure 49).

> *Internal trafficking is estimated to be the most significant form of trafficking in the country; typically characterized by trafficking of children, especially girls, from poor rural areas to urban areas.*
>
> *(Mukuye & Ddumba-Nyanzi, 2009)*

FIGURE 49: PROPORTION OF TRAFFICKED CHILDREN IN KAMPALA (N=420)



Source: Walakira, Bukenya and Ddumba-Nyanzi, 2015

Transnational trafficking is also a growing problem, with children trafficked primarily for adoption, fostering, sexual and labor exploitation. At the regional level, many girls are trafficked for sexual exploitation to neighboring Kenya. Internationally, Ugandan children are primarily trafficked to Canada, Yemen, the United Arab Emirates, Far East Asia, Saudi Arabia and some European countries for both commercial sexual exploitation and forced labor (ECPAT International, 2013)

In terms of age and gender of child trafficking survivors, existing research indicates that girls are more affected than boys. However, boys are reportedly trafficked at an early age (mainly around 10 years old) while girls are usually moved between 15 and 19 years old (ECPAT International, 2013)

Box 2: Trafficking of children and sexual exploitation

Available evidence points to a number of child trafficking incidents for the purpose of commercial sexual exploitation in Uganda. Trafficking for sexual exploitation affects mainly women and girls. In a recent survey of children living and/or working on the streets in Uganda, 7% of the girls, and 3% of the boys admitted to being trafficked for commercial and sexual exploitation (Walakira, 2012). Similarly, a retrospective survey on violence against girls conducted by ACPF also established that 51 (representing 10%) of the 500 young women interviewed in Kampala slums, had been trafficked as girls for sexual purposes (African Child Policy Forum, 2006, p. 120). Of these, 44 girls said they had been trafficked between the ages of 14-17 years, while 7 reported that they had been trafficked at a much earlier age. (African Child Policy Forum, 2006, p. 120). In the same study, 35 young women (representing 7%) admitted being forced into prostitution before they were 18 years old.

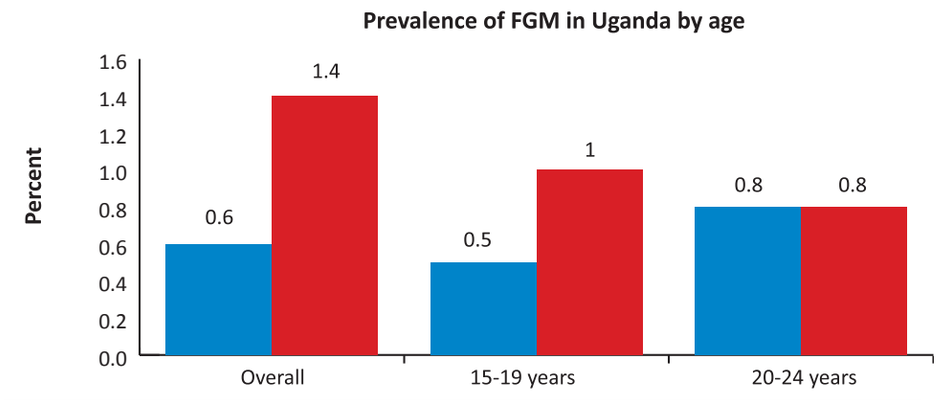
The 2009 PTIP Act prohibits all forms of trafficking, prescribing punishments of 15 years' to life imprisonment, which are sufficiently stringent and commensurate with those prescribed for other serious crimes, such as rape. The anti-trafficking act also prohibits illegal adoption and child selling. The existing data does not give a clear indication if people are generally aware of existence of laws against child trafficking e.g. the Trafficking in Persons Act, 2009; or if they are aware that some of their parenting practices constitute child trafficking. There is also limited understanding of the links between child trafficking and other child protection issues, such as the protection of children's rights in migration or other forms of mobility.

4.2.8 Harmful traditional practices

Female genital mutilation/cutting (FGM/C)

The overall rate of FGM/C in Uganda increased from 0.6% in 2006 to 1.4% in 2011. In the eastern region, the rate has decreased from 2.4% in 2006 to 2.3%, whereas in Karamoja the prevalence is still at 4.8% (UBOS and ICF International, 2012).

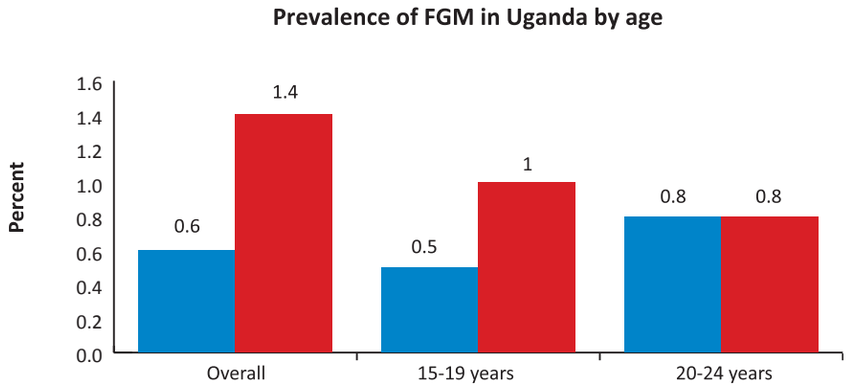
FIGURE 50: PREVALENCE OF FGM IN UGANDA BY AGE



	Overall	15-19 years	20-24 years
2006	0.6	0.5	0.8
2011	1.4	1	0.8

Source: Uganda Demographic and Health survey data 2001-2011

FIGURE 51: PERCENTAGE OF WOMEN WHO HAVE UNDERGONE FGM BY REGION



2006	0.6	0.5	0.8
2011	1.4	1	0.8

Uganda Demographic and Health survey data 2006-2011

FGM/C is practiced by particular ethnic groups living in specific geographic areas, namely the Sabiny in Kapchorwa, Bukwo and Kween districts in eastern Uganda and the Pokot, Tepeth and Kadama in Nakapiripirit, Moroto and Amudat districts in the Karamoja sub-region. Among the Pokot group, the practice is nearly universal (MGLSD & UNICEF, 2015). It is cultural and embraced by the cultural power structures. Girls between 15 and 18 years old are expected to undergo this form of genital excision, as an important rite of passage to adulthood. The practice is thought to promote virginity and reduce marital infidelity due to the female's reduced sexual desire as a result of the removal of the clitoris and in some cases other parts of the genital organ (Yiga et al., 2008). However, the practice has several health implications. Complications as a result of the procedure can arise and can cause severe pain, shock, bleeding, infection and injury as well as long-term consequences such as infertility, bladder infections, cysts, childbirth complications and death (Obermeyer, 2005).

While parents, family members and girls often recognize that the practice causes serious and permanent harm, they are bound to it because it is part of their cultural tradition. In doing it, they believe they are raising a girl in a proper way to prepare her for adulthood and marriage. The failure to adhere to this cultural practice results in social exclusion and harassment (Walakira & Ddumba-Nyanzi, 2012).

While the FGM Act, 2010 criminalizes FGM, a recent study (Ochen-Awich et al, 2014) indicates that parents use the opportunity when a girl is pregnant and circumcise her during the delivery process. In addition, others take their daughters to the Kenyan borders for circumcision where enforcement of anti-FGM is weaker.

Child sacrifice and the mutilation of children in Uganda

Child sacrifice or the ritual killing of children is a grave violation of children's right to life, which is taking place in Ugandan communities. Between 2006 and 2010, a total of 67 cases of *sacrifice* were reported and investigated by the police.[22] However, given the illicit and hidden nature of the practice, the number victims of child sacrifice could be higher. For example, a 2013 report from Humane Africa indicates a higher level of prevalence of practice of child sacrifice – far beyond what has been documented and investigated by the Police. The report shows that over four-month fieldwork period from June to September 2012 there been an average of one sacrifice each week in one of the 25 communities where the research was based (Fellows, 2013).

"While the FGM Act, 2010 criminalizes FGM, a recent study (Ochen-Awich et al, 2014) indicates that parents use the opportunity when a girl is pregnant and circumcise her during the delivery process."

[22] Annual police Report, 2008; 2009; 2010; 2011

TABLE 30: CASES OF CHILD SACRIFICE

	Total # of cases reports (children and adults)	Cases involving children
		Total
2006		25
2007	03	03
2008	25	18
2009	29	15
2010	14	9
2011	08	
2012	11	
2013	12	

Ritual murders are blamed on unscrupulous traditional spiritual healers whose activities and operations lack effective regulation and a monitoring mechanism. Often cited is the quest for material wealth, pleasing ancestors and protection of the perpetrators from evil spirits (Bukuluki, 2009; Fellows, 2013; Walakira & Ddumba-Nyanzi, 2012).

Unfortunately, the existing legislation including the witchcraft Act of 1975, and the Penal Code Act have not been effectively implemented. Also not well known are the circumstances related to domestic entanglements, conflicts over inheritance and land issues that are linked to child murders but often framed as child sacrifices. There is no documentation or research concerning services for survivors and care givers and efforts to stem the practice at the family and community level.

4.3 Processes and Factors Undermining Child Protection

4.3.1 Birth registration

Birth registration is a key step towards protecting children and ensuring that they receive the services they need to survive and thrive. Uganda, being a signatory to the United Nations Convention on the Rights of the Child (UNCRC), has committed itself to ensuring universal birth registration, and registration of deaths is compulsory and mandated under the Birth and Death Registration (BDR) Act, 1973(Cap 307).

Babies registered within the first year of birth increased from 30% in 2011 to 60% in 2014 (MGLSD & UNICEF., 2015; UBOS and ICF International, 2012). Despite this progress, it is estimated that there are still nearly 3 million unregistered under-fives in the country, and nearly one-third of these are in eastern and south-west regions (MGLSD & UNICEF, 2015). This has far reaching implications for children access to basic services and protection of children, including prevention of child labor, trafficking, countering child marriage and protection children from other forms exploitation and abuse (especially sexual abuse).

4.3.2 Child protection and welfare system

While child protection is firmly embedded in a number of laws and national policies and strategies, the enforcement and implementation of the laws and policies, respectively, remains weak. In addition there have been delays in amending the Children's Act to ensure more protection for children. The key amendments proposed have been pending in Parliament since 2005. Suggested amendments include incorporating the welfare principal and the principle of the best interest of the child into the Act, strengthening the law to curb abuses related to adoption and care and preventing trafficking, protecting the rights of the children in conflict with the law, prohibiting corporal punishment and reinforcing government responsibility towards the protection of child rights.

In addition, the effectiveness of the child welfare and protection system continues to be severely undermined by social welfare workforce shortages and gross underfunding at both national and Local Government (LG) levels (MGLSD, 2011b). For example, the social development sector budget in Uganda is less than 0.1% of GDP and has been progressively declining from 0.1% in 2011/2012 to 0.04% in 2013/14. This amounts to about 0.3–0.5% of the budget (MGLSD & UNICEF, 2015).

The effectiveness of the child protection system in Uganda also continues to be undermined by:

- The apparent disconnect between the various child protection sub-systems (such as childcare, justice, law and order, and the basic social services) as well as the lack of effective coordination within the various sub-systems
- The various sub-components of the child protection system are generally fragmented between many sectors and actors and rarely coordinate at the national and local levels. Consequently, child protection issues are rarely addressed in a holistic manner
- The formal and informal structures for child protection are not yet well integrated
- Lack of policy and strategic framework to guide Justice Law and Order Sector interventions for children

4.4 Promising Practices in Child Protection

The following promising practices were identified:

Criteria	Rating 1-3, (3 being the best score)	Evaluators remarks
A: Innovations in promotion of family based care		
1. Effectiveness *(in addressing need and influencing policy & legislations)*	2.7	The USAID/Deinstitutionalization of Orphans and Vulnerable Children in Uganda program targets building capacity of CCIs to deliver quality care for children in need of alternative care and have care plans that result in the de-institutionalization of children by re-integrating them into a nurturing family environment. The program uses a multi-actor approach that brings together government (Ministry of Gender Labour and Social Development) and its structures, other government agencies in the Justice Law and Order Sector, NGOs and grass roots structures, to strengthen the systems of care and support for such children at all levels. Working with CCIs enables improvement in social work practices and improves the welfare of the children.
2. Efficiency	2.4	The program is working to reduce the cost of implementing the Alternative Care (AC) model by focusing more on family re-integration and pooling of resources by communities. However, the cost of care in the institutions is still high. The focus on other alternative care options and the emphasis on de-institutionalization is one way to reduce costs and to deliver better outcomes
3. Innovativeness	2.8	The program built science into implementation, created avenues for learning and is innovating new approaches. One of them includes the creation of Alternative Care Panels at national and district levels to help address the weaknesses in the court systems in making decisions on alternative care; the use of local care givers as a core ingredient in sourcing alternative care services; the use of social media to promote education; and training of staff in a range of approaches concerning alternative care
4. Replicability	2.5	This childcare reform model builds strongly on the Strong Beginnings model and is currently implemented by Child Fund and partners in 12 districts in Uganda. It will provide blue prints for the GOU and other actors to implement effective alternative care programs.
5. Ethical soundness *(including opportunity for beneficiaries to participate in design, implementation and evaluation)*	2.5	The program allows wider involvement of stakeholders; puts the best interests of the child at the forefront and pays greater attention to protection of children from exploitation and other non-ethical practices
Total Score	12.5	
B: Innovations in social service workforce strengthening		
1. Effectiveness *(in addressing need and influencing policy & legislations)*	2.7	The USAID/Strengthening the Ugandan National Response for Implementation of Services for Orphans and other Vulnerable Children (SUNRISE) program implemented by the International AIDS Alliance and partners, worked with Makerere University Department of Social Work and Social Administration to strengthen the national social services workforce, previously a key gap in building an effective child protection system. The program trained over 1500 key staff in local government, police and health services using a nationally approved, innovative curriculum. The impact of the training resulted in 30-50 percent increase in knowledge and skills, improved handling of child protection cases across districts; reduction in the prevalence of violence (See SUNRISE training evaluation reports, 2013, 2014); mobilization of resources for child protection with many districts committing budgets; and the creation and training over 8,000 grass roots para-social workers. Data collected in one sub-county in Kasese district, shows a significant decline in the number of child abuse cases between 2012 and 2014 in sub-counties where PSWs had been trained[23] The interventions resulted in increased front line staff in ¾ of the districts in the entire country.

Criteria	Rating 1-3, (3 being the best score)	Evaluators remarks
2. Efficiency	2.4	The program was largely efficient given its approach to training whereby nationally trained frontline staff helped recruit and train local para-social workers. This multiplied the number of child protection actors across over 100 districts, increased mobilization of resources and created more demand for child protection training.
3. Innovativeness	2.7	The program design was very innovative, bringing together different stakeholders to identify the key skills and knowledge gaps in the social services workforce; used the resources available in national training institutions; developed several tailor made training approaches for adult learning and created room for evaluating the impact of the training on the beneficiaries.
4. Replicability	2.5	The program is replicable and this is primarily because of the existence of a well-conceived curriculum that can be adopted within and outside of the country. Thus, other institutions have adopted elements of the child protection training such as Nsamizi Institute of Social Development; and are rolling out the curriculum
5. Ethical soundness (including opportunity for beneficiaries to participate in design, implementation and evaluation)	2.6	The program puts the best interests of the child at the forefront and pays greater attention to protection of children from exploitation and other non-ethical practices. It also allows wider involvement of stakeholders.
Total Score	12.9	

[23] Data provided from District Probation and Social Welfare officer (DPSWO), Kasese District.

Criteria	Rating 1-3, (3 being the best score)	Evaluators remarks

C: Creation of a cadre of volunteer para-professionals to strengthen child protection systems

Another promising practice involves the use of para-social workers (PSW) to strengthen child protection prevention and response of child abuse, neglect and exploitation; and the prevention of family separation at the community level. Under the USAID/SUNRISE program, over 10,000 volunteers were trained as para-social workers and linked to work directly with government frontline staff to prevent child rights violations in over 80 districts. They played a critical role in mobilizing support for the affected children using community resources, raised awareness on children's rights including reporting of rights violations and were always an important presence. They were recognized as community officials in defense of children and building responsive families. For example, according to data collected at the sub-county in Kasese district, there was a significant decline in the number of child abuse cases between 2012 and 2014 in sub-counties where PSWs had been trained.[23]

Reported incidents of child abuse police records, Kasese District, by sub-county

Sub-county	Cases Oct 2012 - Sept 2013	Cases Oct 2013 - Sept 2014	% change in reported child abuse	Para-social workers
Bulembia	156	211	35%	NO
Kilembe	167	244	46%	NO
Rukoki	135	198	47%	NO
Kyarumba	144	149	3%	NO
Ihandiro	78	89	14%	
Hima Town Council	159	92	-42%	Trained Oct 2012
Bwesumbu	147	39	-73%	Trained June 2013
Maliba	189	72	-62%	Trained Mar 2014
Kitholhu	154	70	-54%	Trained Oct 2014
Karambi	167	175	5%	Trained Oct 2014
Muhokya	176	376	113%	Trained Oct 2014

Source: *This chart was provided by the PWO, Kasese District*

Being voluntary structures however and not being formally recognized undermines the sustainability of the structure for a long time.

4.5 Conclusions

Children have the right to protection from violence, neglect, exploitation and abuse. However, the realization of children's rights to protection in Uganda continues to be critical challenge given that: more over than half of the children in Uganda are critically (8%) and moderately vulnerable (43%). Orphaned children, children living in areas affected by armed conflict, children with disabilities and those outside of family care remain particularly vulnerable. These children face an increased risk of experiencing child protection rights violations, especially in a context where child welfare and protection systems are undeveloped, and social service linkages are limited. The effectiveness of child protection and welfare system continues to be undermined chronic underfunding and human resource shortages both at national and local levels.

"Children have the right to protection from violence, neglect, exploitation and abuse. However, the realization of children's rights to protection in Uganda continues to be a critical challenge given that: more than half of the children in Uganda are critically (8%) and moderately vulnerable (43%). "

[24] Data provided from District Probation and Social Welfare officer (DPSWO), Kasese District.

5 CHILD PARTICIPATION

Broadly, children's participation ought to occur within two domains: the private or personal domain, such as the household and family; and the social or public domain, such as the community, school, and government. This section examines the practice around children's participation in Uganda, including the challenges and barriers to children participation.

HIGHLIGHTS

- There is a paucity of data on child participation at the family and household level in Uganda
- Key barriers to child participation include: a lack of understanding of what comprises genuine child participation; unequal power relations between children and care givers or programs; and the negative attitudes towards child participation rooted in cultural and normative beliefs
- Opportunities for participation in program initiatives are limited in scope and tend to be short lived
- Some avenues exist for children to participate in the social and public domain: ranging from children and youth clubs in schools, to children participation in research initiatives, policy development, and governance.
- Increased access to training and information to various duty bearers is likely to improve the context and practice of child participation
- A National Child Participation Guide (2008) exists. This, however, is a guideline document rather than a policy or action plan, and it does not outline any actions or goals for the Government or relevant stakeholder

5.1 Policy Context

All adults and institutions that work with or have an impact on children and families have the duty to ensure children's participation in different aspects concerning their life. Participation is a right enshrined in the UN Convention on the Rights of the Child (UNCRC) Article 12:

State that parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Other 'participation rights' articulated in the Convention, include the right to freedom of expression (article 13), thought, conscience and religion (14), association (15), the right to privacy (16) and access to appropriate information (17) that provides the basis for the child's right to participate.

The UNCRC provisions were domesticated in The Children Act, Cap. 59 currently under revision and further well catered for in other legal and policy instruments including, among others: The Local Government Act, Cap. 243 which provides for participation of children in issues concerning them; and The National Child Participation Guide developed by the Ministry of Gender Labour and Social Development (see MGLSD et al., 2008). The guide was intended to

(i) provide organizations with a clear approach and methodology on how to involve children, (ii) stimulate action towards providing a safe environment and space that promotes the participation of children at the level of the family, community and institutions. While it provides extensive guidance for organizing consultations with children and promoting children's participation at family, community and policy levels as well as in the media, little is known about its impact, and how stakeholders have been able to utilize the guide.

5.2 Child Participation in Practice in Uganda

The family is the primary place where children grow up, "where they can express their views freely and be taken seriously from the earliest age" (paragraph 90 of General Comment No. 12 of the UN Committee on the Rights of the Child). However, there is a paucity of data on children participation at the family and household level in Uganda. While traditionally children are expected to take part in a range of activities including music, sports and dance, as well as work, it is not well documented how power relations in a family setting do promote or inhibit child participation. The right to expression however in relation to certain aspects of decision making appears to be limited especially where children are simply expected to take orders. Indeed, while there might be varied forms and levels of child participation at family level, these are not well documented and there is need for more research in this area.

Within the social and public domain, a number of avenues have been established to promote child participation. These range from children and youth clubs in schools and at community level to children participation research initiatives, policy development, and governance. In addition, more children and young people are increasingly getting involved in youth initiatives and leadership as well as political activities. Some selected initiatives are elaborated below:

5.2.1 Child participation in child protection

Child Right Clubs (CRCs)

Child right clubs are used by child-focused development organizations (such as Save the Children, Plan International, and Bantwana Initiative) to provide an avenue for children – in and out of school – to participate in child protection. Through these clubs, children learn to protect themselves through discussion of the potential risks they face, how to deal with them and how to access help from the relevant authorities. The clubs raise awareness of children's rights and identify children who are victims of child abuse. Available evidence suggests that child right clubs (CRCs) increase children's awareness of their rights and responsibilities, equip children with information and support to report cases of abuse and build their confidence and understanding about how to report incidents of abuse, and advocate for themselves and their peers (Bantwana, 2013)

Seeking children's views in the justice system

The Justice for Children project (within the JLOS) is piloting the inclusion of children's views in the administration of justice through a questionnaire used during post-trial counseling. The questionnaire according to consultations with actors in the justice system, has brought changes in how cases involving children are handled – e.g. conducting proceedings in the judge's chamber rather than open courts and having judges and lawyers wear informal clothes.

The Uganda Child Helpline (UCHL): giving a voice to children and young people

The child helpline is an important part of the continuum of child protection services in Uganda. The 116 Helpline is operated on a 24/7 basis accessible across all telephone networks free of charge (toll-free). At-risk children can call a trained case worker/counselor, report cases of abuse or endangerment, and seek protection or removal from the situation. There is however still need to develop a structured and elaborate mechanism integrating the child's points of view in the development and evaluation of child helpline services. Also the extent to which the helpline has been used by children has not yet been systematically documented or evaluated.

> *"Within the social and public domain, a number of avenues have been established to promote child participation. These range from children and youth clubs in schools and at community level to children participation research initiatives, policy development, and governance."*
>
> *(Bantwana, 2013)*

5.2.2 Child participation in health

Peer-to-peer approaches

Peer-to-peer approaches are increasingly being used by a range of organizations in Uganda such as Naguru Teenage Health Center, Straight Talk Foundation, Reach a Hand Uganda and Jane Goodall Institute-Uganda (JGI-u) to enhance young people's involvement in promotion of sexual and reproductive health and navigate the challenges of maturing into adulthood. Typically, this approach involves equipping a selected group of youth with information on a range of topics including life skills, HIV/AIDS, other sexually transmitted diseases and reproductive health. These are in turn encouraged to share what they've learned with their peers who are often more comfortable receiving information from people of the same age group rather than adults.

Examples of peer-to-peer approaches

Young people for young people: The Peer Educators Academy (PEA)

The PEA is an initiative that was started in January 2014 by Reach A Hand, Uganda. The program was established to equip young people with information and skills on Sexual Reproductive Health and Rights and other life skills to support their peers. This program is aimed at reducing the vulnerability of adolescents and youth to illnesses through the promotion of SRH information (including HIV prevention) and the adoption of skills to enable a safe transition to adulthood. The approach involves one month long training of peer educators using an academically accredited module. The trained peers in turn reach out to their peers (with whom they have much in common) with information and skills for purposes of influencing knowledge gain and attitude change so that these peers can make informed choices and decisions. This approach uses a multiplier effect that assumes a cascade model to behavior change. Under this approach, behavior change starts with the peer educator. The changed peer educator then influences a positive change among a few youth in schools, mainly from the SRHR clubs. These school SRHR club members are then expected to adopt the promoted behavior/practice. After realizing the benefits of the new behavior or practice, they target their peers who in turn have the opportunity to change behavior.

Youth-led peer education: The Youth-to Youth Initiative

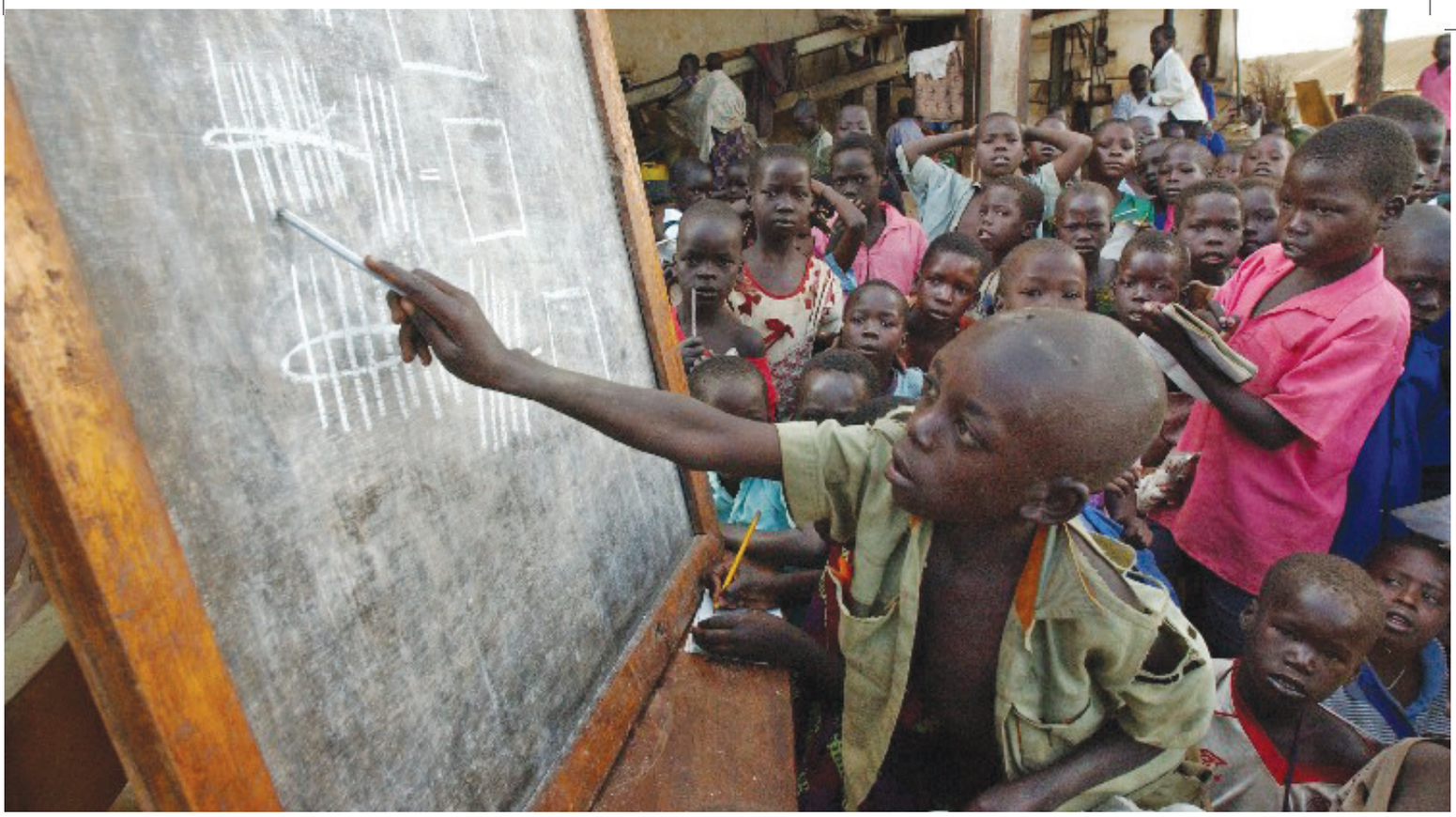
Youth-to-Youth (Y2Y) Initiative offers an innovative and integrated response to the multi-faceted needs of young people between 10 to 24 years in Uganda. Through this program, DSW works in close cooperation with young people with the aim of improving their knowledge, understanding and healthy practice of their sexual and reproductive health and rights (SRHR), as well as their socio-economic situation. At the heart of this initiative is the formation of youth-led clubs. Selected youth club members participate in peer education, SRHR, life skills, club management, and leadership trainings. Trained peer educators and peer counselors in youth clubs offer contraceptives, individual SRHR counseling services, HIV & AIDS testing and counseling or home-based care to their peers in a confidential setting. Referral services between youth clubs and health facilities are set up to ensure young people with SRH-related problems are referred from clubs to health service providers. Health personnel receive training in order to ensure that these services are youth-friendly.

For example, in 2014 Youth champions working with DSW in Uganda, from Kasanje Youth Empowerment Center and Muvubuka Agunjuse Nsangi, were involved in organizing and mobilizing a peer learning session at Jjungo Senior Secondary School, reaching out to young people between the age of 12 and 17. These peer learning sessions were divided into five groups; each group was facilitated by two peer educators, and the topics dealt with included; STI/STDs, HIV and AIDS, menstruation, teenage pregnancy, adolescence, growth and development, and alcohol and drug abuse.

5.2.3 Child participation in the school system

In addition to Child Rights Clubs (CRCs), there are several avenues for children to participate in the school system. At the school level, children participate in a range of cultural, sporting and social activities such as music, dance and drama, football and other sports. In addition, some schools have established child clubs (such as debating clubs, scouting clubs etc.), which provide a platform for children to express their views, opinions, thoughts, and concerns. The USAID/School Health and Reading program established the Family Initiative in participating schools as platforms for girls and boys to learn about HIV education and to discuss relevant issues that may increase the vulnerability of adolescents to HIV infection. This activity has resulted in the identification of vulnerable children who have been subjected to physical and sexual violence in their homes, and to referrals for care and treatment of rape victims and adolescent alcoholism. Plan Uganda and Save the Children have a long history of promoting child participation in the school system.

There are however limited avenues for children to participate in school governance to enhance the quality of learning and teaching. There is no evidence to suggest widespread involvement of children in aspects of school governance, for example, through involvement in the school development plan, lesson observations, learning assessments, deciding content of assemblies, and improving the protection of the most vulnerable children. Issues of unequal power relations and absence of teachers to support children are some of the key barriers (Walakira, 2009a, 2009b).



Children's Self-Organizing

Children, mostly adolescents in school settings, actively claim spaces for their voices to be heard and protest when their grievances are not listened to or addressed by adults. Over the last few years, the media have reported several instances of students protesting publicly over school governance issues. Unfortunately, these protests often fuel adult ideas of an 'out-of-control' youth whose autonomous behavior should be controlled. Media reports of the incidents often quote parents as describing the children's behavior as "disturbing" and as saying that "children should not take matters into their own hands".

5.2.4 Child participation in research, policy development and advocacy

It is also increasingly being recognized that consulting children and adolescents is a practical way to ensure that policies and practices affecting them are effective. For example, during the development of the National Strategic Program Plan of Interventions (NSPPI) for Orphans and Vulnerable children, children were widely consulted to solicit their views and suggestions. Girls and boys of different ages and backgrounds participated in local, district and national consultations, and their views and opinions were reflected in the plan.

Further, research to understand children experiences or views on a range of aspects (including perceptions of their own wellbeing) is becoming more common. Children's own voices are increasingly being used to communicate urgency of the need for efforts to address particular issues affecting children. A notable example is the "Situation Analysis of Children and Poverty in Uganda: Voices of Children" Report (Pereznieto et al., 2011). The report documents what Ugandan children living in a situation of poverty had to say about their lives in general, and more specifically about their experiences of poverty. The report identifies the vulnerabilities and risks facing these children, and the mechanisms children draw on in order to improve their situation.

Further, some organizations produce child-friendly versions of specific reports or manuals to ensure that children have access to information they need.

Children as speakers at conferences and national forums

Another widely used strategy for involving children in recent years has been through their participation in conferences and national forums. Children may be asked tell 'life stories', comment on their experiences in the relevant field, describe the work of their organization or project and/or outline their demands for change. These children are often selected through a process of nominations through schools, youth associations, clubs or NGOs. This practice was developed in Africa and other parts of the world as a means for children living in the most difficult situations to have a voice, to express themselves and to have participatory experiences. Those that promote child participation as speakers believe that their voice represents a real hope, especially for development models that could benefit from children's energy and creativity. The effectiveness of this approach remains to be ascertained.

5.3 Challenges and Barriers to Child Participation

Several challenges and barriers undermine the effective participation of children. The state of child participation in Uganda (*Baseline Survey Report 2008*) indicates that while there is some acceptance of child participation, a great proportion of the population lack knowledge of what child participation is and several demonstrate negative attitudes and perceptions towards it. In some cultures more than others, it is a deeply rooted belief that children should be silent in the presence of adults, never contradicting them. It is understood to be a form of disrespect if a child spoke without authorization on some aspects concerning family affairs. More widely, it is believed that child participation encourages bad behavior. It is also assumed that that children lack competence to participate in issues and decisions affecting them.

There are also limitations with regard to the capacity of politicians and government and civil society officials to facilitate children's participation, which requires a wide range of skills and experience. Initiatives often fail because the adults working with children are unable or unwilling to relinquish full power over to children in favor of an approach based on partnership and collaboration.

In addition, while children's participation involves their right to be heard, insufficient attention has been paid to the other aspects of participation enshrined in the UNCRC – for example, the right to information. There is also concern that many participatory initiatives do not reach the most disadvantaged or excluded children and could even contribute to further social exclusion. For example, such initiatives tend to reach children who are in school (Skeels, 2012). Poorer children tend to be the last to hear about opportunities to participate (if they hear about them at all) and are less able to take advantage of the opportunities (ActionAid International Uganda et al., 2012). Younger children (6-10 year-olds) were found to be much less aware of opportunities available to them and often identified only their immediate family and neighborhood as places where they can discuss their concerns (Skeels, 2012).

Further, there are limited formalized systems and structures aimed at facilitating children's participation. For example, there are no formal systematized participatory processes to allow children's participation in policy development processes. While there have been various child participation initiatives around the development of some policies and action plans such as the National Plan of Action Against Sexual Abuse and Exploitation of Children and National Strategic Program Plan of Interventions (NSPPI) for Orphans and Vulnerable Children, these have been the exception rather than the norm,

and limited in the number and representation of the children reached. As a result, children's participation in policy processes has not been secured as a matter of right, but, instead, has depended on the discretion and willingness of relevant government departments to incorporate the views of children.

Similarly, while some more formal structures exist for youth participation, these tend not to be functional and are not trusted by many young people (ActionAid International Uganda et al., 2012). Weak participation infrastructure is another important barrier as children and young people often lack any direct access to structures within government, media or civil society. In cases where children have been able to influence decisions, complicated infrastructure has tended to limit their impact. Even where 'youth structures' exist at different levels of government, they have been found to be non-operational and unfunded (ActionAid International Uganda et al., 2012). Most participatory initiatives are related to specific programs run by international and national NGOs working with children and young people and may not sustainable beyond the project cycle.

Finally, there are challenges related to ensuring children's participation in the long-term. At community level, NGO supported child participation initiatives are often short-term and give limited attention to establishing processes institutionalize child participation approaches. Consequently, opportunities to participate tend to be specific and time bound and children may not be given further opportunities to engage.

> *"The status of child participation in Uganda (Baseline Survey Report 2008) indicates that while there is some acceptance of child participation, a great proportion of the population lack knowledge of what child participation is and several demonstrate negative attitudes and perceptions towards it."*

5.4 Entry Points for Improved Participation by Children

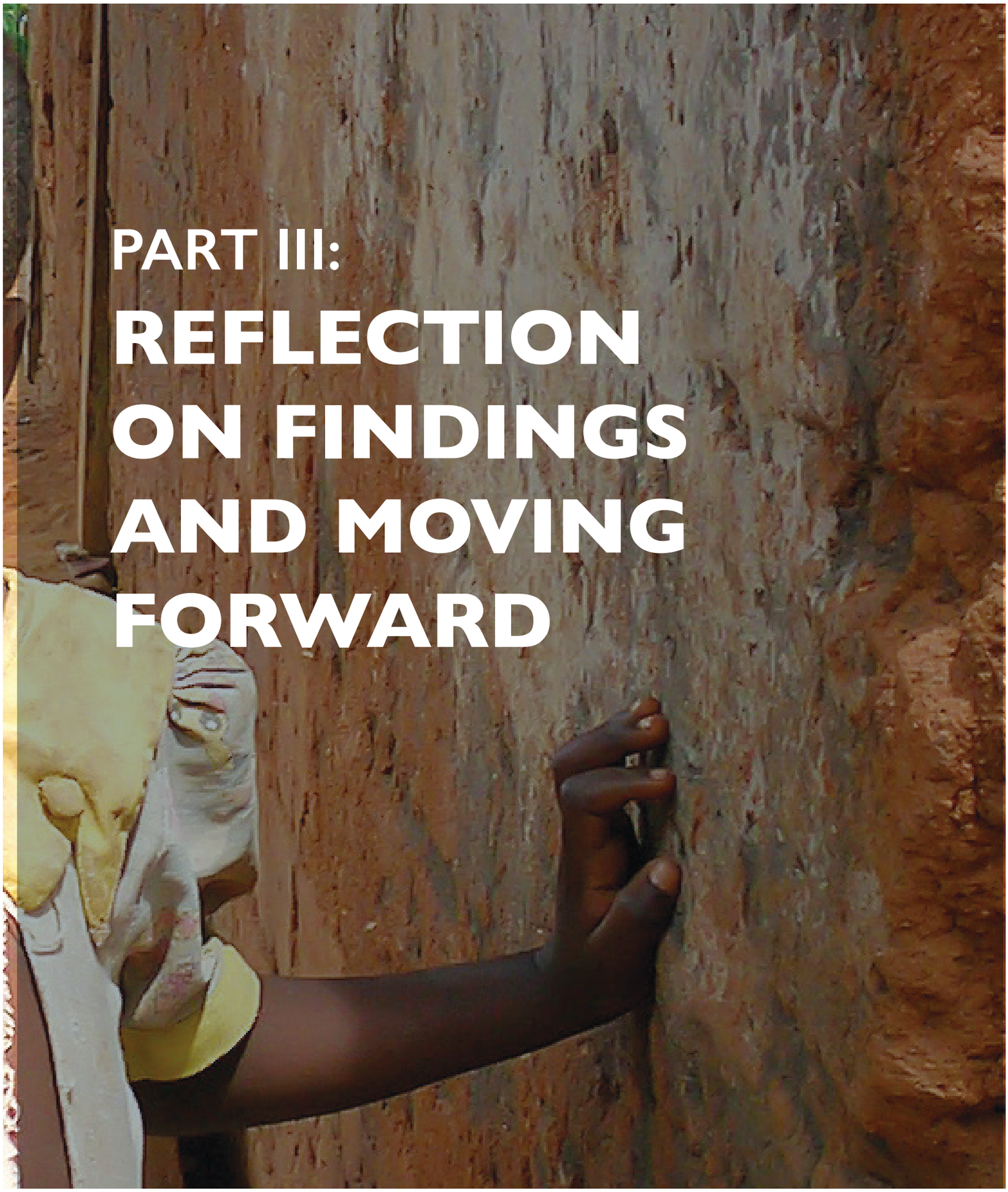
Possible entry points for improved child participation by children in Uganda include:

- At the **national level**, structures for children's participation should be considered, e.g. strengthening the children's parliament, and possibilities for children to participate in key national policy processes, such as the Poverty Reduction Strategy Paper (PRSP) (Witter and Bukokhe, 2004). Visible participation of children in national decision-making could become an important precedent for more localized participation across the country.
- At the **local level,** children could be acknowledged as stakeholders and included in district and sub-district planning activities (Witter and Bukokhe, 2004).
- Children could be involved in school management committees, PTAs and in monitoring the use of UPE funds, and other school governance processes (Witter and Bukokhe, 2004; MoGLSD et al., 2008; Plan UK, 2011).

5.5 Conclusions

Child participation in Uganda is still characterized by fragmented and short-lived initiatives. There are initiatives where children are able to have their voice heard, but these are limited in scope and their impact is not well documented. The issue of power-relations between adults and children in all settings remains a key barrier. To create an enabling environment for child participation in Uganda, there is need to implement the National Child Participation Guide for Uganda to serve as an action plan with specific tools and techniques to engage children. The Guide is intended to facilitate meaningful participation of children from the family level through to national, regional and international levels. The aim is to target the various audiences in the different settings. This Guide is designed to be an invaluable instrument specifically for those working at institutions/organizations including schools and health care providers; legal institutions; probation and welfare institutions; local councils; Non-Governmental Organizations (NGO), Community Based Organizations (CBO) and the media.

A sector wide approach that brings on board several institutions and which specifies role and responsibilities is critical for child participation to be successful.



PART III:
REFLECTION ON FINDINGS AND MOVING FORWARD

6 SYNTHESIS, CONCLUSIONS AND RECOMMENDATIONS

The evidence in this report shows that whereas Uganda has in place an enabling policy framework for improving children's health and nutrition, the progress made in improving children's key health indicators has been too small over the past ten to fifteen years.

6.1 Child Health and Nutrition

The evidence in this report shows that whereas Uganda has in place an enabling policy framework for improving children's health and nutrition, the progress made in improving children's key health indicators has been too small over the past ten to fifteen years. Critical areas that need urgent intervention include addressing newborn care to stop neonatal and infant deaths, reducing the number of deaths from malaria and respiratory infections, strengthening the elimination of mother to child transmission (eMTCT) to reach zero new infections, and halting the startling levels of stunting and other forms of malnutrition. There is need to increase access to life saving commodities in order to save the lives of newborns. Linkages and follow ups should also be strengthened to ensure that all children with HIV are put and kept on treatment. Addressing these needs calls for not only the increased allocation and proper utilization of resources within the health sector, but also using innovative approaches that tackle the problems head on.

However, improving services in health facilities is one side of the coin. Issues of health seeking behavior by care givers after delivery and during pregnancy remain fundamental in reducing infant and neonatal deaths. In the case of nutrition, a multi-sectoral response is needed that addresses both the immediate and the underlying causes of malnutrition, to guarantee adequate nutrition for children during the first 1,000 days of their lives.

Concurrently, there are critical themes concerning children's health that continue to be less prioritized in planning, funding and implementation, for example: mental health and child disability. These ought to be given attention.

Adolescent's sexual health is another challenging area that demands creative solutions to address the apparently increasing prevalence of HIV among young people, to increase access to ASRH information and services, and curtail the wave of high-risk sex, early and unwanted pregnancies, and early marriages. There is need to emphasize approaches that empower young girls with information, skills and confidence to make decisions that keep them safe from pregnancy, STIs and HIV. Data shows that keeping girls in a safe school environment through secondary, is an effective way to reduce adolescent pregnancies , early marriage and other risky behaviors.

Children continue to suffer ill-health on account of the failure to be fully immunized. The coverage of full immunization was 51.6%, implying that 48.4%of children had not received full immunization. This rate is far below the national target of 80% coverage of all vaccines. The Uganda government prioritizes immunization and invests resources to ensure its success, but more effort is needed to ensure all children are effectively protected through immunization.

6.2 Children and Education

In Uganda, there is very limited data on early childhood development in the context of parenting, early learning and stimulation in the early years. Indeed the early years of life are crucial not only for individual health and physical development, but also for cognitive and socio-emotional development. It is necessary that more evidence is gathered on parenting practices bearing in mind that they constitute the majority of child-environment interactions and affect child adaptation.

Recommendations

- Strengthen demand, access to and utilization of life saving commodities
- Scale-up interventions to address HIV and pregnancy among adolescents
- Build a multi-sectoral response to malnutrition especially within the 1,000 days window of opportunity

The results of the analysis with regard to children and education provide a mixed picture. While early childhood development is very crucial (especially the child's first 1,000 days), there is only a handful of information that describes formal interventions being pursued besides the national programs targeting improvement in health and formal early childhood education. Evidence suggests that investment during the early years of the child's life results in multiple benefits. Uganda's children who attend pre-primary education are found to perform better in primary schools and higher levels of education in comparison to those who do not. Sadly, children from wealthier and urban areas are the ones mostly likely to access early childhood education (pre-primary education) to their children, with only 10% of children aged 3-5 years able to access this form of education. Also Ugandan children who received targeted interventions to improve their levels of nutrition showed remarkable weight gain.

Evidence further shows that there is consistent improvement in enrollment in primary and secondary levels of education over a number of years. There is also parity in terms of gender and enrollment at the lower levels but more disparity in favor of the boy child in secondary level. Gross enrollment for secondary school still remains very low with only 26% of children aged 12-18 years enrolled. This implies a very low level of transition to secondary education.

The greatest challenge in relation to the child and education in Uganda concerns retention to primary seven and transition to higher levels of education, on one hand, and on the other the realization of the education outcomes. With only three out of ten children who start primary 1 able to complete the primary school cycle on time, and only four out of ten children are able to complete senior 4; these indicators suggest that there is a very big problem with respect to the quality of education including learning conditions within the school and outside of the school system. Within the school system, congestion, violence against children, hunger, limited facilities, and teacher absenteeism, among others pose the biggest challenges. Outside of the school system, factors that disadvantage the girl child range from negative attitudes towards their education, to vulnerability to poverty, pregnancy and early marriages. Other factors affecting girls and boys include lack of interest, the cost of education, lack of services and a follow up system for children who experience difficulties in attending school.

With regard to realization of education outcomes, very few children are able to read and write with understanding or are able to solve mathematical problems at a specified grade level. This again suggests that the quality of education is poor. It is not under dispute that many teachers require upgrading to be able to deliver the quality of teaching that matches specific grades. Thus the competencies of teachers and knowledge levels are also partly to blame.

The persistent poor quality of education in public schools has greater potential to increase inequalities (intergenerational) between the poor who attend government schools and the rich who largely attend private schools.

Aiming to improve investments in education across the board will improve life-time personal incomes and potentially double Uganda's GDP per capita and HDI by 2040.

Recommendations

- Promote positive parenting
- Enhance access to ECD services
- School authorities and structures such as SMCs should promote community and school-level initiatives to counsel and inspire children and families to keep children in school and learning
- Improve sanitation standards in schools and support initiatives to make sanitary pads more accessible to girls
- Prevent and mitigate violence in schools
- MOESTS should collect systematic data on survival rates through secondary school level through its EMIS

6.3 Child Protection

Uganda has an elaborate child protection system replete with legislations and policies as well as the institutional frameworks, but little in terms of impacts and reduction in the violation of children's rights to protection. The review of the evidence and interventions on children from a protection point of view suggests that while important milestones have been reached regarding the protection of children in terms of development of legislation, policy and strategic framework for interventions, a lot remains to actualize the protection of the Ugandan child. These gaps are visible in the research on children, the absence of a welfare arrangement for children who experience severe forms of abuse to enable rehabilitation; minimal funding for the child protection sector; and the absence of a stronger voice of advocacy for the child protection sector.

Various reasons have been advanced to explain the precarious nature of the child protection regimes in Uganda. This has been attributed to weak laws in place or low level of enforcement of the existing legislation; failure to effectively resource frontline staff occupying key child protection positions in government; fragmentation and lack of coordination of interventions; and poor data systems and utilization of data among others. A more nuanced analysis of the child protection system however suggests that the problem might be much bigger and structural, requiring changes in the way child protection intervention and messages are packaged as well as the overlying strategies for implementing child protection programs and legislations. More insight is needed to determine the connection between the situation of child protection to the nature and scope of existing social protection; existing welfare provisions, coverage of health and other services, and funding of the child protection sector.

A notable observation by the line ministry responsible for child protection connects the ineffectiveness of the child welfare and protection systems with a fragile social service system, a weak social welfare workforce and critical staff shortages; as well as gross underfunding at both national and local government (LG) levels (MGLSD, 2011b). Of concern is the fact that social development sector budget in Uganda is less than 0.1% of GDP and has been progressively declining from 0.1% in 2011/2012 to 0.04 percent in 2013/14. This amounts to about 0.3–0.5% of the budget (MGLSD & UNICEF., 2015). Recent appropriations in the 2015/16 budget show an increase of about 0.5% relative to the last financial year.

Ultimately, the realization of children's right to protection in Uganda ought to target more specifically, the reduction of the levels of vulnerability – especially the medium to high-risk families or moderate to critically vulnerable children. There is an urgent need to explore views of actors on separately creating a fund for child protection especially for the critically vulnerable children in need of alternative care; children affected by war and the children who suffered sexual violence. Other categories include children born in captivity in Acholi region, those who are trafficked and those in worst forms of child labor.

An insight into various forms of violence children suffer from shows that physical, sexual and emotional violence against children in Uganda are widespread; taking place in homes, schools and communities. With violence affecting girls and boys in a differentiated manner, it is not well articulated on how best to target interventions differently for girls and boys. In addition, innovative approaches including use of community-based structures to stem violence need further understanding and incorporation into formal interventions. Case studies in areas of FGM among boys, child sacrifice and child trafficking are also needed to better understand the needs and possible solutions.

In the final analysis, child protection cannot be analyzed in exclusion of vulnerability and the nature of coverage or social protection arrangements that ought to be put in place. Up until now, direct social protection grants in Uganda have been targeted at the elderly. There is need for child-sensitive social protection in order to weave elements of social protection into the child protection efforts of families, communities, and government and non-government actors. Nevertheless, how best to fund child protection agencies—particularly formal government structures in a sustainable manner also remains a critical question. The involvement of grassroots actors could be the game changer if a balance can be found between voluntarism, cultural obligations to child protection and individual and community resourcing of child protection work.

Recommendations

- Prevent unnecessary family separation and support permanent and protective family care for children outside of families
- Strengthen linkages between child protection and social protection
- Support programs that transform cultural and social norms to reduce violence against and exploitation and abuse of children

6.4 Child Participation

Child participation in Uganda is still characterized by fragmented and short-lived initiatives. While there might be varied forms of child participation at the family level, these are not well documented and there is need for more research in this area. There are a few formal initiatives where children are able to have their voice heard, but these are limited in scope and their impact is equally not well documented. The issue of power-relations between adults and children in all settings remains a key barrier. Moreover, the girl child particularly is more vulnerable to power inequalities, one of the reasons that girls are given into marriage in disregard to their right to access education. To create an enabling environment for child participation in Uganda, there is need for a sector wide approach that creates platforms for children's voice and which specifies roles and responsibilities for both adults and children.

> *"To create an enabling environment for child participation in Uganda, there is need to develop a national child participation strategy to serve as an action plan with specific interventions that are well resourced."*

6.5 The Girl Child

The sectoral analysis of the Ugandan child suggested that the girl child does not enjoy her child rights in comparison to the boy child. This is reflected in the low levels of retention and transition to higher levels of education, lower completion rates compared to boys, high prevalence of teenage pregnancy, high levels of early marriages, the prevalence of HIV infection that disproportionately affects the girl child, the high levels of sexual violence against girls and the harmful traditional practices affecting girls.

Regarding access and enjoyment of rights to education, the sector analysis identified lower enrollment, completion and transition rates of girls compared to boys in primary to secondary and tertiary levels, with girls posting worse indicators than their male counterparts. Yet the proportion of girls enrolled in BTVET is even smaller. Data on school dropout shows that pregnancy and marriage are the leading reasons for girls dropping out of school. It is therefore evident that many of the girls who do not continue with education enter early marriages, or end up in child labor and the informal sector. This may affect their future prospects for employment and earnings.

Early marriages and teenage pregnancies remain high, particularly in the eastern and northern regions. This situation is linked to the low levels of progression to secondary education, limited access to and utilization of family planning methods; and negative cultural practices such as early marriage. Increasing access to education, and ensuring retention and progression to higher levels is particularly important in preventing pregnancy and early marriages. It also improves the productivity of the girl child in the market place and contributes to economic progress. Improving access to sexual and reproductive health information and services for adolescent girls could reduce teenage pregnancies.

Assessment of reproductive health parameters suggests that the unmet need for contraceptive use is above 50% for young women married and unmarried who are sexually active. Our study also shows that there are still limited youth-friendly services in public health facilities, making accessibility to contraceptive a challenge to many a young people. While services to girl children remains more complicated with girls more disinclined to use such services especially provoking a condom. This is complicated by the attitude of health workers, who are torn between giving younger girls (below 18 years) contraceptives and advising them to abstain from sex until they are 18. The reality however is that over 40% of young women 20-24 had married before reaching 18 years of age, with over 50% also having had a sexual debut before they were 18. This suggests that there is need to rethink the Ugandan public health approach and contraceptives policy. There may be a need to make health workers and all other actors realize the reality on adolescent and youth behavior and aggressively promote condom and other contraceptives for all those children who are deemed to be sexually active.

Addressing high teenage pregnancies, early marriages and early onset of sex requires much more than contraceptive services. It's a tangent of education, improving household income and redressing poverty levels in the community. The study indicated that children from lower income families are more likely to get pregnant and have early sexual debut. With the evidence suggesting that high utilization of RH and other services among females is contingent upon the level of education exposure and access to economic resources; it implies that besides education, livelihoods interventions are also critical for the girl child and vulnerable households. However, equitable access to resources by the girl child within the home also ought to be carefully assessed and promoted.

Culture and religion also have a big role to play in the efforts to stem early sex and early marriage, as many traditional practices directly and indirectly encourage both males and females to engage in sex after initiation to show their man or womanhood. In other communities, especially amongst those that practice FGM and male circumcision, once a girl and been circumcised and healed she is deemed ready for marriage. FGM remains high in the Karamoja and Sebei sub region in spite of the enactment of the law against female genital mutilation in 2010. The implementation of the law remains weak in the region, with outlying communities more inclined to continue the practice than the communities within the urban areas. In the six districts where FGM is practiced in north-eastern Uganda, about 90% of the girls are affected. But FGM practices still affect about 95% of women in Amudat, the epicenter in Karamoja, suggesting that a radical rethink of the approach needs to be made to complement the existing legislation and policies. Retrogressive cultural practices such as FGM endanger the lives of girls by affecting their sexual and reproductive health, self-esteem and undermine their rights in general. It is important to enlist the views of the local people on the best approaches to change attitudes towards FGM and how to stem the practice out of these communities.

> *"The girl child is experiencing a cycle of structural vulnerability–underpinned by cultural beliefs and practices–and the failure of the programming to adequately address the nature of vulnerabilities and needs of the girl child throughout her life cycle."*

In addition, sexual abuse of girls remains high and persistent. The passage of laws and implementation of various programs, while bearing results in improving the reporting of the vice, have yet to affect specific change in behavior, specifically where the vice is generally overlooked or considered common place and normal. More understanding of the context is needed to design more effective interventions.

Various efforts have been made to improve the situation of the girl child. These initiatives include both those of the state and non-state agencies, including more recently the entry of the private sector foundation and other profit making entities in the area of child protection and development. The study also suggests that many of these initiatives have involved the key structures and duty bearers within the family, community, cultural institutions and local government and other key stakeholders. In spite of all these however, the emerging outcomes for the children in general and the girl child in particular are still inadequate.

The girl child is experiencing a cycle of structural vulnerability–underpinned by cultural beliefs and practices–and the failure of the programming to adequately address the nature of vulnerabilities and needs of the girl child throughout her life cycle. Interventions to eliminate vulnerabilities that undermine the well-being of the girl child must be innovative and tailored to break the long term and socially woven nature of disempowerment. Thus interventions that specifically target support for the girl child's education should be differentiated from those of boys; those that target sexual and reproductive health; and those that target their economic empowerment.

It is imperative that traditional and cultural institutions be brought on board and made the epicenter of anti-FGM initiatives for it to be successful. The weak implementation of child protection laws, and limited convictions against reported cases constrains the achievement of justice for girls and young women who suffer sexual abuse (defilement), and other rights violations.

Recommendations

- Advocate for readmission of girls into school after delivery
- Expand access to adolescent and youth friendly health services
- Engage non-conventional stakeholders: cultural institutions and the private sector to play a role in safeguarding the wellbeing of children

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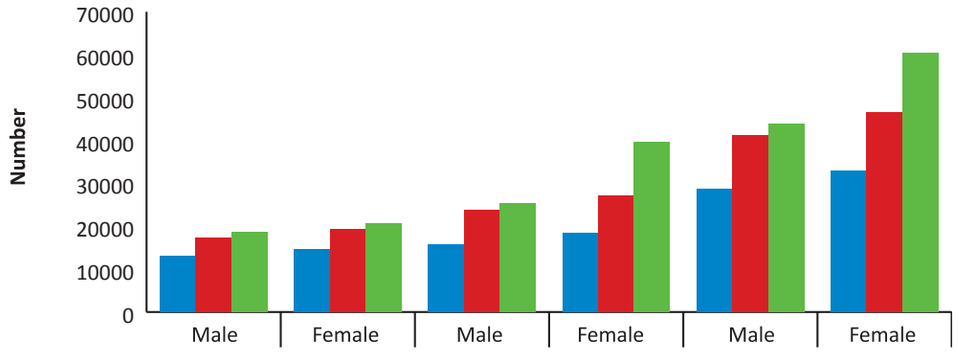
APPENDICES

Annex A: Health

A1: Cumulative number of HIV positive children ever enrolled into care by the end of the reporting quarter

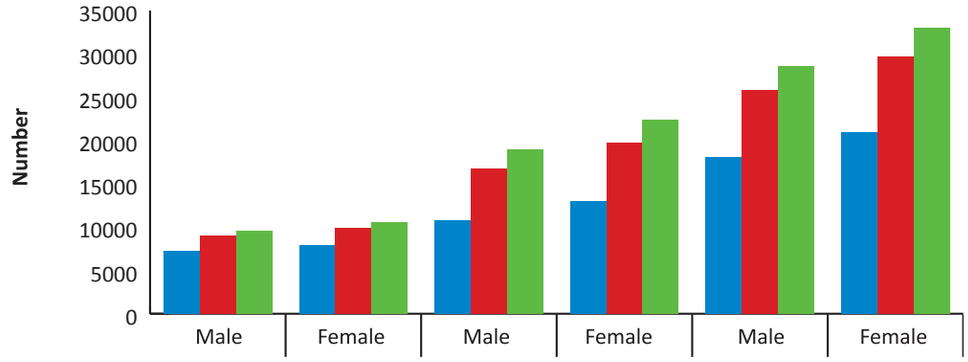


	0 - 4 years		5 - 14 years		Overall	
October-December 2013	13156	14555	15641	18475	28797	33030
October-December 2014	17412	19312	23866	27134	41278	46446
April-June 2015	18588	20646	25328	39669	43916	60315

Source: MoH/DHIS2

A2: Active number of children 0-14 Years

Number of children on ART (ages 0-5, 5-9, and 10-14)



	0 - 4 years		5 - 14 years		Overall	
October-December 2013	7282	7885	10819	13035	18101	20920
October-December 2014	9044	9928	16726	19698	25770	29626
April-June 2015	9599	10503	19009	22437	28608	32940

Source: MoH/DHIS

A3: Number of children infected with HIV through mother to child transmission

	2012	2013	2014	Aug-15
E7a: HIV exposed infants started on CPT(Total)	2829	36657	49862	32850
E4b: Number of DNA PCR results returned from the lab(Within 2 Weeks)	2471	28668	35886	21653
D4a. Total number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	959	15363	25297	18455
D4b. Positive number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	87	1312	1230	624
D5. Number of DNA PCR results returned from the lab that are positive	213	3220	3515	1609
E4c: Number of DNA PCR results returned from the lab(Given to a caregiver)	2157	29896	44076	30212
E6:Number of HIV+ infants from EID enrolled in care	223	2662	3045	5682
Percentages				
% exposed infants with of DNA PCR results returned from the lab Within 2 Weeks (E4b/E7a*100)	87.3	78.2	72.0	65.9
Prevalence of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older (D4b/D4a*100)	9.1	8.5	4.9	3.4
Prevalence of HIV using DNA PCR Results Returned from the Lab (D5/E7a*100)	7.5	8.8	7.0	4.9
% of DNA PCR results returned from the lab Given to a caregiver (E4c/E7a*100)	76.2	81.6	88.4	92.0

A4: WHO classifications of prevalence of Malnutrition

	Acceptable	Poor	Serious	Critical
Stunting	<20%	20-30%	30-40%	>40%
Wasting	<5%	5-10%	10-15%	>15%
Under weight	<10%	10-20%	20-30%	>30%

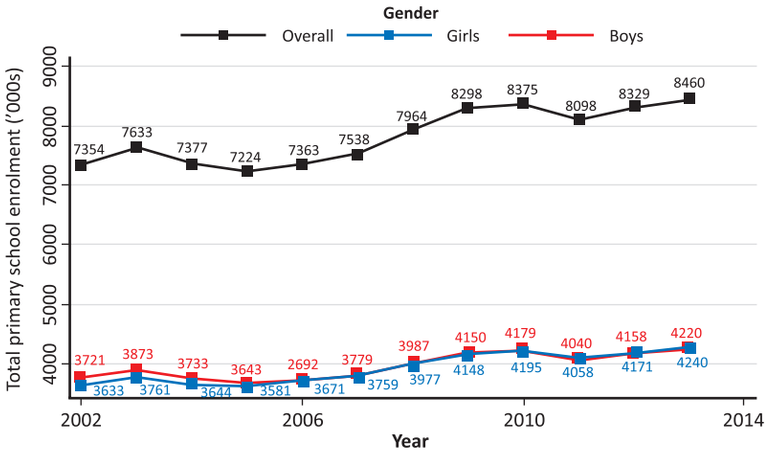
Annex A5: Classification of Districts by Region in UDHS 2006

Region	Districts
Central 1	Kalangala, Masaka, Mpigi, Rakai, Lyantonde, Sembabule, and Wakiso
Central 2	Kayunga, Kiboga, Luwero, Nakaseke, Mubende, Mityana, Mukono, and Nakasongola
Kampala	Kampala
East Central	Bugiri, Busia, Iganga, Namutumba, Jinja, Kamuli, Kaliro, and Mayuge
Eastern	Kaberamaido, Kapchorwa, Bukwa, Katakwi, Amuria, Kumi, Bukedea, Mbale, Bududa, Manafwa, Pallisa, Budaka, Sironko, Soroti, Tororo, and Butaleja
North	Apac, Oyam, Gulu, Amuru, Kitgum, Lira, Amolatar, Dokolo, Pader, Kotido, Abim, Kaabong, Moroto, and Nakapiripirit (Estimates for this region include both settled and IDP populations.) • Karamoja area: Kotido, Abim, Kaabong, Moroto, and Nakapiripirit • IDP: IDP camps in Apac, Oyam, Gulu, Amuru, Kitgum, Lira, Amolatar, Dokolo and Pader districts
West Nile	Adjumani, Arua, Koboko, Nyadri, Nebbi, and Yumbe
Western	Bundibugyo, Hoima, Kabarole, Kamwenge, Kasese, Kibaale, Kyenjojo, Masindi, and Buliisa
Southwest	Bushenyi, Kabale, Kanungu, Kisoro, Mbarara, Ibanda, Isingiro, Kiruhura, Ntungamo, and Rukungiri

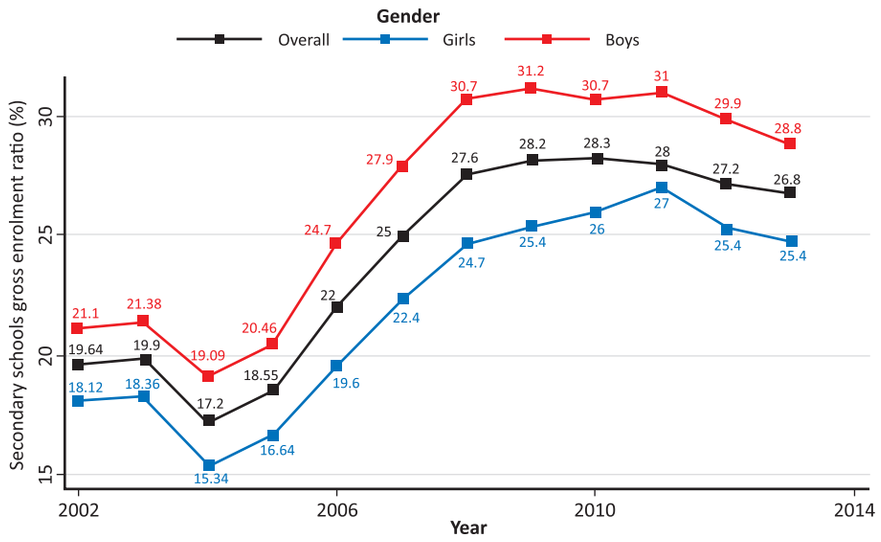
***In 2011, Karamoja was separated from the North and made a separate region.*

Annex B: Education

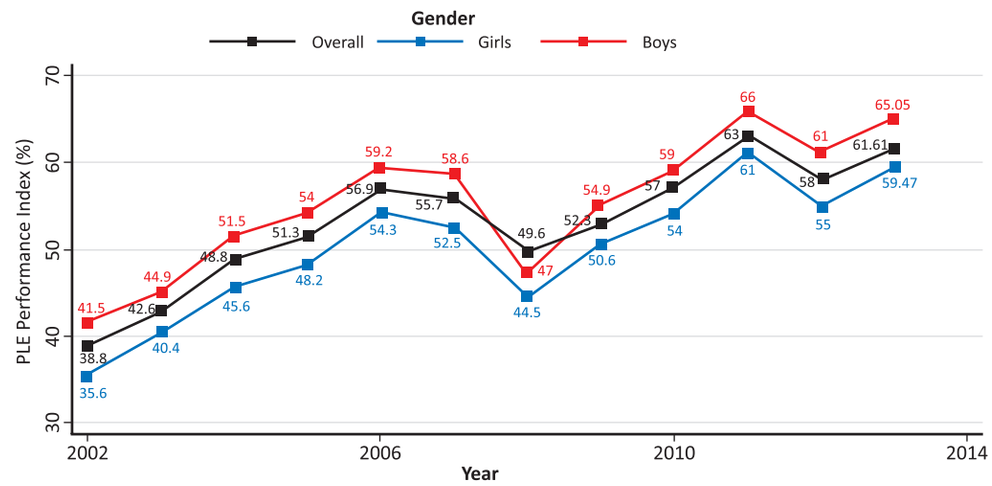
B1.0 Primary School enrolments (source: EMIS, 2014)



B1.1 Secondary school enrolments (source: EMIS, 2014)



B1.1 PLE Performance Index (source: UNEB, 2014)



B1.2 UCE Performance index (source: UNEB, 2014)

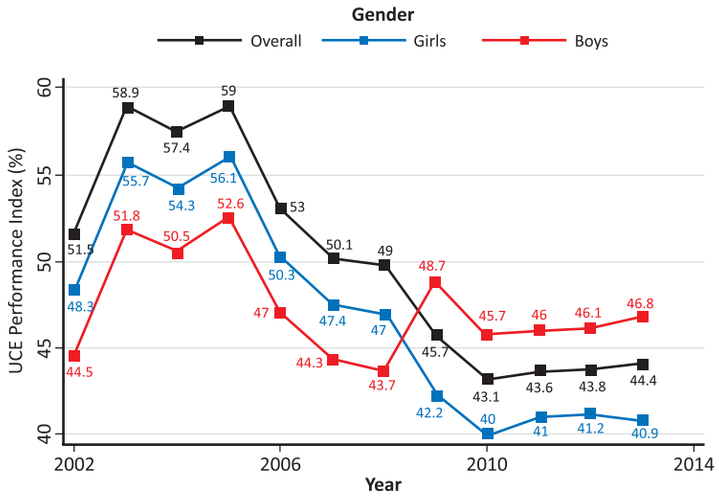
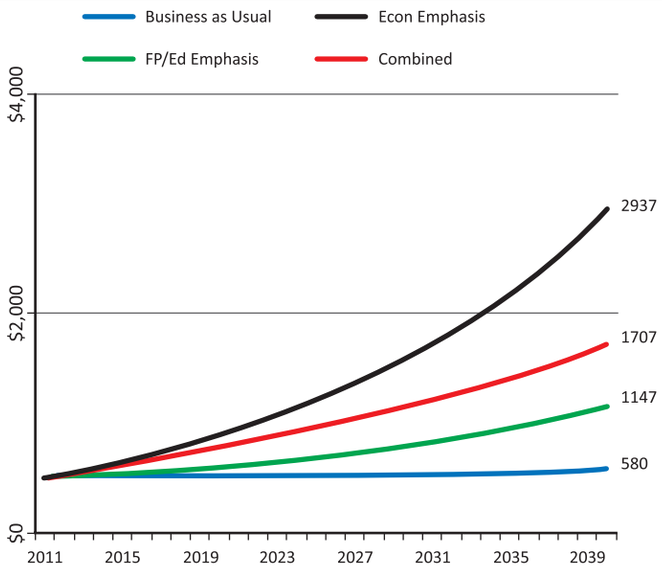
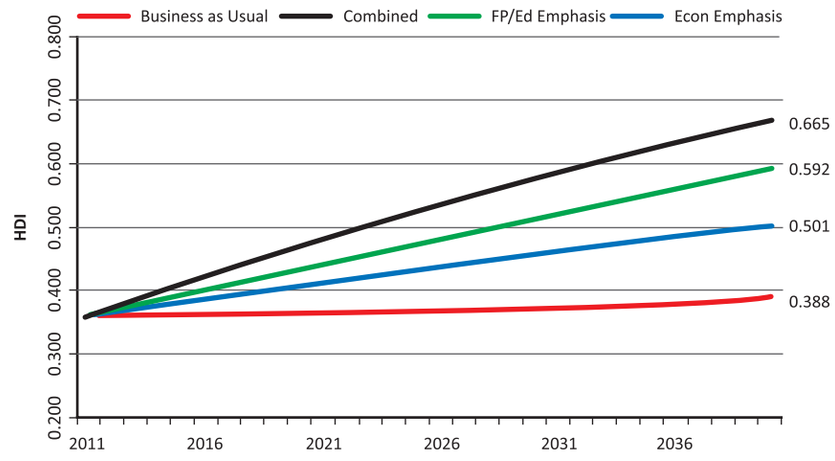


FIGURE B2.1: PROJECTED EFFECT OF EDUCATION INVESTMENT ON UGANDA'S GDP PER CAPITA AND HDI



(Source: UBOS, 2014c)

FIGURE B 2.2: PROJECTED EFFECT OF EDUCATION ON UGANDA'S HUMAN DEVELOPMENT INDEX (UBOS. 2014C)



Annex C: Child Protection

TABLE C1: CHILD POVERTY BY SELECTED DEMOGRAPHIC CHARACTERISTICS

	Child poverty *(deprived in 2 or more poverty dimensions)*		Extreme child poverty *(Extremely deprived in two or more poverty dimensions[24])*	
	0-4	**6-17 years**	**0-4**	**6--17 years**
By region				
Central	49.6	33.1	18.7	11.7
Eastern	58.4	38.9	25.5	19.5
Northern	61.9	54.3	36.5	33.7
Western	49.7	28.2	17.6	10.6
Wealth Quintile				
Quintile 1 (Lowest)	82.2	74.7	52.2	50.4
Quintile 2 (Second)	61.5	43.9	25.8	17.8
Quintile 3 (middle)	56.9	31.4	20.3	10.8
Quintile 4(fourth)	38.9	22	10.8	6.3
Quintile 5 (Fifth)	25.5	12.3	3.3	2
Parental status				
Both parents alive	54.4	36.8	23.3	17.5
Mother or father deceased	62.5	41	36.5	20.6
Both parents deceased		43.5		18.2
Sex of household head				
Male	63.5	41.5	27.9	21.5
Female	52	35.9	22.6	16.3
Household Size				
3 or 4 members	44	31.5	16.2	14.1
5 or 6 members	62.6	41.5	26.8	20.5
7 or 8 members	54.7	36.4	28.1	20.4
9 or more members	55.7	37.8	24.8	14.7

Source:UBOS (2014a)

TABLE C2: ORPHANHOOD, BY SELECTED CHARACTERISTICS

	UNHS 2012/13			
	Orphan	**Double orphan**	**Maternal orphan**	**Paternal orphan**
Uganda	**11.3**	**1.9**	**2.1**	**7.2**
Sex of the child				
Male				
Female				
Age group				
0-4	3.9	0.5	0.7	2.7
5—9	9.5	1.3	1.7	6.5
10—14	17.9	3	3.4	11.5
15—17	21.9	5.4	4.2	12.3
Sex of Household Head	0			
Male headed	5.8	1.2	1.8	2.8
Female headed	24.8	3.9	2.7	18.2
Residence				
Rural	11.1	1.9	2	7.2
Urban	12.2	2.1	2.6	7.5
Region				
Kampala	9	2.4	1.6	5
Central 1	13.1	2.2	3	7.9

Central II	12.4	1.6	3.2	7.6
East Central	9.7	3.2	1.3	5.2
Eastern	8	0.6	1.3	6.1
Mid Northern	15.5	2.9	2.6	10
North-East	15.5	3	2.2	10.3
West Nile	11.2	1.1	1.5	8.6
Mid-Western	9.9	1.5	2	6.4
South Western	11.3	2.1	2.3	6.9

Source:UBOS (2014a)

TABLE C3: PROPORTION OF HOUSEHOLDS HEADED BY CHILDREN (0-17 YEARS)

Proportion of households headed by children (0-17 years), by region				
	UNHS2012/13	**UNHS 2009/10**	**UNHS 2005/06**	**UNHS 2002/03**
Uganda	0.4	0.4	0.3	0.4
Region				
Kampala	0.9			
Central I	0.6			
Central II	0.8			
East Central	0.4			
Eastern	0.4			
Mid Northern	2			
North-East	0.2			
West Nile	0.2			
Mid-Western	0.9			
South Western	0			

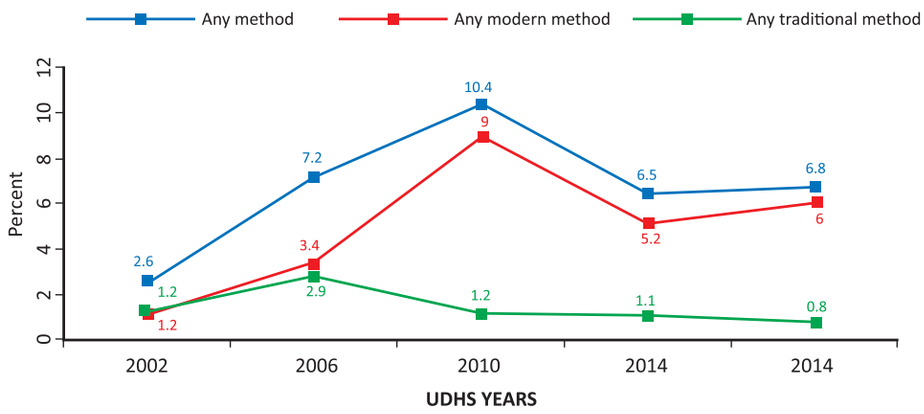
TABLE C4: CHILD LABOUR, BY SELECTED SOCIO-DEMOGRAPHIC CHARACTERISTICS

Background Characteristic	Children aged 5-11 years in economic activity		Children aged 12-13 years in economic activity excluding those in light economic activity		Total in child labour, 5-13		Children aged 14-17years in hazardous work or working excessive hours(ii)		Total in child labour, 5-17 years	
	% of total children	No. ('000)	% of total children	No. ('000)	% of total children	No. ('000)	% of total children	No. ('000)	% of total children	No. ('000)
	(a)		(b)		(a) & (b)		(c)		(a) & (b) & (c)	
Sex										
Male	21.5	734.1	12.4	128.6	19.4	862.7	10.5	183.3	16.9	1,045.9
Female	21.1	715.7	11.3	123.6	18.7	839.4	7.3	124.0	15.6	963.4
Residence										
Urban	6.9	60.7	6.4	17.5	6.8	78.2	13.3	67.1	8.8	145.3
Rural	23.3	1,389.2	12.7	234.7	20.9	1623.9	8.2	240.2	17.4	1,864.0
Region										
Central	33.8	458.6	12.7	55.4	28.6	514.1	12.0	92.7	23.7	606.8
Eastern	20.8	431.8	8.5	54.3	17.9	486.2	4.8	48.0	14.4	534.2
Northern	13.5	184.9	18.5	78.5	14.7	263.5	9.6	58.6	13.4	322.0
Western	21.0	370.4	10.9	61.8	18.6	432.2	9.4	86.8	16.0	519.0
Sub-Region										
Kampala	1.8	4.1	3.5	2.1	2.1	6.2	15.8	21.2	6.4	27.4
West Nile	4.3	18.5	8.3	11.7	5.3	30.2	4.2	8.0	5.0	38.2
Karamoja	17.5	37.4	37.9	22.6	21.9	59.9	27.1	19.7	23.0	79.7
Total	**21.3**	**1,449.8**	**11.9**	**252.2**	**19.1**	**1,702.0**	**8.9**	**307.3**	**16.3**	**2,009.3**

Source: ILO/IPEC & UBOS, 2013

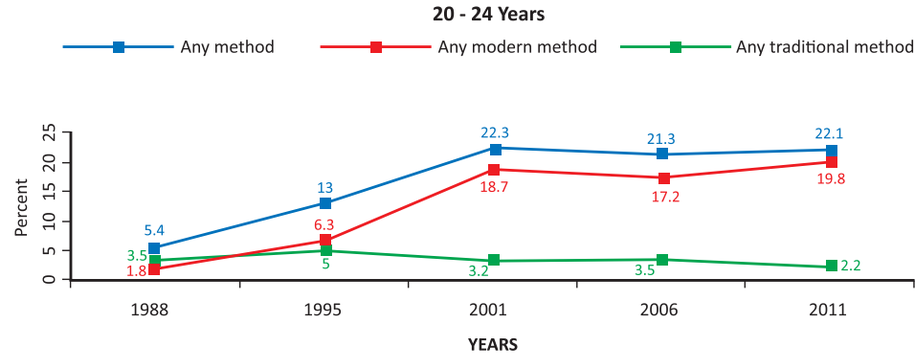
Annex D: Girl Child

FIGURE D 6.1: OVERALL CONSUMPTION OF FAMILY PLANNING SERVICES IN THE ENTIRE INTERVIEW BETWEEN 15-19 YOUTHS



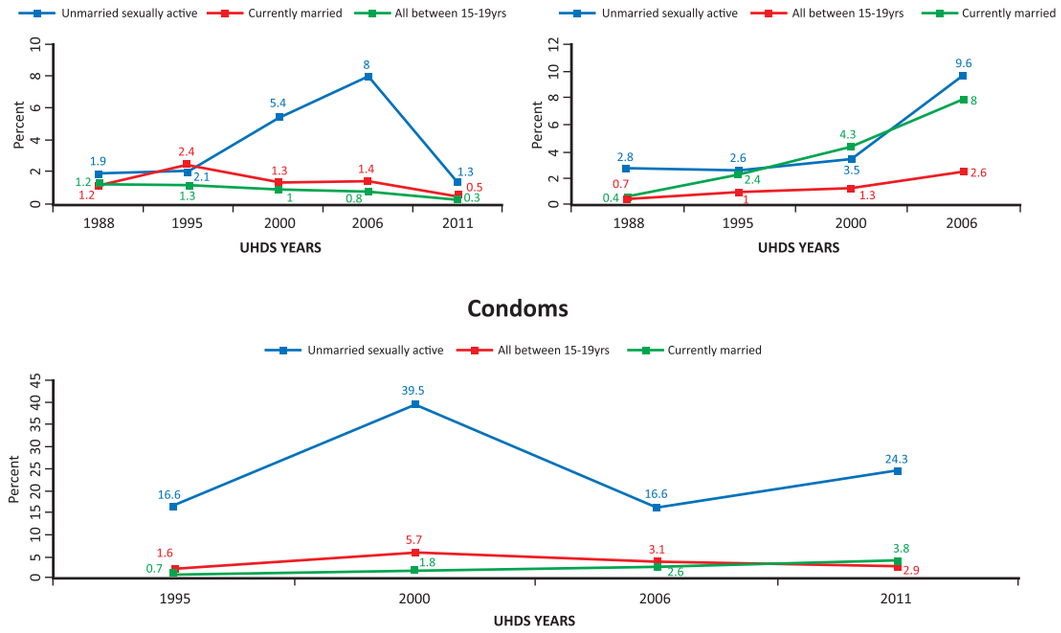
Demographic and Health survey data 1988-2011

Overall consumption of family planning methods among the married, 20-24



Demographic and Health survey data 1988-2011

FIGURE D6.2: CONSUMPTION OF MODERN FAMILY PLANNING METHODS



Demographic and Health survey data 1988-2011

Annex E: Summary of Data gaps, Questions, Respondents and Methods of data collection

Thematic Area	Data Gaps	Key questions	Category of respondents	Methods			Region/ District
				FDGs	KII	Case studies	
1:Health & Nutrition	Reasons why HIV prevalence in adolescents is higher among girls than boys	1a). What are the specific vulnerabilities for girls that puts them at a higher risk of HIV infection compared to boys?	Boys and girls aged 14-16 and 17-19	8 FGDs (2 in 4 regions)	N/A	N/A	Kampala, Mbale, Gulu
		1b). What are the reasons for non-use of condoms among adolescents and young people?					
	Inadequate understanding of ways of empowering young people to keep safe from HIV	1c). What are the examples of innovative and successful programs that empower adolescent/young girls to protect themselves from HIV and AIDS?	Program implementers in government & NGOs, District officials	N/A	4 KIIs	2 case studies	Kampala, Others to be determined
		1d). Why are so many children born to HIV mothers not tested for HIV within 2 months?	Health policy makers & practitioners in **MOH, Health centers, districts & NGOs**	N/A	**10 KIIs (2 national; 2 district; 2 health centers)**	**N/A**	**National, Mbale, Gulu**
		1e). Why are so many children who should be on ART not receiving it?					
	Reasons for regional variations in levels of malnutrition; why malnutrition in food rich areas?	1f). Explanations for the high rates of malnutrition among children in Karamoja, West Nile, Western and South Western Uganda (specific attention to cultural factors)	Caregivers of children under five; District officials; Nutritionists at regional referral hospitals, relevant NGOs	8 FGDs with caregivers (2 in each region)	8 KIIs (2with district staff in 2 districts; 2 with hospital staff; 2 with NGO staff)	N/A	Kiruhura, Bushenyi
	Need to learn from successful examples of initiatives addressing malnutrition in children	1g). What are the best practices in addressing malnutrition?			Same as above in 1f.	2 case studies	Kampala
	Reasons for non-use of ITNs to protect children among some households despite the mass distribution of ITNs	1h). What are the barriers to use of ITNs to protect children? What factors influence decisions to use ITNs to protect children from mosquito bites?	Caregivers of children aged under five	Same FGDs in 1f	N/A	N/A	
	Reasons for non-standard medical practices	1i). Why are children who present with diarrhea not treated with ORS and Zinc?	Health policy makers & practitioners in MOH, Health centers, districts & NGOs	N/A	Same KIIs in 1d.	N/A	Kampala, Gulu, Bugiri
	Reasons for non-standard medical practices	1j). Why are children with pneumonia not treated appropriately with antibiotics?					
	Need to learn from successful examples of initiatives that address key childhood illnesses	1k). What are the best practices in addressing malaria, pneumonia and diarrhea in children under five?	Health policy makers & practitioners in MOH, Health centers, districts & NGOs			2 – case studies	Mbale, Bushenyi
2. Education	Government plans to promote affordable pre-primary education	2a).What is government doing to invest in and improve access to pre-primary education countrywide? How can government partner with the private sector to make pre-primary accessible to the low-income households?	Policymakers in MoESTS Private providers of pre-primary education	N/A	6KIIs (2 at national level-MoESTS, 4 in 2 selected districts in central and Eastern)	N/A	National level Central/Eastern

Thematic Area	Data Gaps	Key questions	Category of respondents	Methods			Region/ District
				FDGs	KII	Case studies	
	Status of ECD in the country	2b). Which best practices exist for promoting ECD in rural and urban areas What is the role of government in ECD programs?	Program implementers in Early Steps Program by PSFU MoESTS policy makers	N/A	2 KIIs at MoESTS	1 case study of performing ECD center from the Early steps program	
	Causes for high drop-out rates and low retention and survival rates at primary and secondary level Interventions to keep children in school and learning	2c). Why have drop-out rates remained high and retention rates low even with reduced financial burden in tuition fees under UPE and USE 2d). What are the examples of successful initiatives and actions to keep children in school?	MoESTS policy makers/ Inspectorate dept/UNEB Private Schools-owner association leaders Selected private schools and Public schools	N/A	2 KIIs at MoESTS 4 KIIs with 2 best performing private schools (1 primary+1 secondary) and public schools (1 primary and 1 secondary)	N/A	Mbale, Bugiri
	Government responses to low education quality in public schools	2e). What policy changes can be made to improve the quality of education in government schools?	MoESTS policy makers Education practitioners (Leaders of teachers; association)	N/A	2 KIIs at National (MoESTS) level 2 KIIs with teachers' association leaders	N/A	Kampala
3. Child protection	**Data Gaps**	**Key questions**	**Category of respondents**	**FDGs**	**KII**	**Case studies**	**Region/ District**
	Explanation for the discordance between policy and programmatic efforts and child protection situation	3a). Why is the trajectory of child protection indicators poor in spite of the substantial developments in the area of legal and policy development and implementation of selected programs. What should be done to fundamentally improve the child protection indicators that are not positive?	Policy Program implementers in government & NGOs, District officials (community-based service department)	N/A	8 KIIs (2 at national level; 4 KIIs in 4 districts; 2 with NGOs)	N/A	National, 4 districts (Gulu, Kamuli, Kumi,Mukono)
	Limited information on the role and utilization of Para-social Workers (PSWs) in child protection	3b). What is the role of PSWs in the child protection system? How can PSWs be effectively integrated in the child protection system?	Policy Program implementers in government & NGOs, District officials	N/A	Same KIIs as in 3a.	N/A	National, Bugiri,
	Linkage between existing GoU social protection interventions and child protection	3c).How is child protection addressed in existing GoU social protection interventions such as SAGE? How can child protection be mainstreamed in existing social protection interventions?	Policy Program implementers in government & NGOs	N/A	Same KIIs as in 3a	N/A	National
	Child Labour In plantation agriculture	3d). What is the nature and work setting of child labour in Sugar/tea plantations? What risks and vulnerabilities are children exposed to in this work environment?	Children and caregivers in Sugar/Tea growing; employers	6 FGDs (3 with children and 3 with caregivers)	2 KIIs with employers	4 case studies of children in sugar cane/tea growing	Mukono
	Inadequate knowledge on how best to assist survivors of child trafficking	3e). What are the examples of good practices and measures created to assist victims of trafficking?	Policy and Program implementers in government & NGOs	N/A	2 KIIs at national level	1 Case study	National

Thematic Area	Data Gaps	Key questions	Category of respondents	Methods			Region/ District
				FDGs	KII	Case studies	
	Inadequate information about teachers' perceptions about violence against children in schools	3f). What are the opinions and views of teachers regarding physical and sexual violence against children in schools?	Teachers and head teachers	8 Group interviews (2 in 4 regions each)	4 KIIs with headteachers	N/A	Mbale, Gulu
		3g). What are the good practices in reducing physical and sexual violence against children in schools? What other forms of punishment have succeeded in schools other than beating?	Teachers and head teachers	N/A	Same as above	2 case studies	Kampala, others to be determined
Girl Child	There is a lack of knowledge on effective strategies to involve or work with the private sector to promote issues of child protection and in particular investing towards protection of the girl child.	4a). What are the examples of good or best practices in private sector support to the girl child?	Staff in private sector agencies e.g. Private Sector Foundation and partners, opportunity Bank, BRAC, etc; MGLSD	N/A	6 KIIs (4 with private sector; 2 with MGLSD)	2 case studies	Kampala
	Inadequate information on the status/extent of implementation of legislation against female circumcision.	4b). What is the extent of implementation of legislation and policies against FGM? What are the barriers to effective implementation of legislation and policies against FGM?	Policy makers in Ministries, law enforcement (police), implementers at LG level, community leaders	N/A	8 KIIs (2 in ministries; 2 in police; 2 in LG and 2 at community level)	N/A	National
	Lack of information as to why eastern Uganda has the highest rates of early pregnancy and early marriage in the country	4d). What factors are associated with early pregnancy and early marriage in eastern Uganda?	Community members (Adult men and women)	6 FGDs (3 with men, 3 with women)	N/A	N/A	Bugiri, Mbale, Arua
	Inadequate knowledge on how best to deal with early sexual debut among girls, early pregnancy and early marriage	4c). What are the best practices in dealing with low age of sexual debut, early pregnancy and early marriage?	Implementers in NGOs, projects and LGs	N/A	6 KIIs	2 Case studies on initiatives promoting re-entry of girls who get pregnant into school;	Kampala, others to be determined
	Inadequate information on the situation of formerly abducted child mothers available support frameworks	4e). What are the needs of formerly abducted girl mothers in post-conflict situations, what support do they have, and to what extent are they reintegrated in their communities?	Formerly abducted girls	4 FGDs	N/A	N/A	Gulu
	Inadequate information on the risks and vulnerabilities experienced young males and females who under-go traditional circumcision	4f). What processes and rituals do young boys and girls go through during traditional circumcision? What risks and vulnerabilities are young boys and girls who undergo traditional circumcision exposed to?	Boys aged 10-12 and 13-16 Girls aged 10-12 and 13-16 Cultural leaders	4 FGDs	2 KIIs with cultural leaders	2 Case studies	Mbale
Totals				**44 FGDs**	**78 KIIs**	**20 Case studies**	

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