



2015

SITUATION ANALYSIS *of* CHILDREN *in* UGANDA



THE REPUBLIC OF UGANDA

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and UNICEF Uganda, 2015

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ABBREVIATIONS

ACRWC	African Charter on the Rights and Welfare of the Child
AGI	Adolescent Girls Vulnerability Index
ART	Antiretroviral therapy
ARV	Antiretroviral
BTVET	Business, technical and vocational education training
DPP	Directorate of Public Prosecutions
DRR	Disaster risk reduction
ECD	Early childhood development
EFA	Education for All
eMTCT	Elimination of mother-to-child transmission
FGM/C	Female genital mutilation/cutting
GAVI	Global Alliance for Vaccination and Immunisation
GBV	Gender-based violence
GoU	Government of Uganda
HSSIP	Health Sector Strategic and Investment Plan
iCCM	Integrated community case management
J4C	Justice For Children
JLOS	Justice Law and Order Sector
LRA	Lord's Resistance Army
MDG	Millennium Development Goal
MoESTS	Ministry of Education, Science, Technology and Sport
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MWE	Ministry of Water and Environment
NAPE	National Assessment of Progress in Education
NER	Net enrolment rate
NGO	Non-governmental organisation
NSPPI	National Strategic Programme Plan for Orphans and other Vulnerable Children
OVC	Orphans and other vulnerable children
PBEA	Peacebuilding, Education and Advocacy Programme
QEI	Quality Enhancement Initiative
RMNCH	Reproductive, maternal, newborn and child health
SP	Social protection
SRH	Sexual and reproductive health
UDHS	Uganda Demographic and Health Survey
UNCRC	United Nations Convention on the Rights of the Child
UNHS	Uganda National Household Survey
UPE	Universal primary education
USE	Universal secondary education
VHT	Village Health Team
WASH	Water, sanitation and hygiene
WSC	Water and sanitation committee

GLOSSARY OF TERMS

CHILDREN'S RIGHTS

SURVIVAL RIGHTS include a child's right to life and the needs that are most basic to existence, such as nutrition, shelter, an adequate standard of living, and access to medical services.

Measures relating to these rights include:

Elimination of mother-to-child transmission (eMTC) – a global approach to reduce rates of transmission and avert new HIV infections among children. The Government of Uganda's revised eMTCT guidelines aim to ensure that HIV-infected mothers and their infants receive triple ARV prophylaxis during labour and through breastfeeding, and that the mother continues treatment for life.

Integrated community case management (iCCM) – part of the Integrated Management of Childhood Illness (IMCI) strategy, where Village Health Teams (VHTs) offer curative treatments for malaria, diarrhoea and pneumonia at community level.

The 2013 **Reproductive Maternal, Newborn and Child Health Sharpened Plan (RMNCH)** to address the country's slow progress on MDGs 4 and 5. The 'sharpened' plan reviews the maternal, newborn and child mortality situation in Uganda, setting an agenda to accelerate progress. The plan will run until 2020 and involves scaling up high-impact health interventions such as the promotion of breastfeeding, emergency eMTCT services and ownership of insecticide treated nets (ITNs).

Village Health Teams (VHTs), a non-statutory community structure where villagers choose people from their own communities to promote the health and wellbeing of the community.



EDUCATION AND OTHER DEVELOPMENTAL RIGHTS include the right to education, play, leisure, cultural activities, access to information, and freedom of thought, conscience and religion.

Measures relating to these rights include:

Early childhood development (ECD), which includes services aimed at providing the optimal development and education of a child from conception to eight years, and support to the mother.

Business, technical and vocational education and training (BTJET/Skilling Uganda), a comprehensive system ranging from basic training to diploma-level technical training provided by a large range of public and private institutions and enterprises in all occupational fields and social and economic sectors.

The Peacebuilding, Education and Advocacy (PBEA) programme to strengthen resilience, social cohesion and human security in conflict-affected contexts.

PROTECTION RIGHTS ensure children are safeguarded against all forms of abuse, neglect and exploitation, including special care for refugee children; safeguards for children in the criminal justice system; protection for children in employment; protection and rehabilitation for children who have suffered exploitation or abuse of any kind including protection from harmful traditional practices, such as female genital mutilation/cutting and child marriage.

Issues relating to these rights include:

Birth registration, which provides a child with an official identity – a name and nationality – as well as other information such as his or her sex, age and parentage. Birth registration is every child's 'first right' and is essential for democracy and good governance through the provision of identity and voting eligibility. It also promotes the inclusion of marginalised groups to promote equity.

Female genital mutilation/cutting (FGM/C), which involves cutting partially or totally the genital area of girls aged 10 and above as part of their rite of passage into womanhood. The practice has severe consequences, including maternal and newborn mortality.

Orphans and other vulnerable children (OVC), those suffering and or living in circumstances where they are likely to suffer abuse or deprivation and are therefore in need of care and protection. They may have lost a parent through death or desertion, are more vulnerable to illness and malnutrition, and are more likely to miss out on education.

PARTICIPATION RIGHTS encompass children's freedom to express opinions, to have a say in matters affecting their own lives, to join associations, and to assemble peacefully. As their capacities develop, children should have increasing opportunities to participate in the activities of society, in preparation for adulthood.



CROSS-CUTTING ISSUES

Vulnerability of adolescent girls

The Adolescent Girls Multilevel Vulnerability Index (AGI) measures vulnerability at three different levels – the individual, household and community level – and a girl is defined as vulnerable if she experiences risks at all of these levels. The AGI was developed in 2013 based on a growing recognition of the need to channel resources to a vital, yet highly vulnerable and vastly underserved, population of adolescent girls in Uganda specifically.

Child poverty

Child poverty, based on international standards and the UN Convention on the Rights of the Child (UNCRC), is defined as the proportion of children suffering from deprivation in two or more of the following seven dimensions: nutrition, health, water, sanitation, shelter, education and information.

Social protection

Social protection is the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation.



FOREWORDS

Poverty affects people of all ages, but children are the single most affected group. Children living in poverty experience deprivation, exclusion and vulnerability, and also face multidimensional circumstances that create lifelong difficulties in gaining access to their basic rights. Poverty also denies children their rights and deprives them of their physical, psychological and intellectual development.

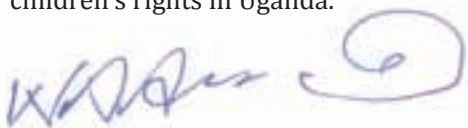
Effects of deprivation in childhood can be irreversible and the impacts of child poverty can last a lifetime, with poor children likely to become poor during their adulthood and have poor children themselves, reinforcing the intergenerational cycle of poverty. In addition, poverty is one of the root causes of violence, exploitation, abuse, and neglect of children, such as child labour, trafficking, sexual exploitation and child marriage.

With close to 60% of the population below 18 years of age, and over 75% below the age of 35 years, our children's cognitive development represents Uganda's greatest natural resource. Moreover, Uganda's vision to become a middle-income country by 2040 remains highly contingent upon our collective ability to safeguard children's right to contribute to national development.

This Situation Analysis focuses entirely on the fulfillment of children's rights as enshrined in the UN Convention on the Rights of the Child ratified by Uganda in 1990. In addition, through a disaggregated assessment of the status and trends of the realisation of children's rights, and a detailed analysis of the immediate, underlying and structural causes of shortfalls and economic disparities, it provides key policy recommendations for equity-sensitive and child-friendly policies, programmes and budget allocations.

I implore all our partners in the promotion and protection of children's rights to use this report to inform their interventions in order to improve the wellbeing of all the children in Uganda. Special attention should be addressed to implementing the policy recommendations made in this report.

I congratulate my colleagues, UNICEF, the members of the steering committee and all stakeholders for your active and relentless engagement in the promotion and protection of children's rights in Uganda.



Wilson Muruuli Mukasa

MINISTER OF GENDER, LABOUR AND SOCIAL DEVELOPMENT

Human rights are entitlements innate to all human beings, without discrimination. The rights are universal, interrelated, inalienable, interdependent, indivisible, equal and non-discriminatory.

Equity for children refers to the provision of an equal opportunity for all children to survive, develop and reach their full potential without discrimination, bias or favouritism whatever the differences in their circumstances in life. Equity is a human rights imperative that is based on the principles of universality, non-discrimination and participation enshrined in various international conventions such as the UN Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women.

Mathematically and in reality, countries can achieve national, regional and international development goals (which are averages and give no information about individuals) in the midst of worsening inequities. This is evidenced by the existence of communities of people who are deprived of their rights, even though indicator targets for those rights have been realised. In recognition of this, as a complement to UNICEF's situation analysis (published here), the Uganda Bureau of Statistics and UNICEF Uganda conducted a child-rights-focused analysis (Appendix 2) to measure, document and understand inequities across Uganda with the aim of generating information on equity patterns. The child/human rights indicators used for the study were selected from those already prioritised in the Government's sector strategic plans (Health, Education, and Social Development) as being key to measuring progress towards the Government's set development goals.

The information is presented in a reader-friendly manner to ensure that it is well understood and consequently applied to the geographical targeting of development programmes in the intervention areas covered by the analysis. I invite you to read and utilise the information.

I would like to thank UNICEF for their dedicated support and their continued efforts to improve the lives of children in Uganda.



Ben Paul Munyereza
EXECUTIVE DIRECTOR
UGANDA BUREAU OF STATISTICS (UBOS)



EXECUTIVE SUMMARY

Children's rights are enshrined in the UN Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC), to which Uganda is a signatory, and are also recognised in the Constitution of Uganda and the Children Act. However, despite sustained and substantial reductions in the proportion of Ugandans living below the poverty line over the past two decades, and not withstanding significant progress in improving the lives of children, 55% of children under the age of five years are deprived of two or more of their rights (MoGLSD et al., 2014).



This analysis aims to provide a robust and comprehensive understanding of the situation of children to identify broad areas of intervention in the national development agenda within which government and key stakeholders can situate emerging opportunities for programming, policy advocacy and research activities aimed at improving the lives of children. While focusing on children's rights in four key dimensions – survival, education and development, protection, and participation – the report also explores the cross-cutting issues of inequality and gender, to give a holistic view of the potential for policies, programmes and practices to yield positive change in children's lives in the short, medium and long term. The four key dimensions include core elements of the UNCRC, including rights areas concerning nutrition, health, water, sanitation, shelter, education and information. Child poverty is addressed as a cross-cutting issue, and one that relies on interdependent rights fulfilment. Deprivation of any of these rights can be seen to be a form of child poverty (MoGLSD et al., 2014).

The analysis is informed by an extensive literature review, key informant interviews at national and subnational level and a number of stakeholder engagement exercises with government officials, parliamentarians and non-governmental organisation (NGO) actors in Kampala. It is framed within a life-cycle approach, which recognises that children's vulnerability, poverty and ill-being are often determined by factors present before conception, but are also affected by additional, overlapping and mutually reinforcing deprivations and rights violations as their lives unfold.

In addition, the report presents a model (see Figure 1) which brings together the three dimensions that need to be addressed in order to improve child wellbeing in Uganda: (i) the core rights and sector dimensions mentioned above; (ii) cohort dimensions (early child development (ECD), adolescent girls and other vulnerable groups); and systems-level

aspects (child-sensitive social protection, child protection systems strengthening and child-friendly governance). In terms of these three core entry points for improving children's wellbeing in Uganda, the key findings can be presented in terms of three lenses – a rights and sectoral lens, a cohorts lens and a systems lens.

KEY FINDINGS

Child survival has improved but undernutrition persists, stunting is at 33%, there remains limited access to clean water and sanitation, and AIDS is now the leading cause of adolescent mortality. Improvement in health-seeking behaviour through addressing social norms (particularly for adolescent girls) and engaging at community level across the continuum of care frequently emerge as crucial areas of intervention.

With respect to education and other developmental rights, primary school enrolment is high but quality remains poor and dropout rates are high in both primary and secondary schools. Important areas of intervention are the national coordination and implementation of ECD policies, the management of informal schooling, and supporting children with special needs.

Children's right to protection continues to be a critical challenge given that: 8% of children are critically vulnerable and 43% are moderately vulnerable (MoGLSD, 2011 and UBOS, 2014a); still only 60% of children are registered within a year of birth (UNICEF Uganda, 2015), and government spending on child protection is marginal. The main areas of intervention are considered to be: the strengthening of knowledge, capacity and interventions that address social norms, such as child marriage; cross-sectoral engagement in child protection law enforcement; and improving the national strategy to eliminate child labour.

The participation of children in decisions that affect them is restrained by the limited scope of existing guidelines and the lack of a coherent national strategy, in addition to limited systematic investments outside of NGO or donor programming. Areas for action in raising awareness about the value of child participation (both because it is a right and because of the benefits it brings to society) include the development and implementation of a national child participation strategy, and an accompanying community of practice to distil lessons relevant for the Ugandan context.

Adjusting to a cohort-specific lens, the critical groups are shown to be those in early childhood (0–8) and adolescent girls (10–18). Children aged 0–8 years are seen to be especially vulnerable, and face a range of regional, income and gender-related inequalities, while adolescents (especially girls) face multiple vulnerabilities from disempowerment at the individual, household and community levels. Many of the factors contributing to this situation have been shown to be persistent or worsening, despite attempts at technical fixes. Attention towards behavioural (social norm) changes that are integrated with economic strengthening components is considered a potentially fruitful area for further exploration.

At the systems level, the main considerations relate to the improvement of child-sensitive social protection systems, child protection systems, and participatory spaces for children, which include issues relating to governance systems. Currently, child-sensitive aspects of social protection activities are not well-articulated, while child protection systems strengthening activities are limited by investment in monitoring and evaluation (M&E) and coordination capacity. As noted above, while child participation is a rights area, it is also related to governance and should be seen as a contributor towards social accountability.

In terms of more detailed summary findings, these are presented according to the four rights dimensions (survival, education and other developmental rights, protection and participation). This section highlights improvements and remaining challenges in service provision, as well as changes needed to secure a fully enabling environment (in terms of sector-specific capacities and legal frameworks) in order to fulfil children's rights and improve their wellbeing.

CHILDREN'S RIGHT TO SURVIVAL

- Uganda ranks among the top 10 countries in the world for high maternal, newborn and child mortality rates.
- HIV and AIDS is now the second leading cause of death among adolescents, accounting for 300 deaths a day (UNAIDS, 2014). Malaria, diarrhoea, pneumonia and infections like HIV account for 70% of under-five deaths (MoH, 2013b).
- Some of the biggest gaps in health service provision include insufficient and unmotivated health workers, inadequate health financing, frequent stock-outs of drugs, and weak institutional and community systems to address implementation bottlenecks.
- Households bear most of the costs for health care, with household expenditure constituting 43%, donors 34% and government 23% (MoH, 2013a).
- Uganda loses \$899 million worth of productivity per year due to high levels of stunting, iodine-deficiency disorders, iron deficiency, and low birth weight.
- The percentage of children deprived of access to safe water decreased from 39% to 30% between 2010 and 2013 (MoGLSD et al., 2014).
- An emerging concern centres around children with disabilities, whose condition is often the result of ante- and neonatal complications related to capacity constraints in the delivery of basic health services.



Progress and challenges in service provision

Children in Uganda face multiple challenges for survival. The immediate causes of under-five mortality are pneumonia, malaria, diarrhoea and HIV/AIDS, while the immediate causes of infant mortality are hypothermia, premature birth and pneumonia. The underlying causes of child morbidity and mortality include the unavailability of basic services, especially in rural areas, where the quality of these key services remains sub-optimal and uptake staggeringly low.

Although the under-five mortality rate has fallen over the past two decades (from 137 per 1,000 live births to 90) (UBOS and Macro International, 2007 and UBOS and ICF International, 2012), it is not declining fast enough to meet the country's Millennium Development Goal (MDG) target of 56 per 1,000 live births by the end of 2015 for children under five. This is mainly due to lack of progress in reducing the neonatal mortality rate, which has remained relatively constant at 27 deaths per 1,000 live births (UBOS and ICF International, 2012). Approximately half of pregnant women have access to good-quality antenatal care services and only 57% of babies are delivered in a health facility (UBOS and ICF International, 2012). In 2011, only 52% of children aged 12–23 months were fully vaccinated and only 40% of children aged 12–23 months were immunised before their first birthday (UBOS, 2012). The Government's Expanded Programme on Immunisation (EPI) is aimed at ensuring all children are fully immunised by their first birthday, but as of 2013 it was only available in 80% of facilities (UNICEF, 2014).

Despite national efforts such as mass distribution of long-lasting insecticide treated nets (ITNs), insecticide residual spraying, the use of appropriate diagnostics and effective antimalarial therapy and integrated community case management, the proportion of children under five dying from malaria increased from 28% in 2011/12 to 31% in 2012/13 (MoH, 2013a). Inadequate nutrition also remains a significant concern, with undernutrition responsible for 40% of under-five deaths (Shively and Hao, 2012). Although there has been progress in reducing stunting from 38% to 33%, it is still far from the MDG target of 13% (UBOS and ICF International, 2012). Moreover, among children with disabilities, succumbing to illness before the age of five was cited as the main cause of their disability in one-third of cases (ACPF, 2011; UBOS, 2002).

There is a high level of unmet need for sexual and reproductive health (SRH) and family planning services and HIV/AIDS support, which means adolescents (particularly girls) have limited information on how to prevent pregnancy and avoid contracting HIV. According to the Uganda AIDS Commission, 34% of those who want AIDS support services are not able to access them. However, Uganda has achieved a remarkable reduction in new HIV infections among children, achieving its National Priority Action Plan (NPAP) target for 2013. A considerable decline was observed in HIV incidence among children, from 27,660 in 2011, to 9,629 in 2013 as opposed to adults (134,634 in 2011 to 131,279 in 2013). Moreover, the number of AIDS-related deaths in children aged 0–4 years decreased by more than 50% from 100,000 between 2000 and 2012, while deaths in adolescents increased from less than 50,000 to over 100,000 during 2000–12 (UNICEF, 2013).

If children survive beyond their fifth birthday, they face ongoing risks to their health due to poor sanitation and hygiene, and lack of access to clean water. At least 30% of the rural population does not have access to a latrine and more than 70% of households have no soap and water for children to wash their hands, putting them at risk of disease (MoGLSD et al., 2014). Children in rural areas are about three times more likely to lack access to improved water sources than their urban counterparts (MoGLSD et al., 2014). Girls are disproportionately affected by limited access to water and adequate nutrition due to prevailing gender norms, which are particularly constraining for adolescent girls in rural areas.

Less than half of all districts will meet the national target for access to safe and functioning sanitation facilities (77% by 2015), but the country is not far from reaching standards in terms of average coverage of over 50% in the country (MWE, 2014). In general, access to safe water and sanitation is constrained by a range of economic and social factors, including the declining sector funding barely matching population growth; inadequate community ownership and participation in the operations and maintenance of water facilities; inadequate decentralised institutions capacity; and cultural beliefs and social norms.

The enabling environment

Numerous contextual factors prevent children from realising their right to survival. The main constraints to good-quality health service provision include understaffing and absenteeism; inequitable geographical distribution of health facilities; poor logistics management (including frequent stock-outs of drugs and other essential supplies); poor linkages between services (e.g. elimination of mother-to-child transmission (eMTCT)) and family planning services); weak monitoring systems to prevent absenteeism and corruption; and budget constraints.

On the demand side, barriers include poor utilisation of health services (continuity of use), social and cultural practices and beliefs, lack of information (on the part of authorities and citizens), and low levels of education among parents. For example, gendered social norms

and traditions, particularly around household decision-making and care responsibilities, have a detrimental impact on women and children's health. Health outcomes are strongly correlated with gender-based violence, responsibility for feeding and caring for family members, and exposure to harms such as forced marriage, marital rape, female genital mutilation/cutting (FGM/C) and sexual harassment.

The Government's Health Sector Strategic and Investment Plan (HSSIP III) recognises the National Minimum Health Care Package (UNMHCP) as the main mechanism for achieving the sector-wide goals by delivering cost-effective health interventions to improve outcomes in key areas such as maternal and child health, and prevention and control of communicable diseases. The National Integrated Early Childhood Development Policy (2013) aims to ensure children's universal access to primary health care services. Similarly, the National Strategic Plan (NSP) for HIV and AIDS seeks to reduce transmission of HIV from pregnant and lactating women to their unborn or infant children.

CHILDREN'S RIGHT TO EDUCATION AND OTHER DEVELOPMENTAL RIGHTS

- While Uganda has made important strides in extending primary schooling since universal primary education was introduced in 1997, dropout rates remain high.
- Early childhood development policies have improved at national level, with implementation and coordination being the next core challenges.
- Conflict and disasters (natural and man made) continue to undermine and disrupt the provision of education, as well as the development and wellbeing of children more generally.
- Violence in schools is widespread, contributing to high dropout rates and poor performance.

Progress and challenges in service provision

In terms of education, multiple deprivations affect the lives of children in Uganda. Early childhood development (ECD) centres are vital to ensure school readiness and future success. Data on ECD services vary greatly. Over 80% of ECD centres are estimated to be privately owned (FENGOU, 2014), pre-primary (3–5 years) enrolment rates are low – especially among vulnerable children living in rural and post-conflict areas, isolated communities, and poor urban and other disadvantaged communities – and facilities are often poor. There are also minimal integrated services available to help parents support their children's ECD needs at home.

The Government has made significant improvements in primary education with the introduction of universal primary education (UPE), having achieved close to universal net enrolment rates for P1 and gender parity. According to the Ministry of Education, Science Technology and Sports (MoESTS, 2014a), the net enrolment ratio (NER) in primary schools was 93.7% in 2014, for both girls and boys. However, many children continue to drop out of primary school, partly due to poor-quality education. There are also concerns about pupil attainment – only 3 out of 10 children assessed nationwide were able to read and understand a Primary 2 level text (Uwezo Uganda, 2012). Children with disabilities face many barriers to attending primary school; they experience discrimination and stigmatisation within their families and communities, and schools are poorly equipped to assess or meet their needs.

Secondary school enrolment rates are much lower (24.1% NER in 2014) (MoESTS, 2014a). Fees and other school-related expenses tend to be higher for secondary schooling, which increases the opportunity cost of sending children to school, so poorer families often opt to keep children out of school to work. Quality of education at secondary level is also a major issue, as are school fees and related expenses along with lack of infrastructure (such as separate toilets) and other protection risks which continue to make schools a difficult and unwelcoming environment, especially for adolescent girls.

Violence in schools is widespread, contributing to high dropout rates and poor performance. Although corporal punishment was banned in 1997, caning by an adult in school remains widespread. Children (particularly girls) are also vulnerable to sexual exploitation.

The enabling environment

On the supply side, the availability of free schooling, limited coverage of ECD centres, location of primary and secondary schools (and therefore ease of access), the poor quality of teaching (insufficient numbers of qualified staff lead to high pupil:teacher ratios), and prevalence of corporal punishment all prevent schools from providing a good-quality education for children and young people in a safe environment. Moreover, gaps between education policy and practice, a focus on enrolment (which is only slowly shifting towards quality and retention), and limited policies on ECD and secondary education (particularly technical education) prevent children from realising their right to an education.

The Education Act (2008) recognises, organises and provides a systematic approach to fulfil children's right to education by specifying what each level of education should constitute, and the key duty-bearers at each level. As a caveat, the Quality Enhancement Initiative (QEI) was initiated in 2008 to improve the quality of primary education in 15 of the worst performing districts.

CHILDREN'S RIGHT TO PROTECTION

- There are 17.1 million children below 18 years¹ (over 56% of the population); 11.3% of these are orphans, 8% of children are critically vulnerable, while 43% are moderately vulnerable (MoGLSD, 2011 and UBOS, 2014a).
- As of 2014, only 60% of children aged 0–4 years have birth registration papers (UNICEF Uganda, 2015).
- Nearly half (49%) of women aged 20–49 years were married before the age of 18 years and 15% by the age of 15 years (UBOS and ICF International, 2012).
- The amount of time juveniles spend in detention before sentencing has decreased from five to three months on average, while the number of juvenile offenders rehabilitated after release has increased.

Progress and challenges in service provision

Violence against children at home or in school – whether physical, emotional or sexual – is a major violation of their right to protection. More than half of Uganda's population is under 18, and 51% are classed as either critically or moderately vulnerable (Kalibala and Lynne, 2010). Some children are highly vulnerable, including those affected by conflict, those engaged in child labour or trafficking, children with disabilities, orphaned children, and street children. Although there is a legal requirement under the Children Act to inform the authorities when an orphan is placed in alternative care (in foster care, through adoption, or institutional care), enforcement is inadequate and kinship care is not covered by law, which is why valid statistics about the number of children in alternative care are limited. Due to a lack of regulation or weak enforcement, there is a proliferation of childcare institutions and most of them are either not registered or fail to comply with rules and regulations. Reintegration services for children (boys and girls) formerly associated with fighting forces have faced many challenges and have often performed poorly.

Adolescent girls are particularly vulnerable to sexual abuse, and rural adolescent girls face additional challenges due to gendered social norms that place high value on girls' reproductive capabilities, while reinforcing harmful practices such as early marriage and, in some communities, FGM/C. Girls in rural areas are likely to marry earlier and have at least three more children than their urban counterparts, yet are less likely to have access to family planning services.

Child trafficking is a major concern in Uganda, with specific groups of children at high risk, including orphaned children, children from poor households, children out of school,

1. According to provisional results from the 2014 census (UBOS, 2014b), detailed data from which are yet to be published and were not available during the drafting of this report, this figure has now increased to 20.2 million.

children who live and/or work on the street, children separated from their parents, children with low formal education, and children living in violent households.

Various studies suggest that boys and girls continue to play an important economic role in contributing to household income and livelihoods, with almost half of children aged 5–17 engaged in some kind of work. About 2.4 million children are engaged in exploitative child labour, of which 1.7 million are below 14 years of age (MoGLSD, 2012a). The proportion is higher among 5–11-year-olds, where 36% of boys and 32% of girls are working. There are also regional and spatial differences; in the relatively deprived Karamoja region, a quarter of working children are engaged in hazardous forms of labour (MoGLSD, 2012a).

Conflict in the north of the country has also had an enormous impact on children's lives. Over the past 20 years, the Lord's Resistance Army (LRA) has carried out widespread sexual and physical violence, particularly against women and girls. Child soldiers and girls who were abducted have wide-ranging needs and face specific challenges reintegrating into their communities, especially young mothers who face persistent stigmatisation.

Birth registration is a central piece of information for child protection and plays a key role in ensuring adequate access to and provision of key social protection services. However, although it is mandatory in Uganda to register a birth within three months, as of 2014, only 60% of all children had birth registration papers (MoGLSD et al., 2014). This may be due to the prohibitive costs involved (UGX 5,000 for a full certificate) and lack of incentives. This makes it difficult for services to track children's development and identify those at high risk of violence, abuse and neglect.

The enabling environment

Poverty and inequality cause many child protection deficits. For example, where children are engaged in the worst forms of child labour, this is usually the result of widespread chronic poverty. Social norms and attitudes in families and parenting also play a strong role, upholding a culture of impunity for perpetrators of violence against children. However, domestic violence and other forms of abuse experienced by children are a result of more serious, systemic elements, including but not limited to: complex and poor law enforcement; lack of trained personnel to handle cases of violence; barriers to accessing care; and lack of coordination among sectors responsible for child protection (MoGLSD et al., 2014).

Uganda has an Integrated Child Protection System, which has adopted a holistic programming approach to protect all children; it is building stronger linkages between sectors (social welfare, education, health, and justice), and stronger linkages between levels (national, sub-national and local). Although it has a robust legal framework, provisions relating to child protection are scattered across several pieces of legislation, and enforcement tends to be weak. There is also a lack of policy and strategic framework to guide interventions for

children by the Justice Law and Order Sector (JLOS). The lack of priority given to diverting children from the mainstream has led to children being remanded for long periods of time beyond the statutory limit. Although the JLOS has reduced the time spent in detention by juveniles before sentencing from an average of five to three months through the Justice for Children (J4C) programme, lack of separate holding facilities for children result in them being held along with adults in some areas.

Although J4C issues are now reflected in sector plans via nine child protection indicators in the Strategic Investment Plan 3 (SIP3) of the Uganda Police Force, the Directorate of Public Prosecutions, and the judiciary, they are not yet included in the sector plan of the Ministry of Gender, Labour and Social Development (MoGLSD) – the ministry mandated with child protection. A child protection mapping report by the Ministry in 2013 (MoGLSD, 2013a) found no explicit reference to child protection in the National Development Plan or budget and medium-term expenditure frameworks (MTEFs).

CHILDREN'S RIGHT TO PARTICIPATION

- The 2008 National Child Participation Guide provides guidelines on participation but does not define actions or goals.
- Existing participation initiatives have limited reach. In particular, children's and youth participation initiatives tend to be related to specific programmes funded and run by international and local NGOs.
- There is a concern that many participatory initiatives do not reach the most disadvantaged or excluded children and, as such, can potentially contribute to further social exclusion.
- There are no institutionalised mechanisms for child participation and for ensuring that children's views are considered in decision-making at national and lower levels.

Progress and challenges in service provision

The issue of child participation is a cornerstone in realising children's rights because, without it, children are invisible to government and other services, resulting in policies and programmes that are potentially poorly designed, implemented and evaluated. However, there is considerable progress to be made in Uganda in realising children's right to participation in matters and decisions that affect their lives. General attitudes are not conducive to children expressing their views; children and young people are not deemed capable of contributing to discussions and decisions; and their needs and demands are



often ignored by duty-bearers within their families and communities, and at all levels of government. Yet where participatory initiatives have been carried out by national or international NGOs, the benefits of enabling children's views to be heard have been significant, as in the case of strengthening protection mechanisms for children in refugee camps.

The enabling environment

In 2008, the Government published its National Child Participation Guide, which explains what child participation means, how it is mandated by the UNCRC and various legal and policy frameworks, and how it fits within a broader rights-based approach (MoGLSD et al., 2008). However, since it is a guideline document rather than a policy or action plan, it does not outline any actions or goals for the Government or relevant stakeholders. Consequently, children's participation remains marginalised, with most participatory initiatives funded and implemented by national and international NGOs.

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 counselling. According to a programme report, the questionnaire 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 MoGLSD and the National Council for Children (NCC) are the key governmental actors in supporting children's participation in decisions affecting their lives. The Children Act (Cap 59) has provisions to uphold the right to participation on issues that affect children's survival and development.² The Local Government Act (Cap 243) seeks to ensure that children's needs are provided for at the local level. A Secretary for Children's Affairs is appointed to each local council and is responsible for ensuring that children's voices are heard. Moreover, this Act mandates councils to consult with the children in their constituencies. District councils and sub-counties are obliged to provide feedback on consultations to adults and children. Ultimately, though, promoting greater participation by children and young people will require major changes in societal attitudes about children and young people's capacities to contribute.

2. Although the Children Act does not explicitly state children's right to participation, it is provided for in the the First Schedule of the Act concerning the guiding principles in the implementation of the Act where reference is made to children's right to 'all the rights set out in the United Nations Convention on the Rights of the Child and the Organisation for African Unity Charter on the Rights and Welfare of the African Child...'

TOWARDS A CHILD WELLBEING MODEL IN UGANDA

Part of the challenge in building a nationally integrated and comprehensive response to fulfil children’s rights and ensure their wellbeing in Uganda is that the four rights areas addressed above largely provide a single ‘lens’ through which the situation of children can be understood. In developing a model for action, additional components are necessary that not only provide alternative opportunities for understanding the situation, but also for catalysing the interests of additional stakeholders who may not necessarily be interested in individual rights areas and/or service sector ‘lenses’. Consequently, it is helpful to frame this discussion around two additional lenses: a target cohort focus, and a ‘systems’ lens.

FIGURE 1: KEY COMPONENTS OF CHILD WELLBEING



Figure 1 encapsulates several dimensions discussed in this situation analysis. It provides three 'lenses' through which to interpret the core dimensions that need to be addressed in order to improve children's wellbeing in Uganda: (i) core rights and sector dimensions (the four rights areas discussed above), (ii) cohort dimensions (early childhood development (ECD), adolescent girls and other vulnerable groups) and (iii) systems-level aspects (child-sensitive social protection, child protection systems strengthening, and child-friendly governance). This model provides entry points for a multitude of actors in order to improve children's wellbeing, and each component is discussed in the Key Findings and Key Challenges sections.

Delivering adequate policy and programme responses will require more tailored approaches. A target cohort 'lens', when applied to the situation of children in contemporary Uganda, highlights the particular concerns of children in early childhood (0–8) and adolescents (10–19) – particularly girls – as well as marginalised groups who are subject to various forms of inequality. Although almost all children face risks that can make them vulnerable, inequalities can increase the level of risk and vulnerability associated with certain situations – including being orphaned, having disabilities, being a girl, and many more.

Northern Uganda, with its large rural population, is one of the most disadvantaged regions. It has the highest child mortality rates (Karamoja) and the lowest school enrolment rates (primary and secondary). The Karamoja region also has a high incidence of hazardous mining and child labour conditions. The legacy of the conflict in the North has led to numerous protection issues, including high levels of gender-based violence. Poverty rates are much higher in the North, with urban populations enjoying better development outcomes such as lower child mortality, maternal mortality and fertility rates.

Target cohort lens: early childhood (0–8 years)

Children aged 0–8 years are especially vulnerable, and face a range of regional, income and gender-related inequalities. For example, children born in rural areas and in households in the lowest wealth quintile are more likely to die before their fifth birthday, while children living in urban areas are more likely to be fully vaccinated. (However, all regions still have mortality rates above the MDG target of 56 per 1,000 live births.) The Karamoja and South-West regions also have the lowest percentage of births assisted by a skilled attendant. Gender disparities in immunisation rates have now been addressed.

Nutrition rates among this cohort also show regional inequalities, and it is notable that children from female-headed households have higher prevalence of chronic under nutrition than children from male-headed households. There are regional disparities in the incidence of stunting; rural children are twice as likely to be underweight as urban children. On nutrition, the Demographic and Health Surveys (UDHS) from 2000 to 2011 show that boys are more chronically undernourished than girls at all ages. While in 2006 boys were more likely to be underweight than girls, this gender difference had been eliminated by 2011.

In terms of preschool and primary schooling, Uganda has achieved some noteworthy targets, with no gender gap in access to ECD centres and gender parity at primary level. But other inequalities remain. In 2011, the proportion of children who had never attended school was more than twice as high in the bottom wealth quintile as in the top quintile. Most ECD centres are in urban areas and the Central region, contributing to geographic as well as socioeconomic disparity in access. Despite solid progress in increasing primary enrolment, there remain major inequalities in access between regions and depending on a child's social identity (children with disabilities and orphaned children are often unable to attend school). Primary school enrolment rates are lowest in the Northern region and in rural areas, with the gap increasing at secondary school level. Girls are also slightly more likely to have never attended school or to have dropped out. Moreover, of the 1.22 million children with disabilities in Uganda, only 5% are able to access education within an inclusive setting in regular schools (Riche and Anyimuzala, 2014).

Target cohort lens: adolescent girls (10–18 years)

Gender inequalities have strong impacts on the lives of adolescent girls, who continue to experience multiple vulnerabilities at the individual, household and community levels. This has serious implications not only for their own wellbeing and development, but also increases the likelihood that these vulnerabilities will be transferred to any children they have.

Evidence from Uganda shows that girls are more likely to experience poverty and marry early (almost half of women aged 20–49 were married before they were 18) (UBOS and ICF International, 2011). Rural girls fare worse than their urban counterparts in many respects – for example, rural adolescent girls are more likely to be pregnant during their teenage years and are also more likely to have been victims of defilement.

Adolescent girls are also at greatest risk of contracting HIV and other sexually transmitted infections (accounting for two-thirds of all new HIV infections). Data for 2013 show that children under 15 account for 11% of all HIV cases in Uganda, with HIV and AIDS now the second most common cause of death among adolescents (UNAIDS, 2014).

At secondary level, the enrolment rate for girls lags behind that for boys, and girls are more likely to drop out early. Schools lack the water, sanitation and hygiene (WASH) facilities adolescent girls need, which partly explains why many girls skip school for several days each month during menstruation. But community/family attitudes also play a strong role, with poorer families prioritising their sons' education, considering that girls do not need education to fulfil their future roles as mothers and that investing in girls' education will only benefit their future husband's household. Studies also suggest that girls' education is undermined by a range of gender bias and discrimination in schools, textbooks, curricula, and in teachers' attitudes towards girls, with a shortage of female teachers as role models. While some responses to these challenges may be technical in nature, it is important to

highlight behavioural change as a key mode of intervention alongside building individual and household capabilities through, for example, economic strengthening or wealth creation. This distinction is critical as many of the challenges relating to service demand and programme impacts with respect to adolescent girls and inequality – as well as to early childhood development – have proven to be persistent or worsening, despite significant investments in services and research. This strongly suggests that national responses to behavioural dimensions such as social norms need to be reinvigorated.

‘Systems’ lenses

In addition to rights-based and service sector approaches, as well as target cohort entry points, several stakeholders prefer to find entry points to improve child wellbeing through ‘systems’ lenses. This view provides an additional layer of analysis, informed by institutional analysis components and focusing on the status and development of encompassing systems and processes. The systems lens therefore includes considerations for mapping and improving child-sensitive social protection systems, child protection systems, and participatory spaces for children, which include issues relating to governance systems.

As social protection is not only a right itself, but also increasingly seen as an important part of the Government’s strategy to fight poverty and promote economic growth, the National Development Plan (NDP) 2010–15 has drawn upon it as a route to prosperity through economic growth and job creation. It also emphasises the need to ensure that wealth creation is accompanied by sustained reductions in poverty and improvements in the welfare of people living below the poverty line. However, the child-sensitive aspects of the current social protection strategy are not yet clearly articulated. It has been shown that target cohorts benefiting from existing programmes (e.g. Social Assistance Grants for Empowerment – SAGE) largely allocate expenditures on subsistence, including (in order of priority) food, education, and health. The relative expenditure on different children within households is yet to be rigorously assessed.

While children are therefore likely to be significant secondary or tertiary beneficiaries of targeted grants, the implications for ECD, adolescent girls, reducing inequity, and clarifying synergies with child protection initiatives are not yet clear. On the other hand, a systems approach to child protection entails a shift from vertical silo-based programming focusing on specific categories of children to integrated programming approaches that protect all children, and promote greater synergies between sectors (social welfare, education, health, and justice), and greater linkages between levels (national, sub-national and local).

Finally, participation and child-friendly governance are crucial but complex ‘systems-level’ entry points. Notwithstanding the existence of the National Child Participation Guidelines, children’s participation remains mainly supported by international and national NGOs working with children and young people.

The issue of birth registration, a cornerstone of child participation given its links to civil rights and identity, has significant cross-cutting implications for child wellbeing, including recognition in terms of access to services. Statistics from 2014 suggest that 60% of 0–4-year-olds have currently been registered, a vast improvement since 2011 when only 30% had been registered (UNICEF Uganda, 2015). This could be considered an ‘easy win’ with potentially significant value-added in terms of representing a ‘passport to protection’ in relation to proof of age in marital engagements, traceability, eligibility of services, and migration.

OVERARCHING POLICY RECOMMENDATIONS

There is a general consensus in Uganda that the major challenges in improving national capacity to realise children’s rights to survival, education and development, protection and participation lie not so much in the policy framework itself but rather in more effective implementation of supportive laws and policies and greater monitoring and enforcement capacity. In this respect this situation analysis recommends the following policy actions.

- **Establish and fully implement an integrated early childhood development (ECD) policy framework:** Developing children’s potential starts in early childhood. The first 1,000 days of a child’s life are crucial to building good nutrition, while early cognitive development is important in preparing children for primary school. ECD goes beyond pre-primary education and includes health, nutrition and protection. As such it is important to establish an integrated ECD policy framework that is adequately funded and monitored. The integrated policy should aim to improve the enabling environment for ECD to ensure that Ugandan children get the best start in life.
- **Prioritise child sensitive social protection policies and programmes:** Uganda faces widespread child poverty and deprivation with many children facing specific vulnerabilities. Children with disabilities, for example, often find themselves cut off from education and other social services. Adolescent girls are highly vulnerable to dropping out of school, teenage pregnancy, early marriage and exposure to risky behaviours. Such dynamics bring a lifetime of consequences which affect them and the future generation. Child-sensitive social protection policies and programmes can help address child poverty and reduce the vulnerabilities children face. Evidence shows that social protection programmes can improve education, health and nutrition outcomes, and in some cases prevent risky behaviour in adolescents. Uganda needs to expand social protection and ensure that programmes are designed to reach the poorest and most vulnerable children and adolescents.
- **Strengthen public finance for children:** This involves increasing the visibility and enhancing monitoring efforts for programmes affecting children in the national budget. The latter is a crucial tool for the fulfilment of children’s rights as budgetary



decisions can affect child poverty, education, health, nutrition and protection. With over 50% of the population below the age of 18, children's cognitive development represents Uganda's greatest natural resource. Mainstreaming of investments in children into fiscal policy through a transparent and participatory budgetary process stands a necessary precondition for Uganda to reap full benefits from the demographic dividend and achieve Vision 2040.

- **Institutionalise child indicators in national statistics, surveys, and policy documents such as the National Development Plan:** Child-specific indicators are necessary to monitor and assess progress in children's wellbeing. The indicators should be disaggregated by socioeconomic characteristics to measure disparities in child wellbeing within the country. The overall policy framework should aim to eliminate inequalities in access to services, opportunities and outcomes for children. This can only be achieved if child-focused indicators are regularly collected and monitored, and national policy includes specific goals to improve children's wellbeing.
- **Develop a National Child Participation Strategy:** Child participation remains characterised by fragmented and time-limited initiatives. Developing a national child participation strategy to serve as an action plan with main interventions, timeframes, targets, key institutions and their specific roles and expected outcomes is a critical step towards establishing a better enabling environment for child participation in Uganda. Anchored on Uganda's constitution and legal framework, and firmly harnessed on the UNCRC, this strategy can pave the way for sustainable avenues for children to participate in discussions around issues that affect them at the national and local level.





1 INTRODUCTION

This situation analysis aims to provide a robust and comprehensive understanding of the situation of children³ in Uganda to identify broad areas of intervention in the national development agenda and emerging opportunities for programming, policy, advocacy and research aimed at improving the lives of children.

1.1 PURPOSE AND OBJECTIVES

The purpose of this report is to provide a comprehensive and varied evidence base upon which strengths and gaps in the data, legislative and policy framework, and response capacity of the state and implementing partners can be assessed and addressed.

Central to this situation analysis is the assumption that inequities⁴ lie at the core of children's and women's experiences due to discrimination based on gender, economic status, region, disability and orphan status. Across all chapters, the report describes the ways in which disadvantaged groups – girls, low-income and geographically distanced households, disabled children and orphans and other vulnerable children – face additional challenges due to their marginalised status.

In summary, the objectives of this report are to:

- investigate the state of children in Uganda with respect to four children's rights (survival, education and development, protection, and participation);
- lay out the trends and challenges on the demand and supply side for all four rights areas;
- analyse the policy frameworks and equity issues associated with the four rights areas to identify gaps and opportunities for policy advocacy and;
- provide policy recommendations for improving the state of children in Uganda, bringing together the three dimensions that need to be addressed in order to improve child wellbeing: (i) the four rights and sector dimensions outlined above; (ii) cohort dimensions (early childhood development (ECD), adolescent girls and vulnerable groups); and (iii) systems-level aspects (child-sensitive social protection, child protection systems strengthening and child-friendly governance).

3. People under the age of 18

4. Equity relates to the equal opportunity for children to survive, develop and reach their full potential without discrimination, bias or favouritism. Inequity exists whenever unfair and avoidable circumstances that deprive children and women of their rights occur.

1.2 ANALYTICAL FRAMEWORK

The reference points for the situation analysis are the UN Convention on the Rights of the Child (UNCRC) and the UN Convention on the Rights of Persons with Disabilities, which to some extent inform policy and legislation on children in Uganda. The report explores the performance of Uganda with respect to more specific child-centred goals, including the Millennium Development Goals (MDGs), the plan of action for a World Fit for Children and, with respect to future positioning and trends, the Post-2015 Sustainable Development Goals. Importantly, the analysis looks at national goals and targets with respect to their focus on children and associated outcomes, as well as the extent to which policy and programmes have been implemented in line with these goals to have an impact on children's lives. The report also identifies current and emerging risks that threaten these goals, such as conflict, regional insecurity and emergencies. It puts children's issues in the context of Uganda's current and emerging national development agenda and, in particular, looks at how addressing the issues of children is a step towards investing in the country's future.

1.3 METHODOLOGY

The methodology used is underpinned by a comprehensive review of the existing data, evidence and research (secondary literature) on children in Uganda, as well as an exploration of the effects on children of other dimensions of exclusion or marginalisation such as location, disability, and ethnicity, among others. This included an assessment of the quality of evidence on different children's rights areas (e.g. the degree of data disaggregation provided and information on the research methodology used). Any data gaps were closed through the analysis of secondary literature and by informing research instruments for data collection during fieldwork.

For each rights sector, a lifecycle perspective was used to detail the many deprivations a child in Uganda might face. Children's vulnerabilities within each of the rights areas are dependent on antecedents that lead to poverty and ill-being, as well as new vulnerabilities and deprivations and rights violations that reinforce the previous ones. This creates a constantly changing and complex multidimensional state of deprivation. Next we detail the trends in that sector across multiple dimensions.

After the lifecycle perspective, the report focuses on the enabling environment, informed by a causality analysis of the existing literature. This identifies determinants of bottlenecks and barriers towards achieving children's rights in three main domains: demand, supply, and quality of services. Finally, the methodology highlights the legal framework in terms of legislation and policies.

This analysis is complemented by a broad assessment of government allocations to sustainable investments in children in the context of Uganda's national development agenda.



Additionally, the report highlights areas where the current situation in Uganda diverges from nationally and internationally defined targets and goals for children, including patterns or occurrences of multiple deprivations.

1.4 REPORT STRUCTURE

Following this introduction, Chapter 2 presents the country context, focusing on social, economic and demographic factors, and exploring the cross-cutting issues of gender and inequality. Chapters 3 to 6 focus on children's rights to survival (incorporating health and nutrition); education and development (including ECD interventions, primary and secondary schooling, and vocational training); protection (incorporating violence against children, child marriage, adolescent pregnancy, trafficking, and child labour); and participation (representing children's right to express their views freely in all matters affecting them, as well as the right to receive information). Each chapter assesses Uganda's progress in realising children's rights, and considers trends and challenges, as well as the impact of national laws and policies. Chapter 7 summarises the main policy challenges in delivering a productive and inclusive framework for children's development in Uganda across the four dimensions of children's rights, and presents recommendations to advance this agenda. Appendix 1 lists the overarching frameworks and national laws and policies that underpin programmes relating to the four rights areas covered in Chapters 3 to 6.

Finally, because national-level indicators are mathematical averages, and because there are vast and growing differences in access to services and the realisation of children's rights between regions and across income levels, Appendix 2 provides additional analysis measuring patterns of inequity across the country. This analysis is based on 43 indicators relating to children's rights and access to services depending on where they live, their household income and the education and age of their mother.



2 THE COUNTRY CONTEXT

This chapter describes the social, economic and demographic factors that underpin children's rights in Uganda. In doing so, it provides an account of the Government's efforts and abilities to reduce income poverty, while introducing key policy challenges, particularly in relation to regional differences and inequity.

2.1 SOCIAL, ECONOMIC AND DEMOGRAPHIC FACTORS

2.1.1 Economic growth

Uganda has made significant economic progress in the last two decades, with an annual growth rate in GDP between 1992 and 2011 of 7.1%. However, between 2011 and 2012, GDP fell to 3.2% due to high population growth, a decrease in export performance and high inflation (AfDB et al., 2013). Projected growth for 2014–15 is 6.2% but requires strong public investment by the government (World Bank, 2015). Economic and social development reveals a mixed picture. The African Development Bank (AfDB) projected real GDP growth at 5.2% in 2013 and 6.6% in 2014. However, the Bank's Economic Outlook observes that an unfavourable investment climate for the private sector and public sector constraints continue to hamper economic growth (AfDB et al., 2013).

Economic growth also remains challenged by demographic factors and non-productive populations. More than half of Uganda's population (56%) is under 18 years of age and the largest percentage of this age group is aged between 0 and 4 years. Of these 0–4-year-olds, 55% are deprived in at least two poverty dimensions, while 38% of those aged 6–17 live in poverty. According to a situation analysis of child poverty and deprivation, 24% of children aged 0–4 and 18% of children aged 6–18 years can be characterised as living in extreme poverty, experiencing extreme deprivation (MoGLSD et al., 2014).

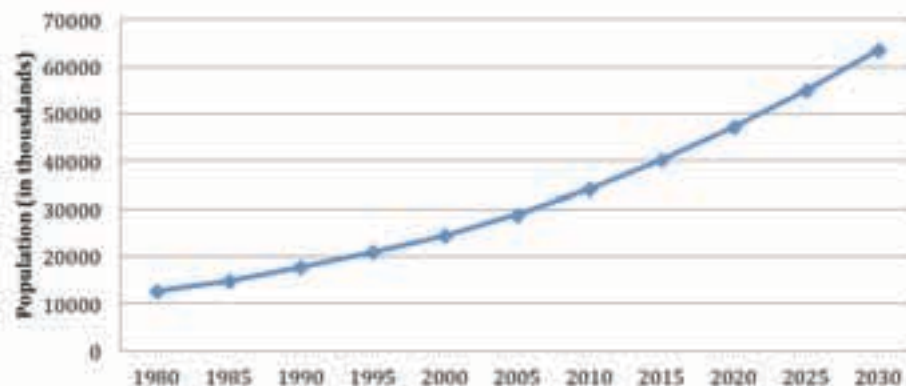


FIGURE 2: TRENDS IN POPULATION AND PROJECTED POPULATION UNTIL 2030

SOURCE: UN/DESA, 2012

2.1.2 Income poverty

The Government has made great strides in reducing the proportion of the population living on a low income, from 56% in 1992/93 to 19.7% in 2013/14, achieving the MDG target of halving the proportion of its population living in extreme poverty by 2015 (World Bank, 2015). However, income inequality is increasing and 22% of children (4.4 million) still live in income-poor households. Recent assessments show increasing incidences of chronic poverty from 2009–11 and an increasing vulnerability to poverty (Ssewanyana and Kasirye, 2012), with around 10% of households categorised as being in chronic poverty (i.e. poverty over multiple years). Furthermore, 70% of those who escaped poverty were simply replaced by households that fell into poverty.

In addition, while poverty is spread across the country, there are big disparities across the regions. Karamoja has by far the highest rates of poverty, with 75% of households living below the official poverty line and eight out of 10 households in the lowest quintile of wealth (UBOS and ICF International, 2012). Table 1 presents the Gini coefficients over the last decades showing that between 2005 and 2013, income inequality increased at the national level from a coefficient of 0.41 to 0.40 (UBOS and ICF International, 2012) and then to 0.39 in 2012/13 (UBOS, 2014a), with greater income inequality in urban areas than rural areas. The majority of children (3,655,200, 84%) living in income-poor households reside in the Northern and Eastern parts of the country which have 47% and 37% of the country's children, respectively (UBOS and ICF International, 2012; see Appendix 2).

TABLE 1: INCOME INEQUALITY BY REGION: GINI COEFFICIENT (2005/06–2012/13)

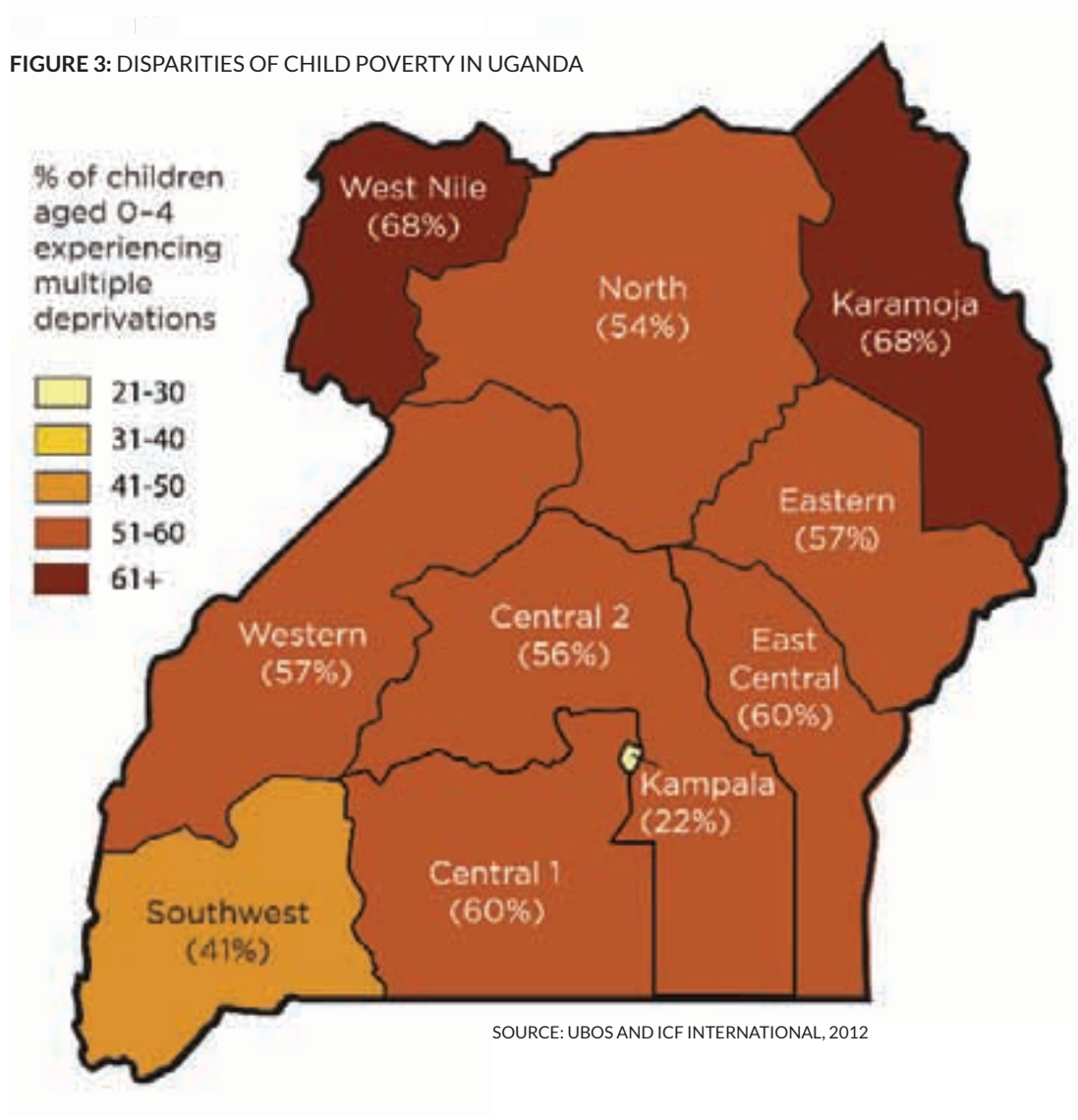
	2005/06	2009/10	2012/13
National	0.408	0.426	0.395
REGIONAL			
Central	0.417	0.451	0.392
Eastern	0.354	0.319	0.319
Northern	0.331	0.367	0.378
Western	0.342	0.375	0.328
LOCATION			
Rural	0.363	0.375	0.341
Urban	0.432	0.442	0.410

SOURCE: UBOS AND ICF INTERNATIONAL, 2012 AND UBOS, 2014A

2.1.3 Child poverty and deprivation

Income poverty contributes to some of the deprivations that children face. However, a child can be deprived even when the household income is above the poverty line. The Situation Analysis of Child Poverty and Deprivation in Uganda report measures multidimensional poverty and captures deprivation in seven dimensions: nutrition, health, water, education, shelter, sanitation, and information (MoGLSD et al., 2014). This showed that about 55% (3.7 million) of Uganda’s under-five children and 38% of 6–17-year-olds are deprived in at least two poverty dimensions. Children aged 0–4 years whose mother has no education are five times more likely to live in extreme poverty than those whose household head has secondary education. Child poverty rates for 0–4-year-olds are highest in West Nile and Karamoja, where 68% are in poverty. For children aged 6–18 years in Karamoja, the percentage of those living in extreme poverty is even higher (82%) (MoGLSD et al., 2014). Child poverty is lowest in the south-west of the country where 41% of children below five years live in poverty. In Kampala, child poverty affects about a fifth of children below five years. The map in Figure 3 illustrates the disparities in deprivation-based child poverty across the country.

FIGURE 3: DISPARITIES OF CHILD POVERTY IN UGANDA



The most common deprivations for under-fives are in the areas of nutrition (38%), health (34%) and access to improved water source (30%). With under-five malnutrition representing the most common form of deprivation in Uganda, and given that 85% of a child's core brain structure is formed by the age of three, undernutrition and stunting early in life can lead to significant impairment of brain cell development with lifelong consequences for children. With child poverty being higher in rural areas and northern Uganda than the rest of the country, there are wide disparities among children living in poverty across the country.

Furthermore, there is evidence that these deprivations create a 'vicious circle of poverty' in which children who suffer deprivations in childhood grow up and become parents who produce children who suffer the same. For example, the health, education and protection outcomes of children whose mother's highest level of education is primary school or none are much lower than those of children whose mothers completed secondary school – thus producing a self-sustaining intergenerational cycle of poverty. Consequently, the evidence shows that children aged 0–4 years whose household's head has no education are five times more likely to be in extreme poverty than those whose household head has secondary education (MoGLSD et al., 2014).

In terms of household size, as expected, child headcount indices are also much higher in rural Uganda than in urban areas (30.5% vs. 12.4%; UBOS, 2010). In addition, 90% of children with disabilities do not access or enjoy their rights to survival, development, protection and participation (USDC and NCC, 2011). Socio-cultural beliefs stigmatise and discriminate against those with disabilities, creating unequal opportunities for disabled children. With such regional, gender, income, age, and disability-related disparities in the country, this situation analysis seeks to show that issues related to poverty and wellbeing deprivations are inextricably linked to inequity across various domains.

2.1.4 Adolescent girls

Of all inequalities, gender is of specific concern as girls in Uganda face various constraints on their capabilities. The country is ranked 73rd out of 86 in the 2012 Social Institutions and Gender Index and 73rd out of 102 in the 2009 Social Institutions and Gender Index. Approximately 35% of girls drop out of school because of early marriage and 23% do so because of pregnancy (UBOS and ICF International, 2012). Over 15% of ever-married women aged 20–49 are married by the age of 15 and nearly half (49%) by the age of 18. Teenage pregnancy rates are high (24% at the national level) with regional variations such that 34% of teenage girls from the poorest households and 24% of rural girls become mothers compared with 16% of wealthier households and 21% of urban girls (UBOS and ICF International, 2012). Antenatal care is more easily available than postnatal care, but family planning and sexual and reproductive health services are limited, especially in rural areas (Perezniето et al., 2014).

Gender-based violence (GBV) continues to be a pervasive problem with about 6 in 10 women (58%) agreeing that wife beating is justified if the woman does not comply with culturally expected gender roles. Harmful FGM/C traditions are declining – with less than 2% of women nationally being circumcised (UBOS and ICF International, 2012). However, it is still widely practised by some ethnic groups living in specific geographic areas. Among the Pokot in the Karamoja sub-region, for example, the practice is nearly universal (95%) (UBOS and ICF International, 2012).

Moreover, in conflict situations, adolescent girls are the most vulnerable and the frequent targets of brutal, indiscriminate acts of violence. Various studies and assessments indicate that children formerly associated with the Lord’s Resistance Army (LRA) and young mothers who were abducted as children and return with babies born in captivity are ostracised and have difficulty reintegrating into their communities (MoGLSD, 2009). In light of these inequalities and discrimination, this situation analysis has a special focus on the status of girls’ and women’s rights in addition to describing the situation of children in poverty in general.

2.1.5 Urbanisation

Children who live in rural areas are three times more likely to be poor than those in urban areas. However, urban environments and the effects of rapid urbanisation exhibit a variety of characteristics that combine to put children in cities and towns at risk. Although service provision and access, as well as child poverty, are less pronounced issues in urban settlements, the degree of unplanned developments in cities leads to concentrated service deprivation for the most vulnerable populations – including migrants and street children. Risks include environmental degradation, unsafe shelters, high rates of HIV/AIDs infections, a lack of land rights and tenure security, contaminated water and sanitation facilities, and higher concentrations of community violence. All of these are potential protection issues concerning children, and are in turn compounded by complex stakeholder responses and limited municipal financing (MoH, 2014a).

The Government’s National Slum Upgrading Strategy provides measures to improve conditions as well as prevent the expansion of new settlements. This strategy moves away from regulation and control through rigid laws and by-laws towards flexible planning, which enables citizens to engage more actively in upgrading initiatives. The strategy includes specific references to the MDGs – particularly the reduction of child mortality and extreme poverty.

2.1.6 Emergency factors

Uganda is surrounded by countries which pose a range of challenges to internal and regional stability. Although the general humanitarian situation has improved, Uganda is repeatedly



3 THE RIGHT TO SURVIVAL

This chapter discusses the situation of women and children in Uganda in relation to the right to survival and the progress being made in relation to maternity, ante- and postnatal care; nutrition; disease prevention; immunisation; access to clean water and sanitation; and care for women and children during natural disasters.

3.1 INTRODUCTION AND OVERVIEW

Uganda's public health system operates at several levels. There are four levels of health centre: village-level HCIs that have no physical infrastructure; parish-level HCIIIs; sub-county level HCIIIs; and county-level HCIVs. Above these are district, regional and national hospitals. The range of services and number of doctors present at a health facility increases as the health centre level increases (MoH and Macro International, 2008), with over 80% of doctors and 60% of nurses located in hospitals, which mainly serve urban populations (MoH, 2013b). Severe human resources deficits in rural areas pose major obstacles to accessing quality health care in hard-to-reach areas (UAC, 2014b). HCIIIs and IVs are provided with only two and three midwives respectively (MoH, 2013b) and, according to the Ugandan AIDS Commission, up to 34% of those who need sexual and reproductive health (SRH) and family planning services are not able to access them (UAC, 2014a).

Although the Government abolished user fees in 2001, people are still often charged for health services. There is a lack of midwives and skilled health workers to assist mothers before, during and after childbirth, particularly in rural areas, and a lack of funding for training and recruitment. Frequent medicine stock-outs cause families to make out-of-pocket payments to pharmacies and drug outlets to obtain treatment (MoH, 2013a). Conversations with stakeholders reveal that informal expenses remain a key barrier to service use – either directly or because of the expectation of additional fees.

A National Health Insurance Bill, which will require formal sector employees to contribute 4% of their monthly income, is currently before Parliament. However, this will not solve the problem of out-of-pocket payments by poor people, who are the most vulnerable (MoH, 2013).

A lack of awareness and social norms present demand-side challenges to health outcomes. Without information, caregivers are unable to identify symptoms and women are unaware of the importance of ante- and postnatal care and skilled assistance during childbirth. Due

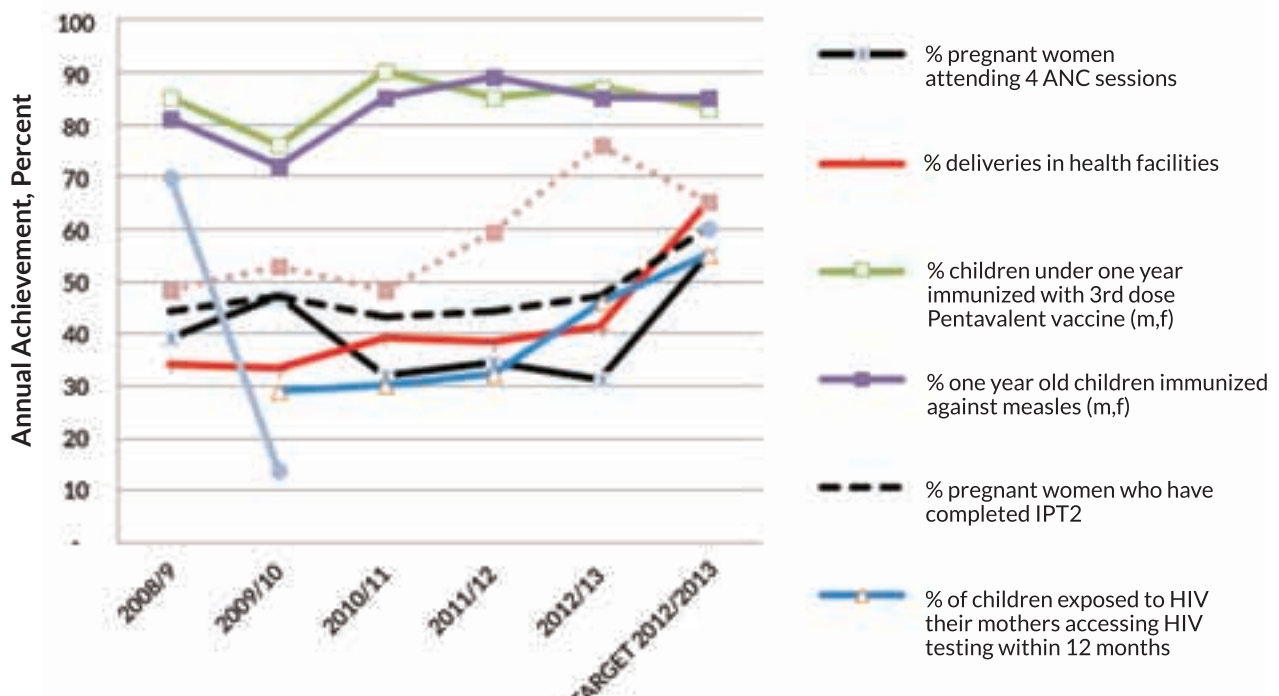
to gender norms about household decision-making and a lack of male involvement in health issues, demand for health care measures such as immunisation, antenatal check-ups and treatment for childhood illnesses (such as oral rehydration salts (ORS) for diarrhoea) is low (UBOS and ICF International, 2012; MoH, 2013b). There are strong traditional beliefs regarding the causes and treatment of diarrhoea, compounded by low perception of ORS efficacy, the safety of immunisations and the appropriateness of long-term family planning methods, among other issues (MoH, 2013b). Women who are poor and/or living in rural areas are less likely to access health services.

3.2 PROGRESS IN ACHIEVING CHILDREN’S RIGHT TO SURVIVAL IN UGANDA

Despite a steady decline in infant and under-five mortality rates – from 147 deaths per 1,000 live births (LB) in 1995 to 90 deaths per 1,000 LB in 2011, Uganda is unlikely to meet its MDG 4 target of 56 deaths per 1,000 LB by the end of 2015 (MoH, 2013b). It is estimated that 167,000 children under five and 101,000 under one year die every year (UBOS and ICF International, 2012). Child mortality levels are higher in rural areas and in Karamoja, West Nile and South-West regions (see Appendix 2).

Figure 5 shows trends in health service coverage between 2008/09 and 2012/13 for vulnerable children and pregnant women.

FIGURE 5: TRENDS IN HEALTH SERVICES COVERAGE FOR VULNERABLE CHILDREN AND PREGNANT WOMEN 2008/09–2012/13



SOURCE: MOH, 2013B

Overall, rural populations have poorer health outcomes and are the most deprived, due to: lack of access to health services; low immunisation levels; and environmental factors such as lack of access to hygiene, sanitation, and safe, clean water, and reliance on firewood for cooking. The regions with the worst child health outcomes and some of the highest levels of vulnerability among adolescent girls are Eastern, East Central and Karamoja (UBOS and ICF International, 2012; Amin et al., 2013). For more details, see Appendix 2.

3.3 PROGRESS AND CHALLENGES IN SERVICE PROVISION

3.3.1 Family planning, newborn health and maternal mortality

FAMILY PLANNING SERVICES

There is high unmet need for SRH/family planning services in Uganda. Although family planning services are available in 92% of facilities, only 21% have all the required tracer items (MoH, 2013d). Only 49% and 44% of facilities have at least one trained member of staff and family planning guidelines, respectively. The adolescent fertility rate has declined from 24% in 2009 to 18% in 2012 but fertility is significantly higher among rural women; rural women will give birth to nearly three more children during their reproductive years than urban women (6.8 and 3.8, respectively) (UBOS and ICF International, 2012), suggesting a rural/urban disparity in access to family planning.

Findings from Perezniето et al. (2014) indicate that adolescent girls in all localities (rural and urban) are concerned about sexually transmitted diseases (STDs), but had limited information about how to prevent infection. For example, the Ministry of Health (MoH) service availability and readiness assessment (MoH, 2013d) found that 84% of family planning services had male condoms but only 14% had female condoms. The Uganda Demographic and Health Survey (UBOS and ICF International, 2012) suggests that approximately 30% of females report using contraception (a 6% increase since 2006). The service availability and readiness assessment in 2013 finds that adolescent health services and HIV counselling and testing are offered in only 59% and 60% of facilities respectively.

MATERNAL MORTALITY

Maternal mortality in Uganda has declined from 527 deaths per 100,000 live births in 1995 to 438 deaths per 100,000 live births in 2011 (UBOS and ICF International, 2012). The current rate is still far from the MDG 5 target of 131 deaths per 100,000 live births by the end of 2015. Regional disaggregation for maternal mortality is unavailable. The main direct causes of maternal mortality are haemorrhage (accounting for 42% of deaths), obstructed or prolonged labour (22%) and complications from unsafe abortion (11%). Important indirect causes include malaria (a factor in 36% of maternal deaths), anaemia (11%) and HIV/AIDS (7%) (MoH, 2013b).

Even though FGM/C rates are relatively low in most areas of the country, they are related to complicated labour and delivery, often leading to maternal mortality. In Sabinu, where FGM/C rates are up to 13.5% (Namulondo, 2009), each family is said to have at least one casualty of FGM due to the fact that there is generally extensive scarring caused by Sabinu excision. A country profile of FGM in Uganda (28 Too Many, 2013) finds that there is also risk to the baby if the mother has been circumcised. For example, girls and women with Type III cutting⁵ are 66% more likely to have babies that need to be resuscitated.

Statistics show that highly educated women (to secondary level and above) are more likely to be assisted by a skilled birth attendant than uneducated women (81% and 38% respectively) (UBOS and ICF International, 2012). The UDHS speculates that respondents in urban areas are often more educated and wealthier than their rural counterparts, so the perceived relationship between education and health may be more to do with urban location, socioeconomic status and greater access to services. These correlations could explain the fact that women in the highest wealth quintile are also much more likely to be assisted by a skilled attendant (88%) than women in the lowest wealth quintile (44%; UBOS and ICF International, 2012). Major disparities in delivery at health facilities by women are noted across regions, Karamoja having the lowest rate (27.1%), followed by South-West (40.3%), Eastern (51.2%), North (51.9%), Western (55.9%), West Nile (58.7%), Central 1 (61.7%), Central 2 (69%) and Kampala (92.9%). In South-West region, 19% of women give birth with no one in attendance (see Appendix 2).

Ante- and postnatal care

Uptake of many lifesaving health services – such as antenatal care – remains low. Although 95% of pregnant women attend their first antenatal visit, only 48% complete the World Health Organization (WHO) recommended minimum of four antenatal visits, and most of these women live in urban areas (UBOS and ICF International, 2012). This is far below the national target of 75% by the end of 2015 (MoH, 2013b). Further, only one in two women who attend an antenatal clinic is warned about pregnancy complications.

Nationally, 71% of facilities offer antenatal care. However, certain regions have significantly greater service provision than others: Central, West Nile and Kampala regions have a high percentage of facilities offering antenatal care. In the North-Eastern, Western and South-Western regions the number of antenatal care facilities is much lower (MoH and Macro International, 2008). Women in the Central and Kampala regions are more likely to receive antenatal care from a doctor, whereas women in the Eastern, Karamoja and West Nile regions are least likely.

Despite the importance of high-quality antenatal care (ANC) services, items that support high-quality ANC counselling (visual aids, ANC guidelines and individual client cards) are not available in most facilities offering ANC services (MoH and Macro International, 2008).

5. Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Items for infection control are available in only one-third of health facilities offering ANC services. Iron and folic acid tablets are not universally available in all facilities offering ANC services. On average, less than one-quarter of facilities have all essential equipment and supplies for basic ANC (MoH and Macro International, 2008).

Although the percentage of births assisted by a skilled attendant has gone up to 58%, only 2% of women receive a postnatal check-up within the first hour after delivery and only one-third in the first two days (UBOS and ICF International, 2012), and again this is mostly in urban areas. In South-West region, just 19% of women receive a postnatal check-up within 48 hours (see Appendix 2).

Child and newborn health

According to the 2013 Reproductive, Maternal, Newborn and Child Health (RMNCH) plan, pneumonia, malaria, diarrhoea and infections like HIV together account for more than 70% of under-five deaths (MoH, 2013b). The immediate causes of infant mortality are hypothermia (37%), premature birth (18%) and pneumonia and infections (15%) (UNICEF, 2014). Barriers to receiving good health care range from a lack of access to poor quality of services.

The highest child mortality rates are in the Karamoja, South-West and Western regions. Children born in rural areas and households in the lowest wealth quintile (UBOS and ICF International, 2012) are more likely to die. All regions still have mortality rates high above the MDG target of 56 per 1,000 live births, but Kampala and the Central regions have comparatively lower mortality rates (see Table 2 and Appendix 2).

TABLE 2: REGIONAL DISAGGREGATION OF CHILD HEALTH INDICATORS

	Infant mortality ^{*1}	Child mortality ^{*1}	Height-for-age (% below 2 SD)	Full immunisation (%)	Handwashing provision (%) ^{*2}	Diarrhoea (%) ^{*3}
Kampala	47	19	10.4	63.4	39.0	24.1
Central 1	75	37	27.7	43.9	50.1	22.3
Central 2	54	35	30.8	43.0	45.1	20.9
East Central	61	48	28.8	39.2	30.6	31.9
Eastern	47	41	21.3	52.4	25.2	32.5
Karamoja	87	72	36.7	62.2	12.5	20.3
North	66	42	19.6	49.0	7.2	23.8
West Nile	88	41	31.0	52.1	16.4	18.7
Western	68	52	35.7	59.7	22.1	18.8
South-West	76	57	36.3	61.6	20.5	14.0

*1 Per 1,000 live births

*2 Percentage of households where a place for washing hands is observed

*3 Children with diarrhoea in the two weeks preceding the 2011 UDHS

No regional disaggregation of maternal mortality

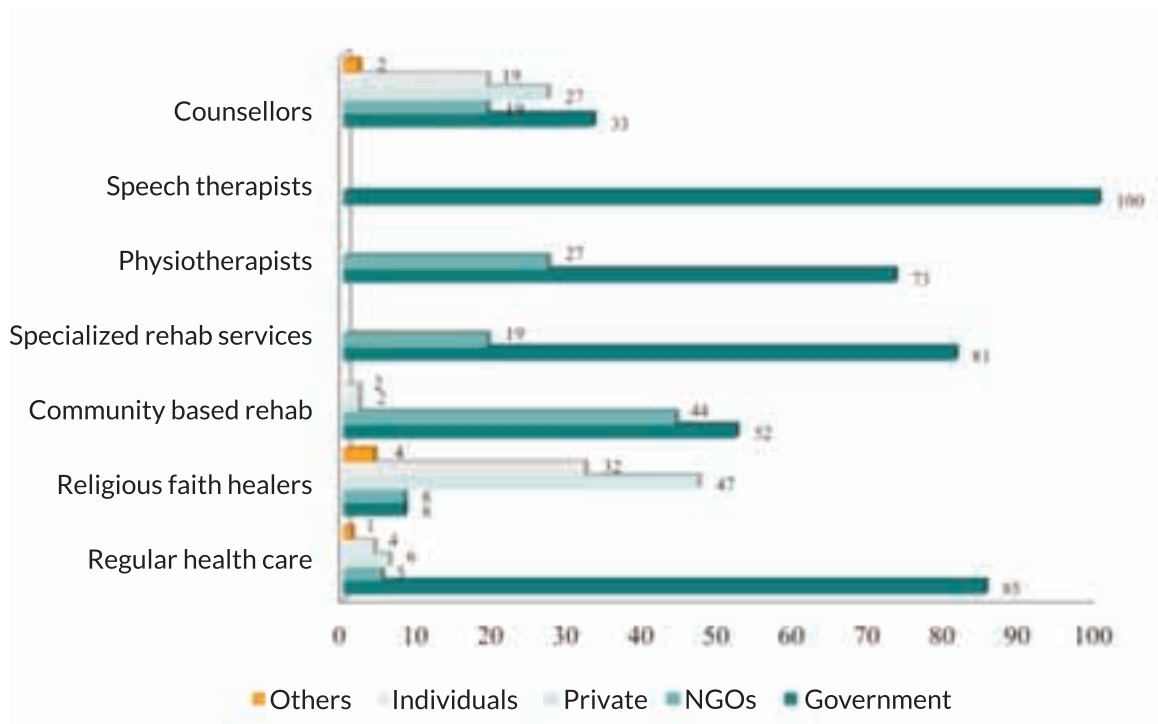
No regional disaggregation of four antenatal visits

No regional disaggregation of percentage of population living with HIV

According to the MoH’s service availability and readiness assessment (MoH, 2013d), only 1% of facilities meet all the child health services across the four readiness components (staff and guidelines, equipment, diagnostics, and medicines and commodities). Moreover, basic emergency obstetric and newborn care (BEmONC) services are available in only 15% of facilities, while neonatal resuscitation is available in 51%.

Children with disabilities are especially vulnerable since the major causes of disability are inadequate ante- and neonatal health care services as well as rehabilitation facilities. Causes of disability range from poor nutrition (lack of Vitamin A may lead to blindness) to the prevalence of communicable diseases. In fact, studies find that from one-third to half of disabled children acquired an illness before the age of five years that led to disability (ACPF, 2011; UBOS, 2002). Figure 6 represents the types of services available to children with disabilities in Uganda.

FIGURE 6: HEALTH CARE SERVICE PROVIDERS USED BY CHILDREN WITH DISABILITIES



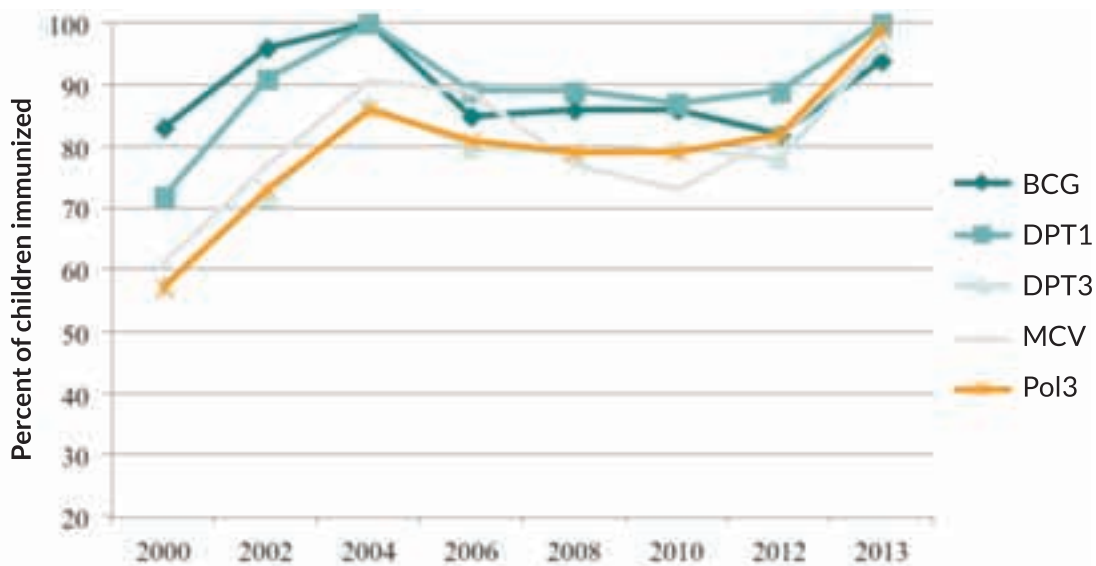
SOURCE: ACPF, 2011

3.3.2 Immunisation

Uganda’s immunisation schedule includes tuberculosis, polio, measles, diphtheria, tetanus, whooping cough, hepatitis B, and haemophilous influenza type B (MoH, 2012a). However, although vaccination coverage in Uganda has improved over the last 10 years (see Figure 7), in 2011 only 52% of children aged 12–23 months were fully vaccinated and only 40%

of children aged 12–23 months were immunised before their first birthday (UBOS and ICF International, 2012). The Expanded Programme on Immunisation (EPI) under the Ministry of Health is aimed at ensuring all children are fully immunised by their first birthday, but as of 2013 it is only available in 80% of facilities (UNICEF, 2014). Previously there were gender disparities in rates of immunisation but by 2011, 51.7% of girls aged 12–23 months and 51.6% of boys had had all basic vaccinations (UBOS and ICF International, 2012). However, 4.4% of girls have no vaccinations compared to 3% of boys, suggesting that there is still a need to ensure that all children – girls and boys – receive their basic vaccinations.

FIGURE 7: TRENDS IN IMMUNISATION BY TYPE OF VACCINE (2000–13)



SOURCE: WHO, 2014

Children living in urban areas are more likely than those living in rural areas to be fully vaccinated (61% and 50%, respectively). According to the 2011 UDHS, children residing in Kampala (63%), South-West (62%), and Western (60%) regions are most likely to have received all their vaccinations, while children living in the East Central (39%), Central 1 (44%) and Central 2 regions (43%) are the least likely to be fully immunised (see Appendix 2). Vaccination coverage decreases as birth order increases: firstborn children are more likely to be fully immunised (58%) than sixth or higher births (43%) (UBOS and ICF International, 2012). Men’s minimal participation in health care, particularly vaccination services, also has a negative effect on the routine immunisation of their children (UBOS and ICF International, 2012; MoH, 2012a).

Children in households from the middle wealth quintile are less likely to have been fully immunised than children in households in other wealth quintiles: in the 2011 UDHS, 50.6% of children from the lowest quintile and 54.9% of children from the highest quintile were fully vaccinated, but only 48.7% from the middle quintile were vaccinated (UBOS and ICF International, 2012).

3.3.3 HIV and AIDS

Uganda has achieved a remarkable reduction in new HIV infections among children. Numbers have gone down from 27,660 in 2011 to 9,629 in 2013, thus achieving the National Priority Action Plan (NPAP) target for 2013, which stood at 10,000 (UAC, 2014a). Although 85% of HIV-positive mothers and 37% of exposed infants received antiretroviral therapy (ART) for the prevention of mother-to-child transmission (MTCT) (UAC, 2014b), according to UNAIDS projections, the number of AIDS-related orphans has increased from 223,811 in 1990 to 1,380,261 in 2012 (UAC, 2014b). With the recorded successes in the eMTCT and ART programmes, the country currently faces an unprecedented HIV/AIDS burden among the adolescent age group as a significant proportion of vertically infected children survive and graduate into teenage years.

The latest Ugandan National Household Survey (UNHS) shows that 11.3% of children in Uganda are orphaned, while 38% are considered to be vulnerable (UBOS, 2014a) and, while this figure has reduced from 14.6% in 2005/06, it is nevertheless a demographic that needs particular attention and resource allocation. In addition urban populations are disproportionately more likely to be infected (8.7%) compared to rural residents (7%). Urban women in particular are more at risk, with prevalence rates at 10.7% vs. 7.7% in rural women (UAC, 2014a).

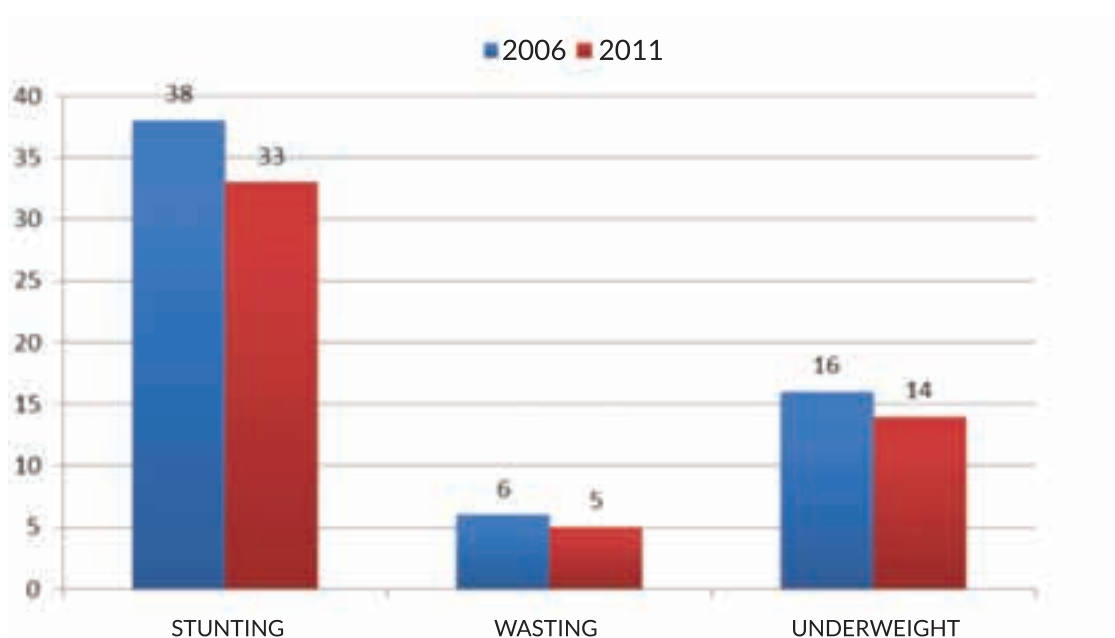
Adolescent girls are also severely and unevenly at risk, with two-thirds of all new HIV infections found in this section of the population. While the number of AIDS-related deaths in children aged 0–4 years decreased significantly from 100,000 between 2000 and 2012, the number of deaths in adolescents increased from less than 50,000 to over 100,000 during the same period (UNICEF, 2013). The 2013 estimates show that children below 15 years of age account for 11% of all HIV cases in Uganda and HIV is now the second leading cause of death among adolescents (300 deaths every day) (UNAIDS, 2014). Although HIV positivity was lower among pregnant adolescents (3%) compared to older pregnant women (4.9%), access to ARVs was lower among the adolescent group (94%) than among older pregnant women (99%).

It is estimated that 18% of new HIV infections are due to mother-to-child transmission (MoH, 2013b). The Government is therefore rapidly rolling out revised WHO guidelines to ensure that HIV-infected mothers and their babies receive triple ARV prophylaxis during labour and throughout breastfeeding, and that mothers continue treatment for life (MoH, 2013b). Coverage of HIV-positive pregnant mothers accessing the package of eMTCT services now stands at 85% (MoH, 2014c). Thirty-three districts have full coverage. However, over half of pregnant women in four districts (Mayuge, Kaabong, Otuke and Abim) who were identified as HIV-positive did not receive ART for the prevention of MCTC and only in 29% of districts did all pregnant women identified as HIV-positive receive ART for the prevention of MCTC (MoH, 2014c – see Appendix 2). MTCT treatment coverage has improved but the level of unmet need is substantial, particularly among eligible children (UAC, 2014b).

3.3.4 Nutrition

Although progress has been made over the last two decades, undernutrition accounts for 40% of all child deaths in Uganda (Shively and Hao, 2012). Improvement has been minimal in the three core areas identified as representing undernourishment – stunting, wasting and underweight (Figure 8).

FIGURE 8: NATIONAL TRENDS IN PREVALENCE OF UNDERNOURISHMENT IN CHILDREN UNDER FIVE



SOURCE: UBOS AND MACRO INTERNATIONAL, 2007; UBOS AND ICF INTERNATIONAL, 2012

From 2006 to 2011, stunting declined slightly from 38% to 33%, wasting from 6% to 5% (UBOS and ICF International, 2012), and the percentage of children found to be underweight decreased from 16% to 14%. The rate of exclusive breastfeeding during the first six months stands at 63%. Vitamin A deficiency was 38% among children under five years and 36% for women of childbearing age (UBOS and ICF International, 2012) while anaemia continues to affect 49% of children aged six months to four years, and 60% of pregnant women. In Karamoja and West Central, the prevalence of anaemia in children is 70% and 68% respectively, while nationally it ranges from 59% in the lowest wealth quintile to 38% in the highest wealth quintile (see Appendix 2).

Stunting

Although progress over the past years was relatively more visible in stunting compared to wasting and underweight, one-third of children under five across the country (over 2.4 million) are stunted, with the highest rates in Karamoja and the lowest in Kampala (UBOS and ICF International, 2012 – see Appendix 2).

Major variations in stunting rates also exist across background characteristics. Children in rural areas, from lower wealth quintiles and with mothers who have been educated to a lower level are disproportionately more affected by stunting than their counterparts. Male children are also more affected than female children (37% vs. 30%). The persistence of stunting – even among children in relatively high-income and agricultural output zones, such as the South-West – suggests that the factors around stunting can be highly rooted in social norms and attitudinal dimensions (see Box 1).

BOX 1: CHILD STUNTING IN SOUTH-WEST REGION

The persistent issue of child stunting in south-western Uganda is testament to the complex challenges facing children’s health and ECD in the country. Given uneven progress in child nutrition and calorie intake compared to steady growth in real incomes and agricultural outputs from other contexts (Deaton and Drèze, 2009), the situation in Kabale appears to be similar. For instance, as of 2006, the stunting prevalence in Kampala was 22%, compared to 49.6% in the South-West region – only a small proportion of which could be attributed to differences in income (EPRC, 2012). Primary research across several sites in Kabale revealed several attitudinal and inequality drivers for these statistics. These included limited awareness of and familiarity with the critical importance of appropriate nutritional intake for children during their crucial first 1,000 days, limited appreciation of the short- and long-term effects of stunting, and mistrust of and speculation about the role of VHTs and district health workers. Major drivers for continued stunting, as outlined by women and men themselves, were the gender dimensions associated with time poverty and the reproductive role of mothers, as well as their inability to bargain at household level to allocate agricultural produce – including more valuable cash crops – to ensure the nutritional wellbeing of children.

SOURCE: PRIMARY FIELDWORK IN KABALE, 2014

Underweight

Nationally, more than 145,000 babies have a low birth weight and 14% of children under five (over 1 million) are underweight, with Karamoja once again recording the highest prevalence (32%), and Kampala the lowest (6%) (UBOS and ICF International, 2012 – see Appendix 2).

There are also disparities across other characteristics: rural vs. urban (15%, 7%); male vs. female children (15%, 13%); mother with a body mass index (BMI) of less than 18.5% vs. those who are overweight/obese (23%, 7%); educational level (11% for secondary plus vs. 20% for non-educated mothers); and income (18% in lowest wealth quintile and 8% in the highest) (UBOS and ICF International, 2012 – see Appendix 2).

There are multiple causes for undernourishment of children and women, as identified by the 2011 Uganda Nutrition Action Plan (UNAP). Household food insecurity as defined by poor access to the range of foods needed for a diversified diet contributes to consumption of food that is deficient in micronutrients. Additional factors include the care-related burdens,

birth-spacing, and limited institutional awareness that nutrition is critical to the country's economic development and to efforts to reduce child and maternal mortality. Finally, poor sanitation is a factor, causing stunting and poor cognitive development of children aged less than two years, which later affects their economic performance (MWE, 2013).

3.3.5 Health promotion, disease prevention and community health initiatives

The Government's recognition of the importance of involving communities in health service delivery is demonstrated in its establishment of Health Unit Management Committees (HUMCs) and Village Health Teams (VHTs). With HUMCs, the government trains community members to promote practices for improving children's health by spreading awareness of prevention methods, home care and recognising warning signs for illnesses. VHTs consist of four to five locally-elected volunteers, one-third of whom must be women (MoH, 2013b). As well as encouraging health-promoting actions, VHTs distribute condoms, and medicines for common childhood illnesses (UBOS and ICF International, 2012). All the four to five VHT members per village are trained in the VHT basic package, which includes disease prevention, health promotion, health education, community mobilisation, and the promotion of good hygiene and sanitation practices. Notwithstanding the visible impact of VHTs, the high member turnover due to irregular supervision and lack of incentives continues to limit the scope of their effective deployment (MoH, 2013b).

Water, sanitation and hygiene (WASH)

In 2010, the UN explicitly recognised clean water and sanitation as a human right, fundamentally tied to the right to survival. In Uganda, the Ministry of Water and Environment (MWE) and the MoH are responsible for setting national policies and standards, managing and regulating water sources and determining priorities for water development and management. Development partners contribute to the water and sanitation sub-sector by mobilising funds, supporting water and sanitation infrastructure development, and building the capacity of communities to demand, develop and maintain WASH facilities. However, a 2013 review by the National Sanitation Working Group noted that insufficient funding for sanitation from the district conditional grant remains a major roadblock to the roll-out of large-scale sanitation programmes. National and international civil society organisations therefore continue to play an important role in mobilising funds for water programmes (MWE, 2013).

The main challenges to providing access to water, sanitation and hygiene are related to declining sector funding from 3.2% in 2012/13 to 2.8% in 2013/14 (MWE, 2014); lack of ownership; inadequate operations and maintenance; inadequate capacity of institutions, particularly the local government's capacity to utilise allocated funds; and low private sector capacity, especially in relation to availability of spare parts for maintenance of water facilities.

The main demand-side barrier preventing adequate hygiene is lack of awareness about the importance of hygiene and handwashing (MWE, 2013). In addition, high enrolment levels have put a strain on school sanitation and hygiene facilities in areas where authorities have not budgeted for increased numbers of users, leaving the pupil to stance ratio at 70:1 in 2013. Other demand-side factors affecting access to water include location, vandalism and the financial inability for some families to pay user fees.

WATER

A recent child poverty report (MoGLSD et al., 2014) shows a substantial reduction in the proportion of children without access to safe water, from 39% in 2010 to 30% in 2013. This finding is consistent with a general decline in poverty and deprivation in Uganda over the decade. The Western region, followed by Central region, has the largest proportion of children deprived of a source of improved water in all survey years (46% and 38%, respectively, in 2011), statistics that are two to three times that of Eastern region (14% in 2011). Indeed, the Eastern region has shown the greatest improvement, with a deprivation rate that was cut by more than one half (from 32% to 14%) between 2000 and 2011 (UBOS and ICF International, 2012 – see Appendix 2).

While the share of children without access to an improved water source fell, the share of children living more than 30 and 60 minutes (return) from the nearest source of water has remained close to 60% and 36%, respectively. Distances to the nearest source of water are greatest in the North (73% requiring more than 30 minutes) and in rural Uganda (66% requiring more than 30 minutes).

There is also a rural/urban discrepancy in access to improved drinking water, with nine in 10 households in urban areas using improved water sources compared to only two in three households in rural areas (UBOS and ICF International, 2012).

SANITATION

The proportion of households with any type of latrine increased from 69.6% in 2011/12 to 71% in 2012/13 for rural areas, and from 81% to 82% in urban areas (MWE, 2013). Rural sanitation coverage is below the 2015 national target of 77% coverage. Based on the current trends, only 53 (of 112) districts will meet the national target by 2015 (MWE, 2013).

Nearly one-third (29%) use an unimproved toilet (generally uncovered pit latrines) and over 40% use either an unimproved or a shared toilet. There are substantial disparities in sanitation deprivation in Uganda. For instance, the proportion of children with no toilet in the North is more than seven times that of the Central region, with Eastern Uganda roughly in the middle (see Appendix 2). The poorest quintile is by far the most affected (36% of children are without any kind of toilet).

Prevalence of diarrhoea varies according to location, although according to the 2011 UDHS, rural children are only slightly more likely than urban children to get diarrhoea (24% and 22%; UBOS and ICF International, 2012). Overall, 72% of children with diarrhoea are taken

for advice or treatment at a health facility and slightly more than half (55%) of children were given either oral rehydration treatment (ORT) or increased fluids (UBOS and ICF International, 2012). Additionally, Perezniето et al. (2014) found in their qualitative work that many mothers in their study had limited knowledge about water-borne diseases and treatment of water, which resulted in children falling ill with easily preventable infections.

HYGIENE

Only four in every 50 households have a handwashing facility with soap and water (UNICEF calculation based on UBOS and ICF International, 2012). Handwashing with water and soap is practised most in households in the Kampala, Central 1, and Western regions and least in Karamoja and West Nile regions. Overall, 8% of mothers of under-five children had soap and water readily available for handwashing, far beneath the MWE 2015 target of 50%. Access to handwashing in rural areas is estimated at 29% (MWE, 2013), meeting the national MWE action plan target for financial year 2012/13.

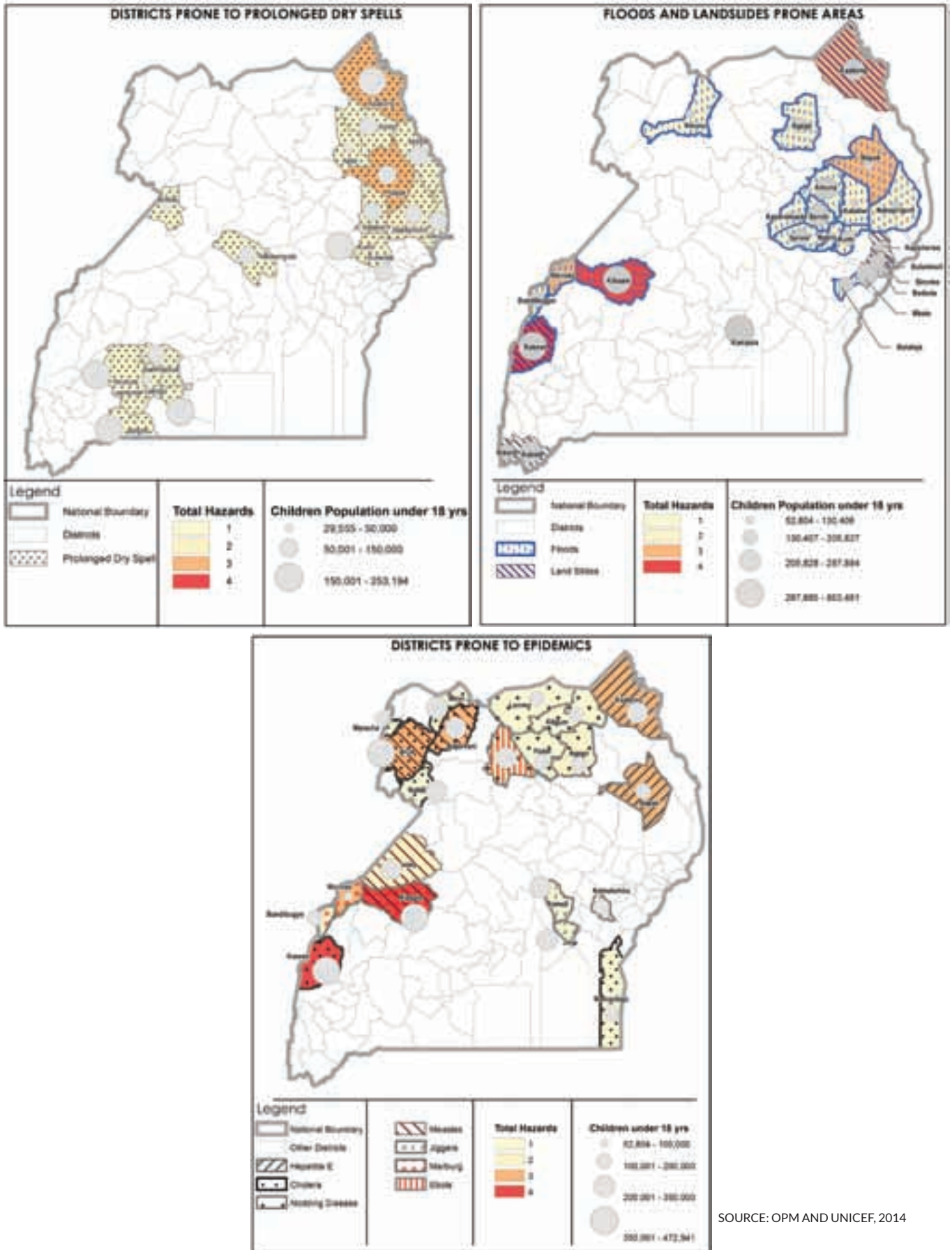
Management of minor repair and maintenance of water facilities is the responsibility of Water and Sanitation Committees (WSCs), who contribute cash, and operate and maintain rural water supply and sanitation facilities from each water point. While there is general recognition of the importance of improving the governance of water systems, there seems to be some inadequacy in commitment and ownership among actors responsible for the different areas of the agreed action plan (MWE, 2013).

3.3.6 Survival during emergencies

As a result of climate change and environmental degradation, large areas of Uganda have been affected by prolonged dry spells and an increase in the frequency and intensity of flooding. Prolonged dry spells have become a regular occurrence in the cattle corridor stretching from Western and Central to mid Northern and Eastern Uganda. Since 1982, at least six drought events have affected more than 500,000 people each, at times over 700,000. The 2014 Child-Focused Vulnerability Capacity Assessment found that communities in Karamoja are more vulnerable to the impact of prolonged dry spells because they practise mass deforestation and bush-burning; have low awareness of the effects of climate change; overly depend on agriculture and have limited alternative sources of income (OPM and UNICEF, 2014). Other studies combine structural effects – such as public under-investment and an over-emphasis on short-term safety net approaches such as food transfers (Restless Development, 2013; Levine, 2010) – as drivers of vulnerability and poverty.

The areas prone to floods are Kampala, Northern, South-West and Eastern regions. These areas are more vulnerable to floods because of low-lying terrain, poor enforcement of riverbank and wetland management regulations, unpredictable weather, poor physical planning, settlement in flood basins and poor infrastructure. Vulnerability to epidemic and epizootic disease outbreaks also remains worrying. Malaria is the commonest cause of morbidity and mortality in the country.

FIGURE 9: DISASTER-PRONE AREAS IN UGANDA



SOURCE: OPM AND UNICEF, 2014



3.4 ENABLING ENVIRONMENT

3.4.1 Fiscal space analysis

The trend in allocation of funds to the health sector shows an average increase of 20% per annum in absolute terms over the past four years of the Health Sector Strategic and Investment Plan (HSSIP). However, the allocation to health as a percentage of the total budget reduced from 9.6% in 2003/04 (MoH, 2014b) to 8.6% in 2014/15 – considerably lower than the Abuja Declaration target of 15%. This decline has taken place in the midst of rising health care demand and costs due to high population growth (see Figure 2). As a consequence, health care financing is largely dependent on household resources (43%) and donors (34%), with the Government and employers providing 23% (MoH, 2014a). Households bear most of the costs for child health care, with household expenditure constituting 61% of total health expenditure on child health in 2009/10 (MoH, 2014a). Government child health expenditure as a percentage of total government health expenditure was 11% between 2008 and 2010, despite the fact that children under five years account for about 20% of the population (MoH, 2013a). The high dependence on household-level financing reduces access to and utilisation of health services, while dependence on donor funding affects the sustainability of health financing in Uganda.

The data in Table 3 shows selected line items in Uganda's health budget that have a direct impact on child survival. It shows, firstly, that a large proportion of health expenditures are earmarked for construction of larger hospitals – especially funds managed at the central MoH headquarters. Specifically, 15% and 19% of the total health expenditures are allocated for construction-related activities in 2013/14 and 2014/15 respectively. Secondly, nearly all infrastructure costs managed centrally are externally financed. The same conditions obtain for expenditures under Global Fund for HIV, tuberculosis, and malaria and GAVI (the Global Alliance for Vaccination and Immunisation). Thirdly, most of the expenditures on health care at district level are in the form of salaries/wages, which account for 76% of district primary health care expenditures and 20% of the overall budget. The relatively high donor dependency of health expenditures suggests that any increase in public expenditures in the national budget is more likely to be financed externally than to come from domestic resources. Furthermore, the level of spending by donors on key line items such as health infrastructure projects, HIV/AIDS treatment and immunisation suggests that Uganda cannot expand these key inputs without external support, unless there is a change in the spending patterns of domestic financing. Notably, in terms of medication availability, addressing inefficiencies both at the procuring entity as well as at the health facility level could provide a cost effective measure to improve outcomes through increased uptake.

TABLE 3: SELECT INTERVENTIONS TARGETING CHILD SURVIVAL IN THE UGANDA HEALTH BUDGET
(UGX BILLIONS)

	2013/14	2014/15
(A) MINISTRY OF HEALTH (HEADQUARTERS)		
Sector monitoring and quality assurance	0.805	0.805
District infrastructure programme (AfDB/Japan)	2.6	1.9
Rehabilitation of MoH	1.6	1.3
Health system strengthening (WB/IDA)	104.4	80.6
Support to Mulago Hospital rehabilitation (AfDB)	13.4	55.8
Rehabilitation/construction of General Hospital (Spain)	12.6	12.6
Rehabilitation and equipping health facilities in Western Uganda	-	43.6
Construction of specialised neonatal and maternal facility at Mulago (IDB)	-	13.4
Construction of public health laboratories (IDA)	5.1	-
Community/public health	3.1	3.1
Disease control (malaria/IRS/nodding disease)	6.1	8.9
Sanitation fund	0.6	-
Global Fund for HIV, TB and Malaria	142.6	255.8
Global Alliance for Vaccination and Immunisation (GAVI)	60.7	48.3
<i>Subtotal expenditures (MoH)</i>	352.8	525.4
(B) DISTRICT (PRIMARY HEALTH CARE)		
Primary health care wages	228.7	248.7
Primary health care non-wage	15.8	15.8
District hospitals	5.9	5.9
Primary health care NGO hospitals	17.2	17.2
Sanitation and hygiene	2.2	2.2
Primary health care development	30.1	30.1
Rehabilitation of general hospital		3.2
<i>Subtotal district primary health care expenditures</i>	299.9	323.1
(C) NATIONAL MEDICAL STORES (NMS)	219.4	218.4
(D) REGIONAL REFERRAL HOSPITALS	70.4	68.5
(E) OTHER HEALTH EXPENDITURES	184.5	135.6
<i>Total health expenditures</i>	1,127	1,271

SOURCE: MOH, 2014B

Finally, with the exception of expenditures under the National Medical Stores, expenditures on both public health and disease control (including nodding disease, which predominantly affects children) is relatively low. Similarly, expenditures on sanitation and hygiene for control of communicable and non-communicable diseases – critical for child survival – are generally low (less than UGX 3 billion in either 2013/14 or 2014/15). Consequently, the heavy reliance on external support to meet health expenditures may be a limiting factor in expanding essential interventions for child survival.

3.4.2 Contextual, supply and demand factors

Contextual factors, social norms and budget factors can act as barriers to the realisation of children's right to survival. For example, Uganda's high maternal mortality rate is linked to various contextual factors, including high fertility, the incidence of infectious diseases and poverty (MoH, 2013b). In addition, discriminatory social norms contribute to high fertility. Women and young girls are more susceptible to HIV due to gender inequality, discrimination and sexual and gender-based violence (SGBV) (UAC, 2014b). The Uganda AIDS Commission states that GBV issues originate from institutionalised male dominance, leading to unequal power distribution in the home and society (UAC, 2014b). Social norms surrounding gender, household decision-making and care responsibilities have a damaging influence on women and children's health, as health outcomes are linked to SGBV. The UDHS acknowledges that SGBV has a damaging impact on women's physical, mental and reproductive health (UBOS and ICF International, 2012).

Structural discrimination against women and girls, including gender-based violence, economic exclusion and the lack of appropriate and affordable reproductive health services, also inhibits women's maternal health outcomes. As mentioned previously, inadequate health financing presents structural and immediate barriers to health and wellbeing.

With respect to **supply**, there are problems with service provision and availability of medical supplies. Regarding immunisation, centres often run out of vaccines, and there are problems with sessions starting late or being scheduled on inconvenient days. According to the 2013 Uganda National Plan for Elimination of Mother to Child Transmission of HIV, the key challenges affecting eMTCT service provision include: limited geographical coverage of core services (only 29.7% of ANC sites are providing eMTCT services) and limited population coverage (only 59.2% of estimated pregnant women access HIV counselling and testing services, and 53% of estimated HIV-positive pregnant women access ARVs for prophylaxis). Additional challenges include understaffing, frequent stock-outs of drugs and other essential commodities, and weak monitoring and evaluation (M&E) systems (UAC, 2014b).

Finally, bottlenecks to maternal and child health service provision include: limited choice of family planning methods, inequitable geographical distribution of health facilities, poor logistics management at facility levels, understaffing, absenteeism, poor quality service,

poor linkages between eMTCT and family planning services, weak postnatal services and lack of basic equipment such as weighing scales (MoH, 2013b). Supply is further restricted because of difficulties in gaining access to services. According to the 2007 service provision survey, 'very few' facilities provide basic emergency obstetric care (EmOc) and those that do are mostly hospitals (MoH and Macro International, 2008). Key factors in maternal mortality are lack of investment in skilled birth attendants, geographical access and poor rural transportation infrastructure impeding access to EmOC (MoH, 2013b). The third and final barrier to supply is corruption, which remains a barrier to effective health service provision in Uganda. Corruption is rampant despite the fact that in 2005 the reallocation of UGX 600 billion and UGX 1.6 billion led to Uganda being suspended from receiving resources from the Global Fund for HIV/AIDS, Tuberculosis and Malaria. Medical drugs and supplies continue to be stolen by medical personnel and, despite the abolition of user fees, people still make payments for some services (UAC, 2014a). In an attempt to tackle corruption, the President has established a Medicines and Health Services Delivery Monitoring Unit in his office and the Government has set up an Anti-Corruption Court, which has brought people to trial for mismanaging public resources (UAC, 2014a).

On the **demand side**, barriers include poor utilisation of health services (continuity of use), social and cultural practices and beliefs, lack of information (authorities and citizens), education of parents and health outcomes, continuity of use, financial assets, and inadequate health practices. There is poor utilisation of maternal health services with a high dropout rate between women's first and fourth ANC visits (95% and 48% respectively) and only 58% of babies are delivered by a skilled birth attendant (UBOS and ICF International, 2012). Sociocultural practices and beliefs result in links between women's attitudes to gender-based violence, household decision-making, contraceptive use and reproductive care services. The 2011 UDHS found that postnatal care is much lower among women who justified domestic violence for any reason at all, compared to women who did not justify domestic violence. Taking children for immunisation is considered a woman's job, but not all husbands support their wives to do so.

Traditional and religious leaders have been known to shun immunisation services, which has a negative impact on both public perceptions of immunisation and health outcomes (MoH, 2012a). Additional barriers to maternal and child health service provision include low male involvement with health care leading to lack of support for health-seeking behaviour in families and communities. Further, lack of information about services and general good practices for health act as barriers to decreasing demand. As a result of the country being restructured into 112 districts (instead of 56) in 2004/05 (creating an influx of local leaders who have never been exposed to information on routine immunisation), and a general lack of public information, not enough children are being immunised against preventable diseases (MoH, 2012a).

The key drivers of HIV incidence in Uganda include personal understanding of and attitude towards HIV, awareness about personal and/or partner HIV status, and high-risk sexual behaviours, including early sexual activity. Without such information, demand is



high. Moreover, there is a strong link between a mother's education and the health of her children. It has been proven that women's education is critical for reducing the incidence of diarrhoea because better-educated women have greater knowledge of the importance of proper sanitation (MoH, 2013b).

Overall, children with mothers who have achieved a higher level of education experience better health outcomes than those with uneducated mothers (UBOS and ICF International, 2012). Demand is also affected by continuity of use. High maternal mortality rates are a result of poor use and quality of services along the continuum of care: from family planning, through pregnancy, to childbirth and the post childbirth period (MoH, 2013b). Inadequate financial assets also place a high demand on health services. Out-of-pocket payments for medicines are unaffordable to most Ugandans but remain the most common form of payment for medicines, given stock-outs of government-subsidised medicines. Limited and inconsistent condom use and transactional, cross-generational and commercial sex are prevalent across the country (UAC, 2014b). Key risk factors for women and children include age at first marriage, low utilisation of family planning and low utilisation of antenatal and delivery services (UAC, 2014b).

Finally, an analysis of **quality of services** which pose immediate barriers to effective health-service provision include: stock-outs of drugs and supplies, inadequate human resources and the lack of integration of HIV/AIDS services with other services such as reproductive health, maternal and child health, curative services and the general health delivery system (MoH, 2013b).



Activities in Our District

Planning:

Cash Crop:

tea — (tea)

Sugarcane



4 THE RIGHT TO EDUCATION AND OTHER DEVELOPMENTAL RIGHTS

This chapter discusses some of the progress made in increasing the numbers of children in education in Uganda and the remaining barriers to achieving high-quality education for all children throughout the country. It focuses on pre-primary, primary, secondary and vocational education, although tertiary, university and adult services (formal and informal) are also recognised as key components of a comprehensive education system.

4.1 INTRODUCTION AND OVERVIEW

Uganda has made important strides in extending primary schooling to the great majority of children across the country. The Universal Primary Education (UPE) programme introduced in 1997 abolished all (official) tuition and parent teacher association (PTA) fees and led to a three-fold increase in enrolment. When universal secondary education was introduced in 2007, enrolment increased by 25%, although enrolment rates remain much lower than those for primary school. In terms of pre-primary education, data are hard to come by but most provision is private and concentrated in urban areas in the Central region, and is beyond the reach of most families. The National Integrated ECD policy (2013) aims to increase access to ECD centres, to improve quality and to develop relevant integrated and multisectoral ECD services.

4.2 PROGRESS AND CHALLENGES IN SERVICE PROVISION

4.2.1 Pre-primary education

Comprehensive data on early childhood development (ECD) service providers, users and children accessing them are not readily available and estimates referred to in different documents vary widely. The UDHS (2011) survey estimates the net attendance ratio (NAR) in pre-primary to be 23% (UBOS and ICF International, 2012), while the MoESTS (2014) estimates the net enrolment ratio (NER) to be 9.5%.⁶

6. The NER for pre-primary school is the percentage of the pre-primary-school-age population (3–5 years) that attends pre-primary school.

The MoESTS statistics (Table 4) indicate no gender gap in ECD enrolment. While authentic data disaggregated by other axes of deprivation remain limited, it is known that most ECD centres are found in urban areas (90%) in the Central region, and that most are private nursery schools, contributing to both geographic as well as socio-economic disparity in access (UNICEF Uganda, 2011). A similar trend is reflected in the May 2013 report on ECD Cost Benefit Analysis where 81% of ECD services are private and located in urban centres, while 0.7% are day care and also private. Only 16.7% are community-based ECD centres (Behrman and van Ravens, 2013). Other key challenges include the fact that current budget allocations are limited to monitoring and inspection, and that there are inadequate numbers of trained ECD caregivers – with only 2,400 of 6,120 certified under the MoESTS. The pupil-to-teacher ratio is on average 24, with a pupil classroom ratio of 47 on average, but with wide variations across regions.

There is no standardised pay scale for early childhood educators, with each privately-managed institution deciding its own rates of pay. According to the ECD Cost Benefit Analysis Report 2013, an early childhood educator earns an average monthly salary of US\$41. In most regions this is not enough to provide a living so parents and communities have to contribute. Community-owned ECD centres receive minimal funding – for salaries and food and equipment for the children – and rely largely on the voluntary services of untrained staff. According to the MoGLSD (2013b), there is a high turnover of non-formally trained ECD practitioners, low morale among practitioners due to the non-recognition of their non-formal qualifications, and, because appropriate physical structures are unavailable, multipurpose halls and informal structures are used as ECD centres.

TABLE 4: ECD CHARACTERISTICS BY REGION

	North	East	Central	West	South-West	North-East	National
ECD centres	831 (11%)	1,640 (22%)	2,858 (39%)	1,098 (15%)	751 (10%)	190 (3%)	7,368
Trained ECD caregivers	1,601 (18.9%)	2,016 (23.8%)	2,935 (34.6%)	1,276 (15.0%)	445 (5.2%)	206 (2.4%)	8,479
Enrolment of children in ECD	42,812 (19.90%)	42,366 (19.7%)	70,798 (33%)	31,523 (14.7%)	12,396 (5.8%)	14,902 (6.9%)	214,797
Male enrolment	21,024 (49%)	20,790 (49%)	35,098 (50%)	15,440 (49%)	6,187 (50%)	6,889 (49%)	105,428
Female enrolment	21,788 (51%)	21,576 (51%)	35,700 (50%)	16,083 (51%)	6,209 (50%)	8,013 (54%)	109,369

SOURCE: MoESTS, 2011B

4.2.2 The case for integrated ECD

Programming and policy approaches have a tendency to equate ECD with early childhood education whereas it should involve, at a minimum, interventions in health, nutrition, education, and social and child protection, and should target pregnant women, young children from birth, and parents and caregivers. Combined interventions provide space for multiple investments to address the same population targets, taking advantage of the same facilities and infrastructure and connections in client contacts as well as other forms of bureaucracy (DiGirolamo, 2014). This integrated approach is key to promoting optimal developmental and healthy physical growth for younger children.

4.2.3 Response mechanism: early childhood development

One of the ways to eradicate poverty and reduce inequality is through the use of ECD programmes that put children on an equal footing prior to starting primary school, regardless of the varied circumstances of their lives (Kisitu, 2009). This notion is expressed in a number of international declarations and frameworks like the MDGs, Health for All, Education for All and the New Partnership for African Development (NEPAD), all of which refer to ECD as a priority area.

Although there is a tendency to equate ECD with early childhood education (pre-primary), it is in reality a complex area, focusing on a cohort from 0–8 years of age, purposely to help the child grow and thrive physically, mentally, emotionally, spiritually, morally and socially. It includes a wide range of services to provide basic health care, adequate nutrition, water and sanitation, nurturing and stimulation within a caring safe and clean environment for children and their families and other child care aspects. Investing technical and infrastructural resources in ECD can have significant effects on a child's developmental trajectory both in the immediate and longer term. In 2011, 62% of children aged three to five years in Kampala were attending pre-primary school, while in Karamoja and West Nile the figure was just 6% and 5% respectively (UBOS and ICF International, 2012 – see Appendix 2). Since more than 80% of ECD services are private, access unevenly favours those who can afford them. A child living in a household in the highest wealth quintile is 7.5% more likely to attend pre-primary school than a child in the lowest wealth quintile (UBOS and ICF International, 2012 – see Appendix 2).

To address the challenges and gaps in providing optimal early childhood development to Ugandan children, in 2007, the Government included ECD in its legislation. Accordingly, through the Uganda Nutrition Action Plan, OVC Strategy and Immunisation Policy, among others, there is an emphasis on the importance of early childhood development in the country. This situation analysis therefore focuses on early childhood development across all sectors.

A recent benefit-to-cost analysis to predict the potential gains of investing in ECD in Uganda found that even in the most modest case, the benefit-to-cost ratio is 1.6. In other words, ‘eventually all the money invested in pre-primary education will pay itself back (in terms of higher income, more productivity, better health and less crime among others) with an additional “profit” of 60% of that investment’ (Behrman and van Ravens, 2013: 2).

BOX 2: THE COST-BENEFIT OF INTEGRATED ECD

Investing in early childhood development is a ‘solid’ investment. Evidence for this is provided in the benefit-to-cost ratio for ECD investments:

Assumptions	Ratio
On the most modest assumptions in all respects	1.6
On the most modest assumptions except that we assume:	
• a higher impact of pre-primary education on further schooling	1.8
• a higher economic impact of schooling on productivity	2.7
• lower costs of pre-primary education that previously assumed	2.6
• a discount rate of 3% instead of 6%	2.6
• a bigger impact of pre-primary education in other areas, e.g. crime, health	1.9
On the most optimistic assumptions in all respects	8.6

SOURCE: BEHRMAN AND VAN RAVENS, 2013

4.2.4 Primary education

The introduction of UPE in 1997 significantly increased access to primary education for both boys and girls, with total enrolment tripling from about 3.1 million in 1996 to 8.5 million in 2014 (MoESTS, 2014c). According to the Ministry of Education, Science, Technology and Sports (MoESTS, 2014a), the net enrolment rate in primary schools was 93.7% in 2014, with no gender gap. Retention/survival rates to Grade 5 are 63.4% (67% for boys and 59.9% for girls), while the survival rate to Grade 7 is 32.1% (MoESTS, 2014a), although these rates vary between regions, with West Nile, Karamoja and Western having the lowest rates (see Appendix 2). However, there is evidence of a major primary school dropout rate. Of the 2.16 million pupils enrolled in Primary 1 (P1) in 1997 (when UPE was introduced), only 32% had reached P7 in 2003 (UNICEF, 2014). In 2014, 66.9% of girls and 67.8% of boys who started primary school completed the primary school cycle (MoE, 2014c).

Although fees have been abolished at primary level, parents are still asked to contribute PTA and examination fees, and there are reports of pupils being barred from school for the



non-payment of fees (ActionAid, 2012; Perezniето et al., 2014). These fees can be prohibitive for low-income households, and failure to pay can lead to informal social pressures regarding obligations that either lead families into debt, or which push children out of school (as indicated by focus group discussions in Kampala and Kabale). Other school-related costs cited as leading to dropout are: school uniforms (51.9%) building funds (21.5%), and books and supplies 20.5% (GoU, 2014). The percentage of children having to repeat years has also not gone down fast enough, from 11.7% in 2009 to 10.3% in 2013 (GoU, 2014).

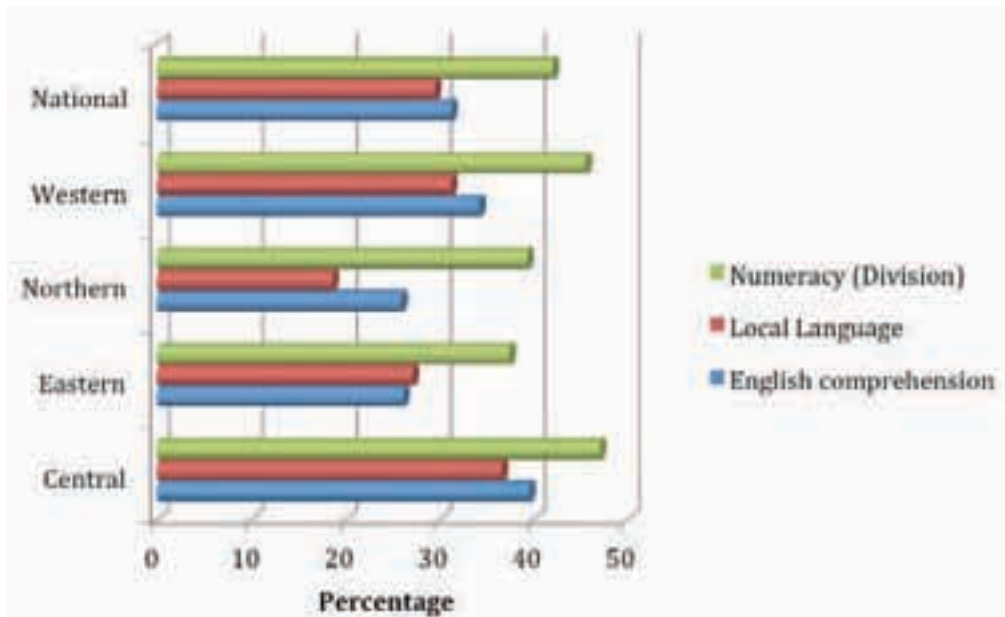
The low quality of education provided in primary schools is playing a key role in low completion rates. According to the 2013 Service Delivery Indicators report, only one in five primary school teachers had achieved competency in English and Mathematics, and in more than half of the country's public schools over 60% of teachers were not in the classroom teaching (World Bank, 2013). Of the latter, 24% were absent from school, 29% were in school but not in class, and 6% were in class but not teaching (World Bank, 2013).

Pupil absenteeism rates are also high. In the 16 poorest performing Quality Enhancement Initiative (QEI) districts, the pupil absenteeism rate at 32% – although it has been shown to be as high as 50% in some areas (MOESTS, 2013c). A gender monitoring study identified sickness (24%) and domestic assigned responsibilities/work (21%) as the major reasons for absenteeism. Although there are limited funds for school inspections and monitoring, the government has attempted to improve the quality of teaching and teacher motivation by introducing a theme-based curriculum which is less focused on exams (MoESTS, 2013a). According to the 2014 Education and Sports Sector Factsheet (MoESTS, 2014c) the national achievement levels in primary school for literacy are currently 56.2% for P3 and 40.2% for P6; and in numeracy 69.9% in P3 and 40.4% in P6. There are vast differences between well-performing and poorly-performing districts, with the competencies at P3 literacy varying anything between 12.3% and 92.5% and at P 6 between 9.8% and 72.2% based on the National Assessment of Progress in Education 2012, the latest district level information available (MoESTS, 2012a).



Findings from a 2012 study of over 80,000 children by the Uwezo initiative indicated that there were no gender differences in literacy, but that boys performed marginally better than girls in numeracy. The findings suggest that overall, only three out of 10 of all the children assessed nationwide were able to read and understand a Primary 2 (P2)-level story text and correctly solve P2-level numeracy questions up to division level – with Northern and Eastern regions lagging noticeably (see Figure 10). Moreover, the study found that children in the Central region outperformed their peers in other regions in numeracy, local language literacy and English comprehension.

FIGURE 10: PERCENTAGE OF PUPILS (PRIMARY 3–7) WHO CAN DO PRIMARY 2 WORK, BY REGION



SOURCE: UWEZO UGANDA, 2012

4.2.5 Secondary education

In 2013, 36% of secondary schools were government-owned and 64% were private (GoU, 2014). Enrolment in government secondary schools in 2014 was 49% and in private schools 51%. Secondary school enrolment rates are much lower than primary school (93.7% NER in primary vs. 24.1% in secondary in 2014) (MoESTS, 2014a). Enrolment rates are lowest in the Northern region and in rural areas, with the gap even larger than at primary level. The challenge posed by school fees and other school-related expenses is more problematic in secondary school than in primary school, as expenses are higher and there is a greater opportunity cost to families with children who attend secondary school – as children get older many families consider their time would be better spent working than studying.

Various studies suggest that both male and female children continue to play a traditionally important economic role in household livelihoods, with almost 51% of children aged 5–17

working and 25% of working children considered to be working in hazardous forms of work (Walakira and Nyanzi, 2012: 65; UBOS, 2010). This is an increase of 19% overall and 9% for hazardous child labour from 2005 to 2010. Equally the study shows almost identical findings among the regions (Walakira and Nyanzi, 2012: 64). These pressures undermine levels of achievement and retention in schools, and constitute a form of ‘time poverty’ (see subsequent sections for specific detail on child labour).

Quality of education at secondary level also continues to pose challenges. As per the 2013 NAPE results (NAPE and UNEB, 2013), in secondary schools about one-half of students (46.9%) reached the defined competency level in mathematics and 43.1% were rated proficient in English language, while less than a quarter of the students (14.5%) were rated proficient in Biology.

BOX 3: THE PEAS INITIATIVE IN UGANDA

The goal of Promoting Equality in African Schools (PEAS) in Uganda is to develop a growing network of high-quality, affordable schools. Initially, PEAS fundraises in the UK to launch a secondary school, allowing it to open debt free. Then, a combination of subsidies from pioneering public-private partnerships (PPPs) with the Ugandan government, boarding school fees and school farms, mean that within two years, the school itself will generate enough revenue to cover its running costs, including teacher salaries, indefinitely.

The first step involves searching for land in counties and districts that are most in need of secondary school provision. Examples of specific criteria that qualify for PEAS schools are that there must be at least 250 primary school leavers within a 5 km radius of the proposed school site and at least half of these children must be girls. After choosing the site, the land is purchased ensuring strict anti-bribery standards. Initial construction includes a bore hole, security fence, a three-classroom block that also converts into a hall, another block with two classrooms and administrative offices, a dormitory with attached sanitary facilities, and a separate sanitary block for general use. Each school has a kitchen for school lunches.

PEAS then expands the school gradually over three to five years according to demand and the availability of funding, until the school reaches maximum capacity for 1,000 students. The finished school has at least 20 learning spaces, including a fully stocked library, two laboratories and a computer lab, a dormitory capacity for 250–300 students, the necessary separate sanitary facilities for girls and boys, a sports pitch and one or two income-generating projects to provide income for the school. A PEAS school will also provide accommodation for most or all of its teachers, particularly if it is in a very rural location where no other housing is available.

By 2011, PEAS in Uganda was providing secondary education to at least 3,300 children, nearly half of whom were girls. By 2017, PEAS aims to have 100,000 sustainably financed secondary school places in Uganda.

SOURCE: PEAS.ORG.UK/



4.2.6 Education in emergencies and conflict

Despite relative stability, regional and community-level conflicts continue to undermine and/or disrupt education service delivery in Uganda. The country is prone to several natural and human-induced disasters. These include: drought, floods, human and epizootic epidermic disease outbreaks, landslides, fires, hailstorms, lightening, episodic hunger across many communities, terrorism acts and events of civil strife, ethnic/tribal tensions, and land wrangles that result in violent conflict.

Conflict and disasters have resulted in extensive destruction of infrastructure, loss of life and disruption of education activities. The Child-focused Vulnerability Capacity Assessment (OPM and UNICEF, 2014) revealed that schools are often used as evacuation centres during disasters. Education facilities continue to face incidents of lightening and pupils and teachers lack disaster risk reduction (DRR) skills, yet school safety plans seldom exist. During disaster times in flood-prone areas, there is increased absenteeism as schools become inaccessible and school latrines fill with water. The MoESTS has launched guidelines for mainstreaming DRR in the National Curriculum. These guidelines seek to strengthen understanding and best practice in assessing and managing all risks (e.g. climate, disaster, conflict) through education and peacebuilding.

A qualitative conflict analysis of the education sectors of the 28 focus districts of UNICEF's Peacebuilding, Education and Advocacy programme (PBEA) points to conflicts between local authorities, education institutions and communities as undermining access, quality and constructive community engagement in education. The study also reveals that in many areas of Uganda, education services are disrupted by prevalent community-level land disputes that pitch communities against school management over land claims and alleged encroachment (IPSS, 2014).

Creating a conflict-sensitive and disaster-free environment in school communities and education institutions for the safety of learners and teachers, and creating safe learning environments is crucial (MoESTS, 2014b). Inadequate preparedness by local education authorities and the MoESTS to respond to these crises has emphasised the need to mainstream conflict/crisis-sensitive approaches in education sector planning. Despite these ongoing setbacks, education in emergencies is not budgeted for, making the successful delivery of these services heavily dependent on donors and stakeholders. There is a need to ensure that education is systematically included in inter-agency and national emergency preparedness and response planning, policies and budgets. Moreover emphasis should be placed on strengthening systems to provide multiple and alternative pathways to accessing and completing education for disadvantaged and marginalised children.

4.2.7 Violence and sexual exploitation in schools

Violence at school is widespread in different forms and is an important contributor to dropout and poor performance. High numbers of pupils in primary schools continue to report having been emotionally abused by a teacher or bullied in school (MoESTS, 2012b). Although corporal punishment in schools was banned by the MoESTS in 1997, caning by an adult remains common. In a 2005 report by Raising Voices, over 60.4% of in-school children reported routinely being beaten and humiliated (Naker, 2005).

A report by UNICEF found that, among study participants, 77.7% of primary school children and 82% of secondary school students reported having experienced sexual abuse at school (UNICEF Uganda, 2013). In the case of primary schools, 67% of this sexual exploitation had been perpetrated by male teachers. Of those children who participated in a MoESTS study (MoESTS, 2012b), 60% of girls and 61% of boys indicated that they had never reported, partly for fear of being victimised by perpetrators. Boys felt ashamed to report acts of sexual abuse for fear of being stigmatised as 'not being man enough'. The Ministry of Gender, Labour and Social Development has acknowledged these findings and stated that 'male teachers sexually harass girls, sometimes confiscating their books, and demanding that they individually pick up their books from the teacher's house' (MoGLSD, 2009: 52).

4.2.8 Water, sanitation and hygiene (WASH) in schools

When the government introduced UPE in 1997, enrolment in primary schools increased drastically, without a corresponding increase in school infrastructure such as new classrooms and sanitation and hygiene facilities. As a result, many schools far exceed the national standard student/pupil latrine stance ratio of 1:40. The current pupil latrine stance ratio is at 1:70, while access to (and using) handwashing facilities in schools has slightly improved from 29% in 2013 to 32.8% in 2014 (MWE, 2014). UNICEF has supported government efforts to increase WASH interventions in primary schools with the construction of ventilated improved pit (VIP) latrines. However, pit latrines produce high levels of odour and fill up quickly, so have to be replaced frequently. Although a number of partners are now supporting the Government in developing innovative and affordable WASH solutions through effective micro-organisms (EMO) and bio-latrines technology, only a small proportion of schools countrywide have so far been covered.

Other initiatives include the School Sanitation and Health Education programme which focuses on building separate toilets for girls and boys and providing hygiene education in Uganda and several other countries in east and southern Africa. SNV Uganda, a non-profit international development organisation, finds that lack of access to good and affordable sanitary pads is contributing to low attendance rates for girls. As a result, a number of innovative low-cost solutions such as AFRIPads and Makapads have been developed and organisations – including SNV, ASB and Plan Uganda – are starting to train girls to make reusable menstrual pads using locally available materials (SNV and IRC, 2013).

4.3 DISPARITIES IN EDUCATION

4.3.1 Disparities in quality of education

An under-discussed issue relating to the quality of education is the introduction of the thematic curriculum in 2007, which promotes the use of local languages to enhance learning outcomes. With 52 ethnic groups in Uganda, each with its own dialect and orthography, the policy is rooted in the idea that children pick up foreign languages more easily if first grounded in their mother tongue. However, the thematic curriculum is experiencing challenges for a number of reasons: the local languages are not written in text books, which defeats the purpose of teaching in local languages; some teachers cannot read and write these languages and therefore cannot teach them; parents are often opposed to their children learning in the local language; and transitioning to English after the initial years of learning in a different language can be difficult. Although no evaluations or studies have been undertaken, it can be assumed that there are likely to be associated impacts on high dropout rates and poor learning outcomes of children at higher grade levels. Additionally, emphasising local language results is weakening social cohesion and the resilience of communities in a country already battling several inequalities across ethnic groups.

4.3.2 Geographic and wealth disparities

Wealth seems to be one of the clearest determinants of access to schooling. In 2011, the share of children who had never attended school was more than twice as high in the bottom wealth quintile (22%) as in the top quintile (11%). Similarly, secondary school enrolment rates rise from 3.3% for the poorest quintile to 32% for the richest (MoGLSD et al., 2014). Due to economic disparities between regions, wealth and geographic inequalities intersect. There are significant rural–urban divides, with 96% of non-attendees living in rural areas, compared to 89% of school-going children (Grogan, 2009). This suggests that education attainment is much higher among the urban population than among their rural counterparts. Differences also exist across regions. For instance, the Northern region has the highest levels of educational deprivation (20% of children had not attended school in 2011), followed by the Central region. The East region generally has the lowest levels of educational deprivation. Rural deprivation rates are somewhat higher (MoGLSD, 2014b).

4.3.3 Gender disparities

Data presented by MoESTS (2013b) suggests that girls and boys have very similar enrolment rates at primary level (in FY 2013/14, there was a 50:50 percentage of net enrolment rate by sex (4,235,669 boys; 4,249,336 girls). At secondary level, girls' enrolment rates are lagging slightly behind boys', with a net secondary enrolment ratio of 26% for boys and 25% for girls in 2011 (MoESTS, 2012b). The sex of the household head also matters: children from

male-headed households have a higher risk of dropping out of school than those who live in female-headed households (MoGLSD, 2014b).

Because secondary school enrolment figures remain extremely low, they only give a picture of a minority of secondary school-aged girls and boys. Table 5 provides a regional breakdown of girls' (aged 15–19 years) education status. Between all regions, Karamoja has the highest proportion of girls who are not in school and/or have never been to school. Additionally, the North, West Nile, and Western regions have the lowest proportions of girls who are in school and at grade for age. With respect to school performance at secondary level, girls (45.3%) performed significantly better than the boys (40.9%) in English language.

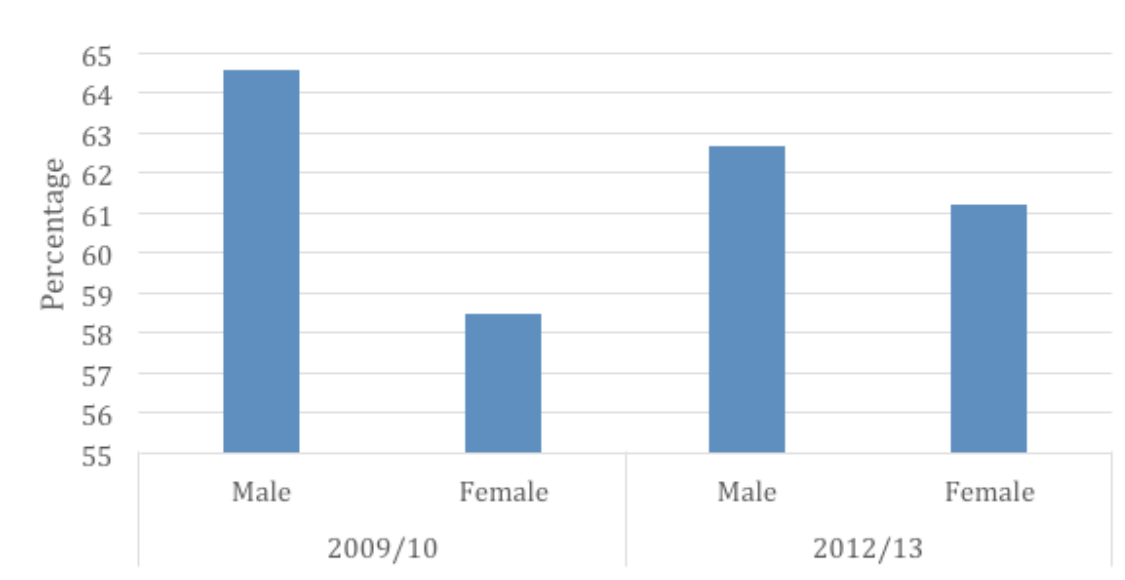
TABLE 5: CHARACTERISTICS OF ADOLESCENT GIRLS IN UGANDAN SECONDARY SCHOOLS (%)

Region	2006				2011			
	Never been to school	Been to school but not in school	In school, not grade for age	In school and grade for age	Never been to school	Been to school but not in school	In school, not grade for age	In school and grade for age
National	3.7	42.3	37.4	16.6	2.7	38.9	41.9	16.5
Central 1	0.3	40.9	25	33.8	1.9	35.4	30.7	32.1
Central 2	1.9	40.4	36.8	20.9	0.3	35.8	37.3	26.7
East Central	1.6	36.2	43.6	18.6	0	38.7	44.3	17
Eastern	1.4	38.4	47.4	12.7	0.7	36.8	52	10.5
Kampala	1.3	38.2	15	45.5	1.1	58.5	6.4	34
Karamoja	n/a	n/a	n/a	n/a	46.3	27	18.9	7.8
North	n/a	n/a	n/a	n/a	1.1	40	55.2	3.7
South-West	3.6	46.2	38.1	12.2	0.5	34.6	51.9	13.1
West Nile	4.5	40.3	52.5	2.7	3.5	46.1	46.4	4
Western	4.4	47.2	42.6	5.9	2.3	37.2	49.4	11.1

SOURCE: UNHS 2007–11; MICS 2006–2008, AS CITED IN AMIN ET AL., 2013

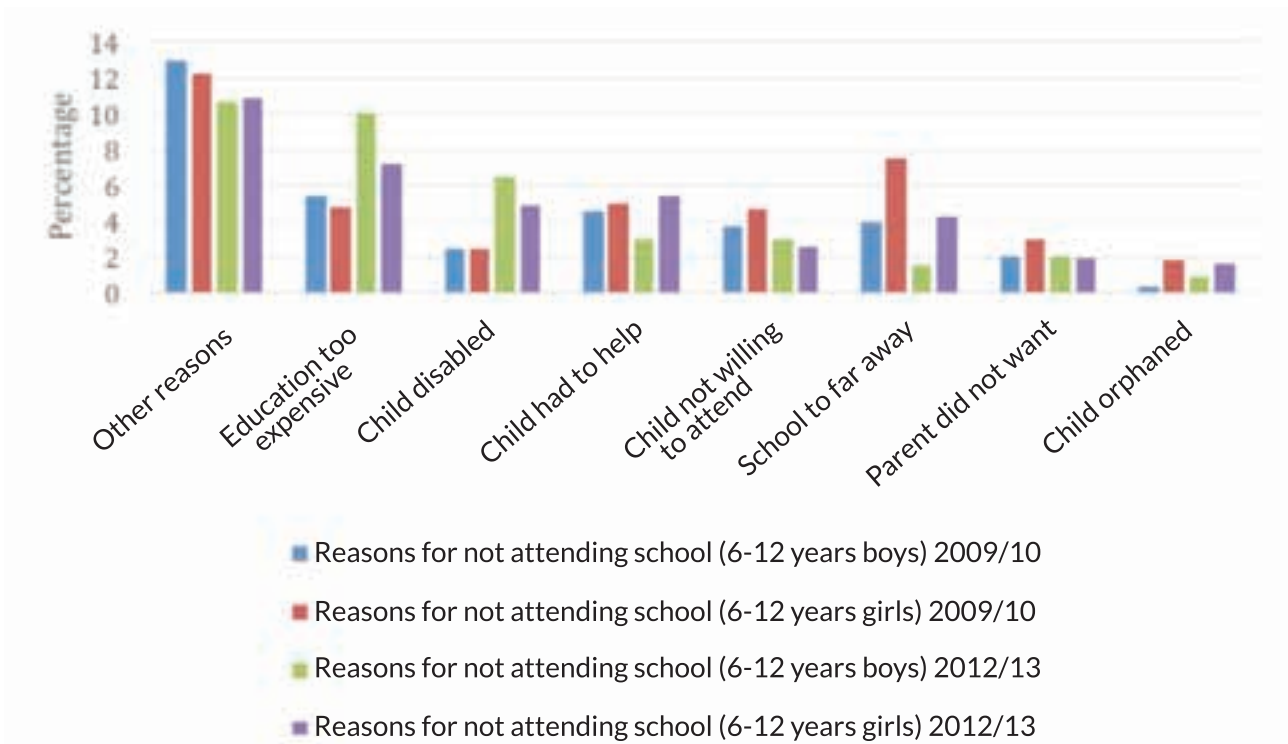
These findings are echoed in the UNHS 2012/13 data (UBOS, 2014a), which show that views regarding the age at which girls should attend school have progressed negatively in relation to boys between 2009/10 and 2012/13 (Figure 11). Figure 12 shows some disparities in reasons for non-attendance, particularly with regard to girls being needed to assist at home and the view that schools are too far away for girls to attend.

FIGURE 11: TOO YOUNG AN AGE AS A REASON FOR NOT ATTENDING SCHOOL (BY SEX, 6-12 YEARS)



SOURCE: UBOS, 2014A

FIGURE 12: REASONS FOR NOT ATTENDING SCHOOL (BY SEX, 6-12 YEARS)



SOURCE: UBOS, 2014A

Community/family attitudes are often reported as common reasons for girls' low school enrolment/attendance. The economic decisions involved around children's education mean that many families prioritise their sons' education, seeing girls' education as less needed in their future role as mothers and as a poor investment as girls will be expected to contribute to their husband's household. Adolescent pregnancies are also noted to be both a cause and consequence of school dropout (Pereznieto et al., 2014). The school system also remains a dominant source of gender bias and stereotyping. Education processes are instilled with persistent and inbuilt gender differences. Females and males are subjected to differential socialisation in classrooms and are rewarded for different things. As a result, schools are largely unable to provide a gender-responsive environment for effective teaching and learning. There is limited capacity for implementing gender-related programmes for a gender-responsive education system. Although schools recorded sex-disaggregated education statistics, some staff were not able to draw out the inequalities nor utilise the statistics to address the inequalities reflected. Local governments, civil servants, religious leaders, civil society organisations, guardians and many others in and outside schools did not have the skills to analyse or respond to scenarios relating to girls (MoESTS, 2013e).

4.3.4 Disparities due to disability

There are about 2.5 million children with disabilities in Uganda with challenges in seeing, hearing, communicating, mobility or moving, touching, learning, and/or emotional development, among others. According to data cited by Riche and Anyimuzala (2014), of these children, only 5% are able to access education within an inclusive setting in regular schools while only 10% access education through special schools and annexes. The MoESTS's Uganda Education Statistical Abstract 2009, 2010 and 2011 suggests that only about 9% of children with disabilities were enrolled in either pre-primary, primary or secondary schools over the 2009–2011 period. Data from UDHS surveys, however, suggest that children with disabilities have only slightly lower enrolment rates than the general population in primary school (80.5% vs. 81.0%) and slightly more markedly lower enrolment rates in secondary school (11.5% vs. 15.2%). They also found that only 10% of children with disabilities are unable to attend school. Latest UNHS data also show that disability increased markedly from 2.4% 2009/10 to 5.7% in 2012/13 as a reason for not attending school (UBOS, 2014a).

The *Situational Analysis on the Rights of Children with Disabilities in Uganda* (Riche and Anyimuzala, 2014) takes note of the discrepant findings between the MoESTS and UDHS surveys and suggests that different methodologies are perhaps the reason for the different statistics. It is also possible that enrolment and attendance rates are vastly different because of the severity of the disabilities that children have. In secondary school, the differences are clearer: the MoGLSD (2014b) results show that disabled children have lower secondary school attendance rates than other children (11% vs. 15%). Indeed, among children aged 13–17 years who have never been to school, about one in five cite disability as the major reason for never enrolling in school (MoGLSD, 2014b). Other reasons for high dropout are lack of facilities, shortage of trained teachers with specialised skills and an inaccessible school environment (i.e. to classrooms and latrines).

4.3.5 Disparities due to orphan status

Paying school-related costs proves particularly difficult for children who do not have one or both parents. As mothers are usually in charge of paying school-related costs (albeit often from income generated by the father), those children relying on stepmothers reported concerns about their stepmothers (or other caregivers) refusing to provide support for school costs (Perezniето et al., 2014). In the statistical data (MoGLSD, 2014b) orphan status has no clear relationship with educational deprivation. Adopted/foster children also have higher secondary school enrolment rates, possibly because some were taken in specifically to attend secondary school where none existed in their village. Orphan status does not appear to play an important role in secondary school participation.

BOX 4: U-REPORT COMMENTS RELATING TO EDUCATION

U-report is a free SMS-based system that allows young Ugandans to speak out on what's happening in communities across the country, and to work together with other community leaders for positive change. The following quotes have been retrieved from Ugandan U-reporters relating to various components of education.

In Nyakagyeme-Rukungiri, to some extent Universal Primary Education has brought some young girls back into primary schools. The same has been done by Universal Secondary Education. Churches, market places, mosques, football playgrounds, radios, and TVs also increasingly accessed by some few individuals amidst digital migration.

U-reporter, Rukungiri

Some parents can't even buy the school requirements required at school despite the introduction of UPE for primary education – this is especially so due to high levels of poverty.

U-reporter, Rukungiri

In my community some parents can't afford to buy exercise books for their children who are attending UPE today. It is really sad to me because their children are not attending free primary education. May the government help such children?

U-reporter, Oyam

The government should continue with the issue of universal primary education and universal secondary education in Uganda. It should also promote girls' education, put law and order and rules against domestic violence and child abuses in the country.

U-reporter, Pader

Lack of Role model(s) is/are affecting my community most. Also most parents are peasant farmers who can't afford basic needs & sponsor their children beyond free primary education. The few who join secondary schools always drop out.

U-reporter, Nebbi

4.4 ENABLING ENVIRONMENT

4.4.1 Fiscal space analysis

The analysis in Table 6 shows a profile of expenditures in the primary and secondary education sub-sectors targeting child development. The table indicates that overall spending on primary education accounted for 42% of the total education budget in 2013/14 and is expected to account for 50.4% in 2014/15. However, primary teacher salaries account for over 82% of the total expenditures in the primary sub-sector (MoESTS, 2014a). This means that Uganda cannot adequately meet other primary education costs. For instance, the budget for primary school supplies through the capitation grant has stagnated at UGX 7,000 per enrolled UPE child despite demand from the sector to increase the grant by at least 40% to UGX 10,000. This has implications for addressing the quality of education and learning outcomes for children.

TABLE 6: SELECT INTERVENTIONS TARGETING CHILD DEVELOPMENT IN THE UGANDA EDUCATION BUDGET (%)

	2013/14	2014/15
PRIMARY SUB-SECTOR		
Instructional materials	2.3	1.8
Assessment of pupil (PLE)	0.8	0.7
Classroom construction	0.2	0.2
Karamoja primary education project (5% GoU financed)	0.0	2.2
Support to war-affected children in Northern Uganda (Laroo)	0.0	0.0
Teacher development (recruitment physical education training)	0.1	0.1
Teacher's SACCO	0.0	0.5
School facilities grant: teacher's houses	7.2	5.5
Capitation grant for pupils in UPE schools	6.6	5.0
Teacher's salary	82.6	84.0
Sub Total	100.0	100.0
Primary education budget (UGX billions)	750.6	978.6
Share of primary education in total education budget (%)	42.6	50.4
SECONDARY		
Instructional materials	1.0	1.0
Monitoring and supervision of secondary schools	0.6	0.1
USE tuition support	0.0	0.2
Secondary examinations	2.7	3.0
Teacher training	1.2	1.0
Classroom construction	26.0	21.7
Monitoring USE placement in private schools	0.1	0.1
Capitation Grant for USE and UPOLET students	24.4	25.1
Wages for secondary school teachers	44.0	47.8
Subtotal	100.0	100.0
Secondary education budget (UGX billions)	433.5	423.4
Share of secondary education in total education budget (%)	24.6	21.8
Share of non-primary and secondary education expenditures (%)	32.8	27.8
Total expenditures on education	1,761.6	1,940.8

SOURCE: MOESTS, 2014A

The 2008 Education Act stipulates that financing of ECD is not the mandate of government. As such, the MoESTS is only involved in the monitoring and supervision of ECD centres set up by the private sector.⁷ Overall, spending on pre-primary education or ECD centres is very low. According to the 2014/15 education sector ministerial statement, UGX 800 million (less than 0.1% of the total education budget) was allocated for monitoring and supervision of pre-primary schools during 2013/14 (MoESTS, 2014b).

4.4.2 Contextual, supply and demand factors

Societal factors such as the legacy of the conflict in the North, the HIV/AIDS pandemic and other public health crises have had an impact on the realisation of children's right to education. Moreover, gaps between policy and practice, as well as a focus on access – which is only slowly shifting towards implementation, funding, quality and retention – are barriers to creating an enabling environment for learning and education. Additionally, the public sector budget is not sufficient to enable free schooling with reasonable class sizes and adequate facilities, and there is very limited public funding for pre-primary education. Efforts by local authorities to promote UPE vary between regions/localities.

On the supply side, there are several factors that act as bottlenecks, including the availability of free schooling, physical access to schools, and the availability of good-quality education that meets the needs of the community and creates a safe learning environment. Poorly equipped and inadequate institutions are reflective of a lack of availability of commodities that fulfil the need for education. Access to adequately staffed services, facilities and information is a barrier to the supply because the number and accessibility of schools varies between regions and is particularly low in the North. Leakages of resources are also major barriers to ensuring supply: leakages between central government and schools (e.g. ghost teachers, misuse of the grants disbursed by the MoESTS to districts to implement the UPE programme); leakages of resources within schools (e.g. high rates of absenteeism by pupils, teachers and head teachers); deployment of teachers across districts in a way that is unrelated to measures of need; and inefficient allocation of resources within government schools (e.g. large class sizes in early grades and lower sizes at higher grades) (ODI, 2008, cited in Ezati, 2011).

In 2010, the Government conducted a country-wide mapping of existing educational provision for children requiring special educational arrangements (MoESTS, 2010) and in 2011 the MoESTS adopted its first ever Policy of Special Needs and Inclusive Education (MoESTS, 2011a). The aim of the policy is to streamline approaches across the country vis-a-vis specialised instructional materials, equipment and services, accessibility concerns, learning approaches and provisions, affirmative action, specialised support services, research, partnerships and monitoring and evaluation.

The demand for schooling is furthermore affected by the broad societal context (e.g. conflict in the North, economic shocks), socio-economic factors and the (perceived) incentives of

7. Private sector investments in ECD through schooling take the form of private for-profit initiatives by individuals, as well as not-for-profit foundations. A mapping of the balance of these contributions has not been conducted in Uganda.



attending school as well as beliefs and norms related, for example, to girls' schooling or the schooling of disabled children. Financial access and incentives create barriers to ensuring a steady demand for education. Household income is one of the clearest determinants of children's enrolment. As a result, school fees and other costs (PTA fees, examination charges, uniforms, meals, school books and materials) act as a deterrent. Forms of livelihood, e.g. a pastoralist lifestyle, can also affect schooling, and there are pressures on children to support families with domestic work at home and to provide extra labour during planting and harvesting seasons.

Opportunity costs (work) including earning a wage or helping at home/on the family farm are an obstacle, particularly at secondary school level. Socio-cultural beliefs/practices and beliefs related to early marriage and early pregnancy make it difficult for adolescent girls to continue their schooling. Menstruation – a lack of sanitary pads (at home or school) and inadequate sanitary facilities in schools also affect demand for education.

Studies also suggest that girls' education is undermined by a range of gender bias and discrimination in schools, in textbooks, curricula, and teachers' attitudes towards girls, as well as by a shortage of trained female teachers to provide role models. Misunderstood ideas about teacher–pupil relationships, corporal punishment, ideas about who should receive what kind of schooling (e.g. girls, disabled children) are deeply embedded in discriminatory socio-cultural beliefs and practices. Many parents see children as too young to go to school, possibly because they are not educated themselves. Finally, the availability of vocational training for girls and boys is largely shaped by gendered understandings of the appropriate professions for men and women.

With respect to quality of education, high pupil and class/teacher ratios undermine good-quality teaching, and absenteeism of both pupils and teachers can undermine increased access to education enabled by UPE. The lack of teacher training also contributes to poor learning outcomes. Gender stereotypes in the division of labour, different reward systems for girls and boys, and discriminatory or abusive behaviour towards children with disabilities or other vulnerable children undermine the ability of girls and other groups to reach their educational potential. Finally, corporal punishment, violence against children, and hierarchical teacher–pupil relationships are also barriers to providing good-quality education in schools.



5 THE RIGHT TO PROTECTION

This chapter provides an overview of child protection issues in Uganda, including violence against children and the circumstances that make some children particularly vulnerable. It describes the measures being taken, or which need to be taken, in order to provide a more comprehensive and systematic response.

5.1 INTRODUCTION AND OVERVIEW

Uganda has been a signatory to the UN Convention on the Rights of the Child (UNCRC) since 1990 and has taken some substantial steps in fulfilling its obligations under the Convention. These obligations include children's right to be protected against any form of violence, abuse and exploitation.

Most children in Uganda have faced some form of violence – physical, sexual, emotional or domestic. Over 8 million children, 51% of the child population, are considered vulnerable (Kalibala and Lynne, 2010). Girls are especially vulnerable to sexual abuse, some 32,130 children head households and over 40,000 children live in institutional care. After the age of 10 years, adolescent boys and girls face specific protection risks, especially those whose families are poor and who send their children to work instead of attending school or who marry off their daughters as part of their survival mechanisms. Girls also face challenges with regard to social norms that dictate female genital mutilation/cutting (FGM/C), early marriage and teenage pregnancy. Living in poverty also places vulnerable children further at risk because of high rates of child labour and child trafficking. Child-related offences (as victims and as offenders) are prevalent in Uganda, with defilement being a serious concern.

5.2 PROGRESS AND CHALLENGES IN SERVICE PROVISION

5.2.1 Violence against children

According to a study conducted by the MoGLSD and UNICEF, almost 40% of Ugandan children have suffered physical violence⁸ that has negatively affected them (Matovu, no date:

8. UNICEF defines violence against children as 'any form of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse' (UNICEF, 2014).

21). Likewise, a 2011 report by the Ugandan Police stated that over 20,100 children had been victims of offences ranging from ‘neglect to infanticide’ (Matovu, no date: 21), including ‘widespread forms of punishment and discipline against children, either through physical assault or harm’. The 2011 UDHS found that 58% of 15–19-year-old women had experienced physical or sexual violence and that 25% and 23% of women in Eastern and West Nile regions respectively had experienced violence during their pregnancies (UBOS and ICF International, 2012 – see Appendix 2).

Other studies have found that the risk of sexual abuse remains significant in the country (MoGLSD et al, 2014: 103) and is the most common form of violence with gender as a major risk factor. For example, a regional study by the MoGLSD highlights data from the North of the country. It states that 32.4 % of women specified having first experienced sexual violence during their childhood (MoGLSD, 2009: 25). The number of defilement⁹ 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).

Much of the sexual violence is inflicted by family members or other people residing in or visiting a child’s family home. In a 2005 report by Raising Voices, 42.6% of the children interviewed said they experienced emotional violence mainly at home; 21.2% said mainly at school; and 35.5% said at home and at school. Similarly, more than 24% of the children interviewed reported having experienced sexual abuse in schools (Naker, 2005). An additional 34.3% reported having experienced sexual violence both at home and at school. In addition, 77.7% of primary school children and 82% of secondary school students surveyed in a study conducted by the MoESTS and UNICEF in 2012 declared that they had experienced sexual abuse at school (UNICEF Uganda, 2013). Of those 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.

5.2.2 Birth registration

Birth registration provides a record of a child’s age, a central piece of information for child protection, as it can serve for timely enrolment in school as well as for the enforcement of minimum age of employment and eligibility for marriage. It also plays a key role in ensuring adequate access to and provision of key social protection services. Key civil protection treaties, including the UNCRC, the International Covenant on Civil and Political Rights, and the African Charter on Human and People’s Rights highlight the importance of birth registration and it is compulsory under Uganda’s 1973 Birth and Death Registration (BDR) Act (Cap 307), which made it mandatory for babies to be registered within three months of birth.

In the last few years there has been good progress on the proportion of babies registered within the first year of birth, with the figure rising sharply from 30% in 2011 to an estimated 60% in 2014 (UNICEF Uganda, 2015). This is largely the result of the introduction of electronic registration in all referral hospitals and at sub-county level using the Mobile Vital Registration System.

9. Defined in Ugandan law as sexual abuse of a child by an adult

5.2.3 Children with disabilities

It is estimated that in Uganda there are approximately 2.5 million children living with some form of disability. These children are disproportionately vulnerable to mental and physical violence and sexual abuse through isolation, a lack of access to services and socio-cultural beliefs. A study in the four districts of Iganga, Jinja, Kampala and Masaka found that 90% of children with disabilities do not access or enjoy their rights to survival, development, protection and participation (Riche and Anyimuzala, 2014).

The 2009/10 Uganda National Panel Survey was the first national survey to examine the extent of disability in the country. Table 7 shows that at least 5.4% of all children are affected by some form of disability and that hearing difficulty is the most frequently cited form of disability. However, only 1.2% of children have disabilities classified as severe, defined as having significant difficulty or total inability in performing the specified function. People with severe disabilities may require continuous rehabilitation and this process can be costly.

TABLE 7: EXTENT AND EFFECTS OF DISABILITY BY GENDER (AGE 5 YEARS AND ABOVE), 2009/10 (%)

	All Ugandans	Gender	
		Female	Male
Nature of Disability			
Seeing	1.2	1.2	1.1
Hearing	2.1	1.9	2.3
Physical	1.1	1.0	1.1
Mental	1.1	1.1	1.1
Care	0.4	0.4	0.5
Communication/Language	0.7	0.5	0.9
<i>Disability (any of the above forms of difficulty)</i>	5.4	4.9	5.9
<i>Severe Disability</i>	1.2	1.2	1.3
Rehabilitation during the past 12 months			
None	65.8	60.5	70.2
Medication	30.5	36.6	25.5
Assistive Devices	1.7	2.5	1.1
Spiritual/Traditional Healer	1.2	0.2	2
Other	0.8	0.2	1.2
Sub Total	100	100	100

Effects of Disability: Does the disability reduce the amount of work the individual can do at home, school or work?									
	All Ugandans			Female			Male		
	Home	School	Work	Home	School	Work	Home	School	Work
Yes, all the time	21.4	17.4	3.7	21.4	17.5	3.3	21.4	17.3	4.1
Yes, sometimes	50.1	48.1	20.7	52.4	49.6	18.4	48.3	46.8	22.8
No	25.3	11.6	17.8	24.4	7.7	15.4	26	14.8	19.9
Not applicable (if not working or attending school)	3.2	22.9	57.7	1.8	25.3	63.2	4.2	21	53.3
Sub Total	100	100	99.9	100	100.1	100.3	99.9	99.9	100.1

SOURCE: AUTHOR'S CALCULATIONS BASED ON 2009/10 UNHS (UBOS, 2010)

Notably, Table 7 indicates that the majority of disabled children (approximately 66%) did not receive any form of intervention. About 36% of disabled girls are on some form of medication compared to 26% of disabled boys. Use of assistive devices is relatively low and girls are about twice as likely to report using assistive devices than boys. It is also worth noting that some of those affected report turning to spiritual/traditional healing for rehabilitation. Table 7 also examines the effects of the disability on the ability to either work at or outside the home as well as attend school. At least seven out of every 10 children report some sort of difficulty. About 20% indicate that their disability affects their home activities all of the time. Furthermore, two out of every three children reporting disability indicate that their schooling is affected in some way.

5.2.4 Orphans and other vulnerable children (OVC)

Of the 17.1 million children below 18 years (over 50.7% of the population) in Uganda, 11.3% are orphans, 8% are critically vulnerable and 43% are moderately vulnerable (MoGLSD, 2011 and UBOS, 2014a). Of those who are orphaned, 46% (1,108,080) have lost their parents through AIDS (GoU, 2013). High child mortality before the age of five years, malnutrition, abuse, inadequate access to education, increase in commercial exploitation, and neglect are prevalent in the lives of OVC. According to the UDHS (2011), 18% of households have orphans and close to one-third of households have foster children (UBOS and ICF International, 2012).

Although there is a legal requirement under the Children Act to inform the authorities when an orphan is placed in alternative care (in foster care, through adoption, or institutional care), enforcement is inadequate and kinship care is not covered by law, which is why valid statistics about the number of children in alternative care are limited. Due to a lack of regulation or weak enforcement, there is a proliferation of childcare institutions – official statistics put the figure at 500 with approximately 40,000 children (MoGLSD, 2012c) – and most of them are either not registered or fail to comply with rules and regulations.

In towns and cities, homeless children (children living on the street) face violence by members of the public, urban authorities and sometimes the police, other homeless adults, local government officials and their homeless peers. A survey by the African Network for the Prevention and Protection against Child Abuse and Neglect (Fallon, 2014) estimated that there are 10,000 street children in Uganda, a 70% increase in the number of children on the streets since 1993, with approximately 16 new children coming to the Kampala streets every day.

In light of the alarming statistics on OVC and the proliferation of illegal children's homes, the government has developed a National Alternative Care Framework 'to provide guidance to government and non-governmental actors in providing or facilitating access to appropriate care options for children, based on the continuum of care available to children; ensuring that institutional care is used as an option of last resort' (MoGLSD, 2014a: 12). If kinship

care is not possible, institutional care that replicates a family environment – whereby a child is placed in a small group setting with one primary caregiver – is the next best option (MoGLSD et, 2014a). Table 8 provides a summary of the alternative care options available to OVC in Uganda.

TABLE 8: SUMMARY OF ALTERNATIVE CARE OPTIONS IN UGANDA

Care type	Description/duration	Type of care	Exists in Uganda
Children’s shelter/receiving home	1–30 days’ stay while the child’s needs are assessed and a more permanent solution found, which could include returning to parent(s)	Temporary	Yes – but timelines vary greatly
Group home	6–8 bed facility as emergency shelter for a limited period of time	Temporary	Limited
Emergency foster care	Days, weeks or months with a vetted/qualified and paid temporary foster caregiver(s)	Temporary	Very limited
Foster care	More permanent foster care arrangement/leading to adoption	Temporary and Permanent	Yes
Kinship foster care (informal)	Short- or long-term informal support provided by relatives	Temporary and Permanent	Yes
Kinship foster care (formal)	Relatives take legal responsibility for the child/children	Temporary and Permanent	Rarely do relatives legally foster
Adoption	Permanent legal family environment	Permanent	Yes
Specialised foster care	Foster families for children/youths with special needs	Temporary and permanent	Yes but limited
Kafalah (Muslim practice but also prevalent in other parts of society)	Individuals in the community to voluntarily care protect and educate a child while retaining the child’s name, family and lineage connection.	Temporary and permanent	Yes
Residential care in a ‘group’ setting (traditionally described as an ‘orphanage’)	Children cared for, fed, educated in a group setting. There could be multiple homes and/or large rooms on the same site.	Temporary and permanent	Yes – an estimated 400+ such institutions with an estimated 40,000+ resident children
Boarding school	Boarding school facilities but where children are resident 365 days of the year	Permanent	Yes – there is a growing trend to start ‘orphanage’ schools

SOURCE: MOGLSD, 2014A

BOX 5: U-REPORT COMMENTS RELATING TO ORPHANS AND OTHER VULNERABLE CHILDREN

U-report is a free SMS-based system that allows young Ugandans to speak out on what's happening in communities across the country, and work together with other community leaders for positive change. The following quotes have been retrieved from Ugandan U-Reporters relating to orphans and vulnerable children:

We have big number of Orphans and widows in my community who have no assistance at all - which has forced young girls to drop out of school and get married.

U-reporter, Palisa

I have a problem in my village: we have children who are orphans and HIV-positive and some of them have disobeyed their Guardians and some of them are girls. This is a threat to married women for their Husbands because they're sleeping with them. Please how can help us with this girls?

U-reporter, Kumi

Thanks a lot u-reporters team, my community particularly where I live has gained a lot from u pple, especially the young ones. It has open the chance to the orphans, the widows, the neglected among others, to report their grievances somewhere, thanks for the nice services keep it up.

U-reporter, Pader

5.2.5 Child marriage and FGM/C

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 Nyanzi, 2012: 16).

According to the UDHS (2011) report, 49% of women aged 20–49 years were married before the age of 18 and 15% by the age of 15 years (UBOS and ICF International, 2012) while 9% of males were married by the age of 18 and 25% by the age of 20. The UDHS also found that 58% of 19-year-old teenaged girls, 37% of 18-year-olds, 21% of 17-year-olds, 9% of 16-year-olds and 2% of 15-year-olds had already begun child bearing. Factors affecting the likelihood of early child bearing include education (45% of teenagers aged 15–19 years who have no education give birth in their teens), poverty (34% in the lowest wealth quintile) and region, with girls in the eastern part of the country more likely to begin child bearing before the age of 20 (see Appendix 2). Regional studies (Walakira and Nyanzi, 2012) have confirmed the high incidence of female child brides and mothers, detailing one of the underlying causes to be children being pressured to marry by family members. Reports also refer to economic motives for children getting married, either as an escape from poverty-stricken families or as an opportunity for the discharge of care or to provide for the protection of minors.



Ministerial reports and national reports conducted by UNICEF (c.f. Matovu, no date and MoGLSD et al., 2014) have highlighted the negative effects of child marriage, indicating a strong negative effect on children, often resulting in early pregnancy, social isolation and the abandonment of education. In fact, the Adolescent Girls Vulnerability Index (AGI) conducted by the Ministry of Gender, Labour and Social Development and UNICEF has highlighted early marriage as key driver of pregnancy and school dropout (MoGLSD and UNICEF, 2013).

In comparison to many of the other countries in Africa where FGM/C is practised, Uganda has a very low rate. Since the 2010 anti-FGM/C act, there has been good progress in ensuring that this harmful practice is eliminated. Only 2% of women are circumcised (28 Too Many, 2013; UBOS and ICF International, 2012). In 2011, over 56% of Ugandan women had heard of female circumcision. Of the women interviewed for the UDHS survey in 2011, only 9% reported wanting to continue the FGM/C practice and over 80% stated that they wanted this practice to stop.

FGM/C is practised 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 (95%). The overall rate of FGM/C increased from 0.6% in 2006 to 1.4% in 2011. In the Eastern Region, where there has been a longer history of intervention against FGM/C, 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). The Sabiny practise Type I or II FGM,¹⁰ usually around the age of 15, although girls as young as 10 are at risk. Among the Pokot, who mostly practise Type III infibulations,¹¹ girls are cut aged 9–14 (28 Too Many, 2013). Among the Tepeth, girls are cut between the ages of 11 and 14 years. FGM/C has a direct relationship with early marriage and subsequently teenage pregnancy. Among the Sabiny, for example, FGM is usually performed on girls who are considered to be reaching maturity for marriage (between the ages of 12 and 15). Similarly, among the Pokot, adulthood is marked by both FGM/C and marriage, therefore putting girls as young as nine at risk (28 Too Many, 2013).

10. Type I: Clitoridectomy; Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)

11. Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).



BOX 6: U-REPORT COMMENTS RELATING TO ADOLESCENT PREGNANCY

U-report is a free SMS-based system that allows young Ugandans to speak out on what's happening in communities across the country, and work together with other community leaders for positive change. The following quotes have been retrieved from Ugandan U-reporters relating to various components of adolescent pregnancy:

I am working in a community that is 100% rural and a majority of the school going girls who get pregnant are even below 17 years of age. The worst is that after conceiving, parents of such girls including educated parents force these girls to get married to the responsible persons without considering circumstances of the pregnancy or giving them a second chance.

Girls who get pregnant while at school should be left at school for these reasons: most of them are mothers and if they are out of school, they will get involved into more child labour activities eg. hazardous work like prostitution, house girl activities in order to earn her living, hence it affects their growth physically, emotionally & spiritually. When a girl gets pregnant, they drop out of school - but leaving the man to continue with his studies. It should be applied same to girls. For fear of dropping out of school, some commit abortion or even suicide.

The high rate of teenage pregnancies and early marriages is threatening the future development of both the youths and community. Most of them drop out of school to start these young families. With no education, the door will be opened for unemployment, poverty, alcoholism, domestic violence, crime, high infant mortality rate, street children etc. I believe fighting teenage pregnancies is the first step to development of youths and communities in many other villages in Uganda.

I know of 10 girls: 2 died during an attempt to abort, 3 died because of difficulty in delivery, 5 are ok. Almost 20% of the girls whom I know got pregnant from school & probably 15% try to abort & 5% drop out of school because of unwanted pregnancy & early marriage of which some of them have been forced by their parents.

5.2.6 Child trafficking

Although Uganda has not ratified the Palermo Protocol (2000), it has a Prevention of Trafficking in Persons Act (2009) which is in harmony with the Palermo Protocol and defines trafficking as 'the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation' (Walakira and Nyanzi, 2012: 69).

However, available data (Walakira and Nyanzi, 2012: 70) suggest growing incidents of commercial sexual exploitation and trafficking in the country. A recent survey showed that 7% of girls and 3% of boys were reported to have been trafficked, while a comparative study suggested that almost 10% of 500 girls interviewed in the slums of Kampala had been trafficked (ILO, 2007). The latter suggests that the majority of girls were trafficked at the ages of 14–17, with only a small minority being trafficked at an earlier age. Almost all (35 of 50 women) were forced into prostitution. Trafficking is associated with multiple risk factors but, as studies show, gender-related vulnerabilities are the most significant. Children with orphan status (either due to HIV/AIDS or conflict), children from poor households, children out of school, children who live and/or work on the street, children separated from their parents, children with low formal education, and children living in violent households are particularly at risk of being trafficked (Walakira and Nyanzi, 2012: 70).

Women and children are trafficked from numerous regions (MoGLSD et al., 2014: 103), with more children being trafficked internally than across borders. Trafficking for sexual exploitation affects mainly women and girls, and many of the girls are trafficked by guardians (if they are orphans) or by their parents if they are the children of polygamous marriages or homes where their parents cannot provide for them (MoGLSD et al., 2014: 103).

Trafficked children are often recruited and sold to serve as domestic workers, child soldiers, street beggars, bar and restaurant attendants, commercial sex workers, workers at night clubs and vendors, ‘with no access to education, no freedom of movement and working long hours in poor conditions for little or no pay’ (Walakira and Nyanzi, 2012: 69).

TABLE 9: REGISTERED VICTIMS OF INTERNAL AND TRANSNATIONAL TRAFFICKING (2013)

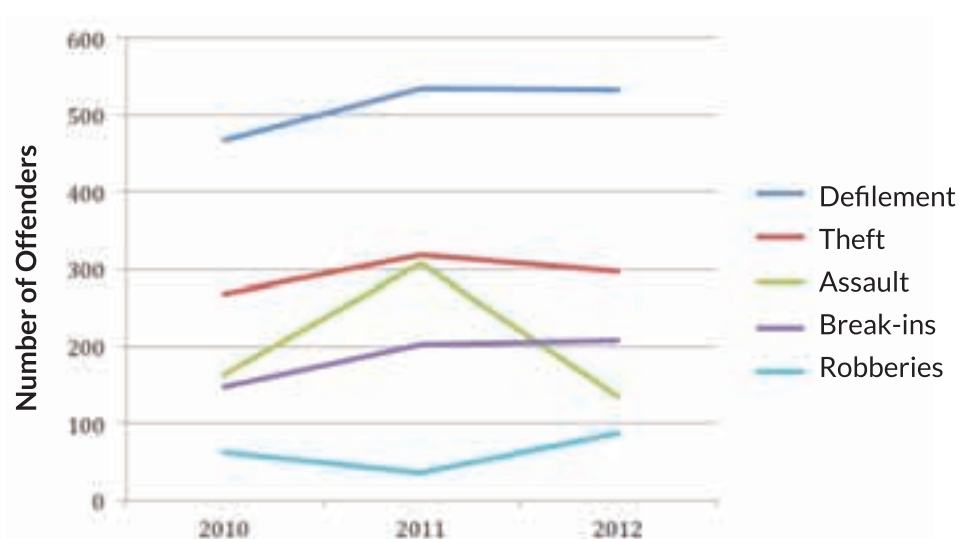
	Male adults	Female adults	Male children	Female children	Total
Internal trafficking	4	5	192	207	408
Transnational trafficking	163	186	44	36	429

SOURCE: COCTIP, 2014

5.2.7 Child-related offences

Child-related offences relate to young people both as offenders and victims. The Justice Law and Order Sector (JLOS) Annual Report (JLOS, 2013a) indicates that in the year 2011–12, there were 1,256 juvenile offenders. In 2012 the Uganda Police Force arrested on average six juveniles per 100,000 of the child population. Figure 13 presents the decreasing trends in juvenile crime between 2010 and 2012.

FIGURE 13: TRENDS IN CRIMES COMMITTED BY JUVENILES OVER THREE YEARS



SOURCE: JLOS, 2013A

The proportion of juveniles who receive non-custodial sentences has increased to 75%. Prior to sentencing, however, children are often held with adults because of a lack of separate holding facilities at police stations, although some progress is being made in newer police stations constructed by the JLOS. Currently Uganda has four operational remand homes with plans to increase the number to seven by 2016/17 (JLOS, 2013b). The JLOS is also working towards ensuring that juvenile offenders are quickly reintegrated into society. In 2012, 230 juveniles were rehabilitated and resettled after release, a marked increase in the number of juvenile offenders rehabilitated in previous years.

The JLOS has also reduced the time spent in detention by juveniles before sentencing from an average of five to three months through the use of the Justice for Children (J4C) programme, which ensures juveniles are fast-tracked in the system. The aim is to take children through the formal justice system using child-friendly procedures, with coordination between the police, the Directorate of Public Prosecutions (DPP), and courts through the District Chain Linked Committees (DCC) and the J4C subcommittees.

TABLE 10: JUVENILES REMANDED AND OR COMMITTED TO REHABILITATION IN 2012/13

Name of district	Boys	Girls	Total
Fort Portal Remand Home	170	5	175
Mbale Remand Home	159	13	172
Naguru Remand Home	854	80	934
Ihungu Remand Home	116	6	122
Gulu Remand Home	82	13	95
Kampiringisa NRC	284	37	321

SOURCE: JLOS, 2013A

Nevertheless, there remain critical challenges. There is lack of policy and a strategic framework to guide JLOS interventions for children. In addition, although justice for children issues are now reflected in the sector plans of the Uganda Parliamentary Forum for Children (UPFC), DPP and judiciary, they are not yet included in the MoGLSD sector plan. A key challenge is the disproportionate emphasis on children in conflict with the law without regard for children at risk or victims of violence, or for safeguarding the best interests of children who are adopted and those who are placed in residential care.

5.2.8 Hazardous forms of child labour

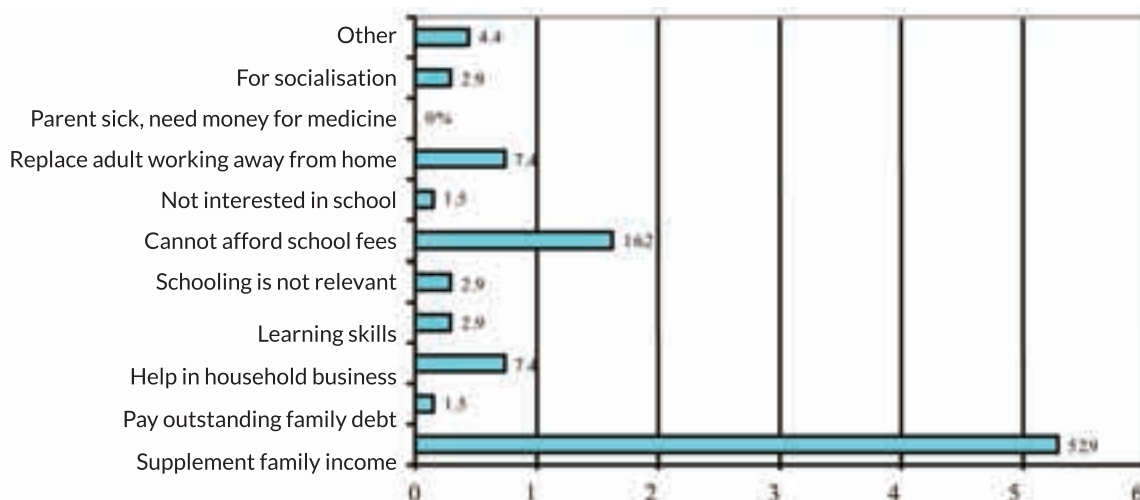
It is estimated that about 2.4 million children are engaged in exploitative child labour, out of which 1.7 million are below 14 years of age (MoGLSD, 2012a). Almost 93% of children in rural areas are believed to be engaged in commercial or subsistence agriculture (land tilling, sowing, weeding and harvesting) and fishing. Those children in plantation agriculture are suspected to work in the most hazardous conditions and risky forms of labour, as they are exposed to chemicals, heat, extra hours and harsh conditions. Children aged between 5 and 17 years also make up the majority of the workforce in the informal sector (Walakira and Nyanzi, 2012: 67).

TABLE 11: PERCENTAGE OF WORKING CHILDREN (5–17 YEARS) BY REGION

Working	Kampala	Central	Eastern	Northern	Western	Uganda
Male	25.2	53.3	54.4	47.1	55.4	51.8
Female	25.4	50.3	51.4	43.5	56.0	49.4
Both sexes	25.3	52.1	53.0	46.3	55.7	50.6

SOURCE: UBOS, 2010: 134

FIGURE 14: MAIN REASONS FOR CHILD LABOUR IN UGANDA (2005)



SOURCE: WALAKIRA AND BYAMUGISHA, 2005

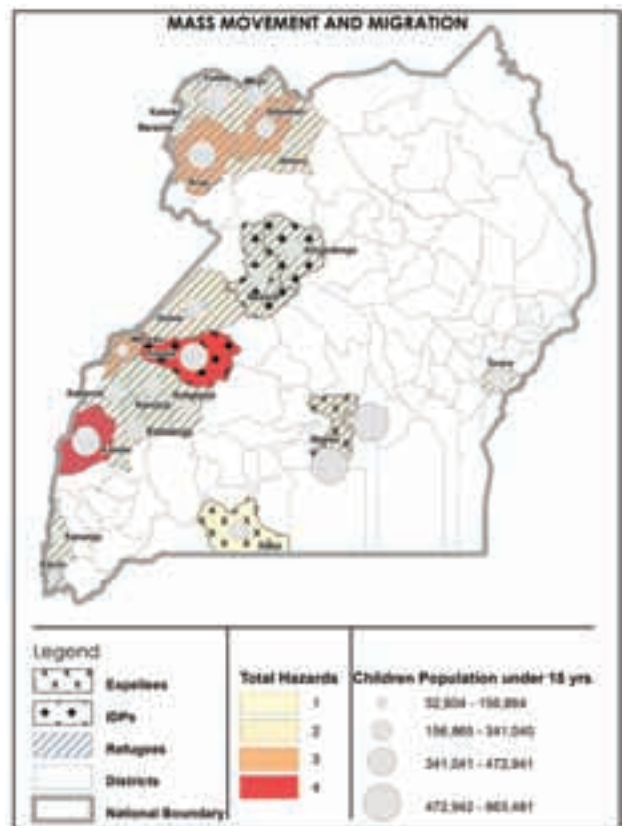
5.2.9 Displacement, ex-combatants and children affected by conflict

Children, along with people with disabilities, breastfeeding mothers, pregnant women and people living with HIV, are most affected by displacement during disaster times in communities prone to floods and landslides (OPM/UNICEF, 2014). Children are also the most vulnerable in conflict situations, and are frequently targets of brutal, indiscriminate acts of violence. During the 20 years of terrorism by the Lord’s Resistance Army (LRA), widespread sexual violence against women and girls was reported (Matovu, no date: 63) and countless numbers of children were abducted, murdered, mutilated, tortured, beaten, raped, and enslaved as child soldiers or for sexual purposes.

Since the outbreak of violence in South Sudan in December 2013, an estimated 116,000 new refugees have arrived in Uganda. Planning estimates project that an additional 60,000 refugees may arrive in the country in 2015. These refugees include women, child survivors of sexual violence, and separated and unaccompanied children in urgent need of protection. The Government is offering refugee status to those fleeing the latest outbreaks of violence in both South Sudan and the Democratic Republic of Congo (DRC) on a prima facie basis, including more than 100,000 refugees from the DRC who arrived in Uganda in 2013.

However, the capacities of local government and social services to respond are stretched to their limits, with health centres requiring additional staff, space and supplies to address refugee health and nutrition needs, and with schools trying to cope with a dramatic increase in enrolment (for example, more than 300 students per classroom have been reported in Adjumani alone).

FIGURE 15: MIGRATION PATTERNS IN UGANDA



5.3 ENABLING ENVIRONMENT

5.3.1 Fiscal space analysis

The figures in Table 12 illustrate some of the major child protection interventions proposed for 2014/15 by the MoGLSD. The total expenditure allocation for MoGLSD is UGX 6.2 billion (\$2.2 million), compared to UGX 1,271 billion for child survival, and UGX 1,940 billion for education. Other expenditures on child protection made in other sectors include those by

the JLOS, which implements the Justice for Children programme, providing support to children interfacing with the law. In addition, JLOS institutions such as the Law Development Centre (LDC) train people to provide counselling for juveniles and also offer legal aid to child offenders. Similarly, the DPP offers training to public officials involved in the handling of cases involving violence against children such as defilement. Other child protection-focused activities of the JLOS in 2014/15 include: construction of juvenile cells and privacy rooms to conduct interviews with children who are victims of sexual violence; constructing a juvenile reception centre at the LDC; and training Grade One magistrates in juvenile justice.¹²

TABLE 12: SELECT CHILD PROTECTION INTERVENTIONS IN THE MOGLSD BUDGET 2014/15
(UGX BILLIONS)

	2014/15
(1) Salaries for 17 staff in the Youth and Child Affairs department	0.165
(2) Printing and dissemination of the Children Act	0.045
(3) Commemoration of the Day of the African Child and Youth Day	0.283
(4) Support supervision and monitoring institutions for vulnerable groups	0.149
<i>Payment of salaries for 45 contract staff</i>	
<i>Inspection of 50 children and baby's homes</i>	
<i>Holding quarterly Kampiringisa board meetings</i>	
<i>Monitoring of programs for children and youth in 20 local governments</i>	
(5) Empowerment and support for vulnerable children	0.345
<i>Holding 24 coordination meetings for the department and children institutions under the MoGLSD</i>	
<i>Holding 2 national stakeholder meetings on child protection and youth programming</i>	
<i>Empowerment of 100 children in conflict with the law (provide rehabilitation material and resettlement kits for children released from Kampiringisa)</i>	
<i>Operationalise 7 children and youth institutions</i>	
(6) Support for National Council for Children	1.355
(7) Renovation and maintenance of child centres	0.596
(8) Other expenditures in the children and youth department	2.369
(9) Support for street children activities	0.985
Total budget for child protection	6.292

SOURCE: MOGLSD ET AL., 2014

5.3.2 Contextual, supply and demand factors

Recognising that one of the major challenges to child protection comes as a result of poor coordination and gaps in the enforcement and implementation of laws and policies, the Government has devised a strategy to strengthen the child protection system in Uganda. The new strategy recognises that the system embodies 'a series of components (e.g. laws, policies,

12. Given the way JLOS institutions' budgets are captured, it is not possible to isolate funding for child protection services from the overall institutional budget.

regulations, services, capacities, monitoring, and oversight) organised around the goal of preventing and responding to protection risks such as abuse, abandonment, exploitation, and neglect' (MoGLSD, 2013a: 1). The system's new approach to child protection entails a shift from vertical silo-based programming focusing on specific categories of children (e.g. street children, sexually abused children and working children) to integrated programming approaches that protect all children, greater linkages between sectors (social welfare, education, health and justice), and greater linkages between levels (national, sub-national and local).

This strategy aims to deliver benefits for all at-risk children, instead of only specific groups that have been identified or assumed to be vulnerable. Where the scale of response is sufficient to reach all children in need of support, or a good proportion of them, this may significantly increase impact. Moreover, a systems approach can be used to prevent protection problems arising, helping to reduce economic burdens for the country. Finally, by strengthening existing child protection processes and structures through their emergency response, higher levels of efficiency can be reached.

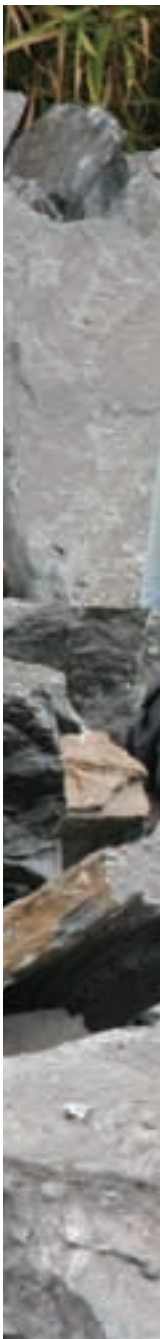
Factors that restrict **supply** include the availability of adequately staffed services, facilities and information. Lack of a structured database in the protection sector is linked to the limited issuance of birth certificates. This is a key challenge, as different protection services and programmes need to be measured over reliable and functional databases, which aggregate up-to-date data.

Domestic violence and other forms of abuse aimed at children are a result of more serious, systemic elements including, but not limited to: complex and poor law enforcement; lack of trained personnel to handle cases of violence; barriers in accessing care; and the lack of coordination among sectors and civil society responsible for child protection. Lack of access to basic social services, including health, sanitation and education, contributes to child protection violations. Safe school environments need to be made a priority and more awareness needs to be fostered to empower children in making informed decisions.

On the **demand** side, parents and communities do not fully appreciate and demand child protection services. Children themselves lack information about the available services and how to access them. Probation and social welfare officers are also limited in the kind of services they can deliver. In most cases, available services are largely provided by NGOs.

There is also a general lack of awareness of what constitutes child abuse or dangerous work, including by many children themselves. Some children are exploited by hazardous work because of the traditional value placed on child labour, e.g. in peasant farming communities parents often withdraw children from school during planting and harvesting seasons.

Direct, indirect and opportunity costs are also important barriers preventing poor families and those living in hard-to-reach areas from demanding services, even when they might be available. Evidence suggests that the main cause of children's involvement in hazardous



work is the need to supplement family income. Lack of skills for gainful employment and vulnerable livelihoods also drives families to force minors into child labour. Further, widespread levels of HIV/AIDS continue to contribute to a vicious cycle of child labour by worsening the poverty levels of households and adding to the supply of child labour into the labour market. Finally, demand for birth and death registration services is low because of the prohibitive cost of acquiring a birth certificate (UGX 5,000 for a long birth certificate and UGX 1,000 for a short birth certificate).

To conclude, poor **quality of services** results in a high likelihood for children and women to be vulnerable to dangerous settings. This dynamic is significantly exacerbated by the absence of effective mechanisms for systematically tracking and monitoring key child protection indicators including birth registration, child labour, internally displaced and refugee children, children in residential care, children in conflict with the law, and violence against children.





6 THE RIGHT TO PARTICIPATION

This chapter outlines general trends in children's participation, the benefits it brings, the challenges and barriers that limit or prevent it, and ways in which children in Uganda could become more involved in decisions that affect their lives.

6.1 INTRODUCTION AND OVERVIEW

Participation is a right enshrined in the UN Convention on the Rights of the Child (UNCRC) to ensure that a child who is capable of forming his or her own views is able to express them freely in all matters affecting him or her, and that the views of children are given due weight in accordance with their age and maturity. Uganda recognises all citizens' right to participation in the Constitution of the Republic of Uganda (1995), the Local Government Act (Cap 243), and the Children Act (Cap 59). All adults and all institutions that in some way work with or have an impact on children and families have the duty to ensure children's participation in different areas of life.

However, it is not always clear what is meant by children's or young people's 'participation' (e.g. Restless Development, 2012). The term can often be obscure or ill-defined, which does not encourage children's participation or its promotion by authorities. 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.

Participation is also a particularly difficult area to research and to support through programming, as the changes required are highly qualitative, there are no widely used indicators or objectives, and programme work tends to be small-scale, localised and require high levels of input from facilitators/organisers.

In general, attitudes within Ugandan society are not conducive to children and young people expressing their views as they are not considered capable and their concerns and demands are often ignored. However, in a society where many children enter the labour force in their early teens, carry out domestic or farm duties as soon as they are physically able, and often get married or have children before they turn 18, it is particularly important to develop ways in which they are able to influence decisions that affect them.

Where participatory initiatives have been carried out in a meaningful way, the benefits

become clearly visible. Children and young people's participation can help ensure better protection outcomes in refugee and IDP camps (Skeels, 2012); build a more complex and nuanced understanding of poverty and discrimination (Witter and Bukokhe, 2004; Perezniето et al., 2014); research and build dialogue on conflict issues with affected communities (Karamoja Action Research Team with Scott-Villiers, 2013); support the monitoring of child-related services (MoGLSD et al., 2008; Plan UK, 2011); and produce radio programmes that are relevant and pertinent to young listeners (MoGLSD et al., 2008). Finding creative and meaningful ways to promote children's participation is manifestly a central component of successful programming for children.

6.2 WHAT IS BEING DONE TO PROMOTE CHILDREN'S PARTICIPATION?

In 2008, the Government published its National Child Participation Guide (MoGLSD et al., 2008), which explains what child participation means, how it is mandated by the UNCRC and various legal and policy frameworks, and how it fits within a broader rights-based approach. It also provides extensive guidance for organising consultations with children and promoting children's participation at family, community and policy levels as well as in the media. However, since it is a guideline document rather than a policy or action plan, it does not outline any actions or goals for the Government or relevant stakeholders. To date, it remains the only document produced at national level explicitly concerned with children's participation.

6.3 WHAT ARE THE MAIN CHALLENGES AND BARRIERS TO CHILDREN'S PARTICIPATION?

Attitudes of adults were the most commonly mentioned barrier to participation by children and young people in a number of reports. This is something that children themselves are very aware of, which tends to have a diminishing effect on their willingness to get involved and their trust in participatory processes (ActionAid International Uganda et al., 2012; Restless Development, 2012; Skeels, 2012; Witter and Bukokhe, 2004). For example, the adult key informants interviewed by Witter and Bukokhe were 'clear that children are dependent, that children lack knowledge and means, that only adults can address the issue of child poverty' (2004: 649). 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 children in favour of an approach based on partnership and collaboration.

There are no official national structures aimed at facilitating children's participation. Some

more formal structures exist for youth participation, but 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 programmes run by international and national NGOs working with children and young people and may not be sustainable beyond the project cycle.

There is also concern that many participatory initiatives do not reach the most disadvantaged or excluded children and can therefore 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 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 neighbourhood as places where they can discuss their concerns (Skeels, 2012).

6.4 ENTRY POINTS FOR IMPROVED PARTICIPATION BY CHILDREN

The following have been identified by the literature as possible entry points for improved participation by children in Uganda.

- At the **national level**, structures for children’s participation should be considered, e.g. a 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 localised 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, building on the smaller-scale initiatives discussed above (Witter and Bukokhe, 2004.; MoGLSD et al., 2008; Plan UK, 2011).
- Creating ‘**child friendly spaces**’ – by setting up specific spaces exclusively for children and those who take care of them and using the child friendly space principles in public spaces – schools, ECD centres, health centres, local government offices, community spaces, etc. (Skeels, 2012). In addition, safe places for girls could empower them to discuss and address the issues that affect them specifically.

Guidance for this kind of work already exists, at least in specific policy areas such as education (Raising Voices and UNICEF, 2014; MoGLSD et al., 2008). The value-added benefits of community engagement in specific implementation activities have been found to have tangible impacts on public resource efficiencies – including in Uganda (Bjorkman and Svensson, 2009). Box 7 below discusses how community participation can provide an entry point for children’s participation.

BOX 7: COMMUNITY-BASED HEALTH SYSTEMS MONITORING IN UGANDA

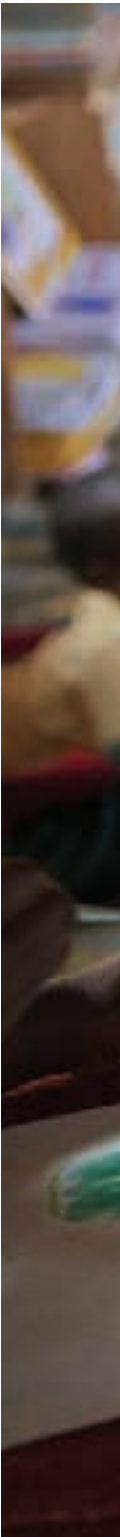
Rural level 1 health centres, which are at the lowest level of the Ugandan health system, provide preventive outpatient care, maternity and laboratory services. A number of actors are responsible for supervision and control of these facilities, including the Health Unit Management Committee, which monitors the day-to-day running of the facility, but has no authority to sanction workers. The health sub-district, one level above, monitors funds, drugs, and service delivery, although this monitoring is variable in consistency and quality. The chief administrative officer of the district and the district service commission have the authority to inspect and oversee human resource management – while health centres at a primary response level have few lateral or vertical accountability structures, which in turn limits incentives and peer-to-peer oversight.

Intervention: A team of researchers constructed a randomised control trial involving 50 health centres to determine whether community monitoring might be able to support accountability deficits in health centres, as well as provide detailed and real-time feedback on performance and health outcomes.

Impact on health outcomes: The research showed that the use of outpatient services was 20% higher in the treatment group, i.e. the group involved in participatory monitoring of health services. Furthermore, childbirth deliveries increased by 58%, while 19% more patients sought antenatal care. In addition, family planning consultations increased by 22%, with immunisations increasing for all age groups, especially newborn babies, self-treatments and traditional healers became less involved in health decisions, and a 33% reduction in child mortality under five was observed. These observations were intimately linked to the degree of community involvement in health services in targeted sites.

Such significant and multiple health outcomes arising through community mobilisation and monitoring bring into question other potential roles for participatory measures to inform service provision, such as community scorecards and citizen report cards. While this study did not focus on children per se, it nevertheless suggests that involving children directly with monitoring oversight in the decisions that affect them, whether it be with respect to health interventions or schooling, or water and sanitation services, would add dividends to service-delivery measures.

SOURCE: INNOVATIONS FOR POVERTY ACTION (WWW.POVERTY-ACTION.ORG); BJORKMAN AND SVENSSON, 2009



Increasing children's participation beyond specific participatory initiatives involves scrutinising the school, health care, justice and security systems to ensure that they better enshrine the principles of equality, respect and security needed for meaningful participation. An example of this would be the attempts to end corporal punishment in schools and promote positive discipline and safer schools (Raising Voices and UNICEF, 2014). More collaborative approaches between adults and children are a precondition for children to be able to voice their views in a meaningful way.





7 KEY CHALLENGES AND POLICY RECOMMENDATIONS

This chapter presents key challenges and makes recommendations for equity-focused programming and systems strengthening to promote child wellbeing across the target cohorts and the four rights-based areas of survival, education and development, protection and participation.

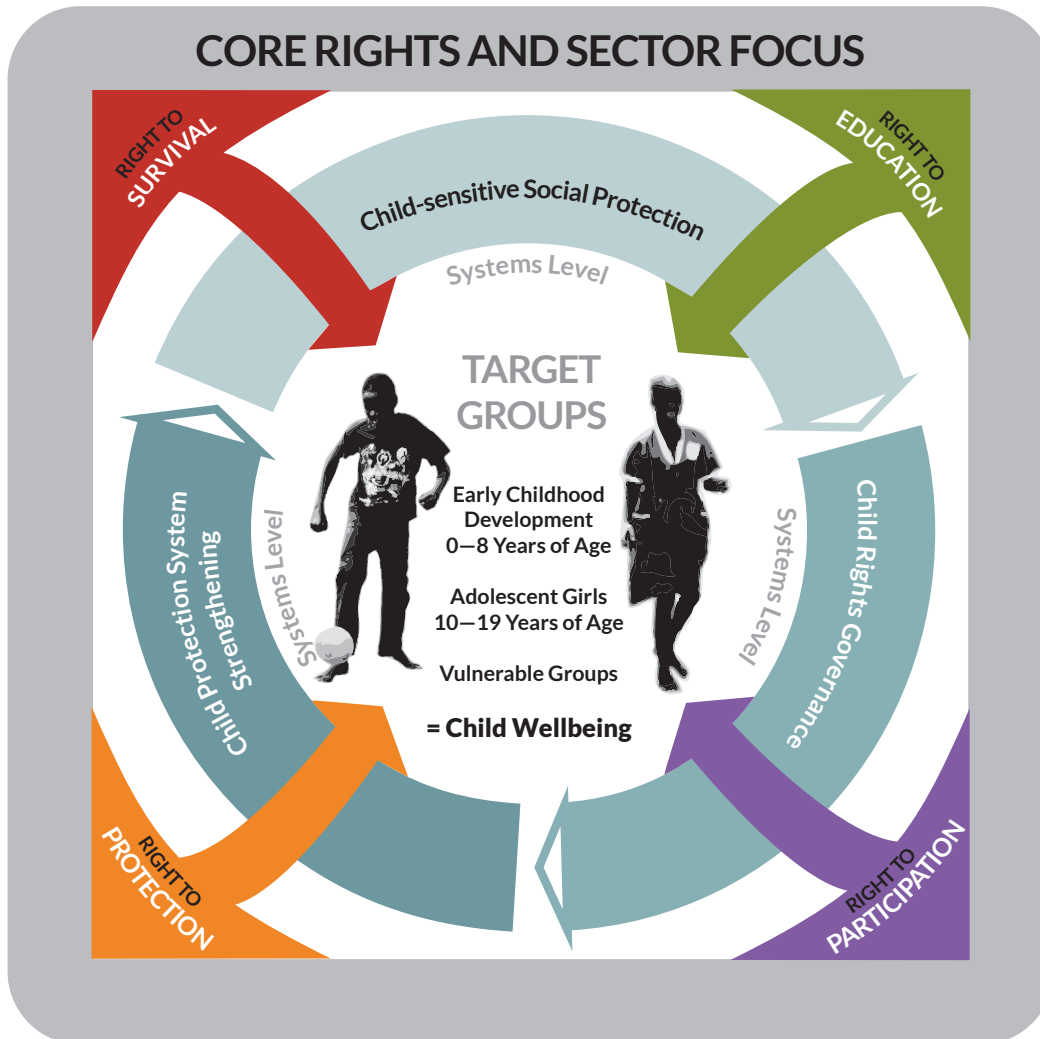
7.1 INTRODUCTION

Uganda's national response capacity for the realisation of children's rights is defined by several factors. First is its national laws and policies, which provide the underpinning framework for programmes and actions to be taken in favour of children (see Appendix 1). Uganda has a comprehensive policy and legal framework for the protection of children's rights and is signatory to all key international agreements on children's rights. The second is the extent to which these laws and policies are implemented so that they actually have an effect on children's lives. There are many factors that contribute to or hinder the implementation of these laws and policies, ranging from the adequacy of programmes, to their level of funding, the human resources available, and decision makers' knowledge and understanding of the barriers that need to be overcome to more effectively implement these actions.

7.2 TOWARDS A CHILD WELLBEING MODEL IN UGANDA

As well as making overarching recommendations and recommending policy actions to promote the realisation of specific children's rights, this situation analysis provides a model for action that addresses the key components necessary to provide for the overall wellbeing of children (Figure 16).

FIGURE 16: KEY COMPONENTS OF CHILD WELLBEING



Early childhood development (ECD) requires a thorough understanding of the complementarities between health, nutrition, education and protection, and an appreciation of a variety of target groups – including pre- and postnatal women, young children, caregivers and the ECD workforce. While the proposed Uganda Integrated Early Childhood Development Policy makes these issues clear, the future challenge will be ensuring that it is firmly anchored in the Government’s budgeting frameworks, and adequately funded and monitored. A second key area requiring urgent attention is the wellbeing of adolescent girls. The major persistent policy and practice challenges here concern sexual and reproductive health rights – particularly with respect to teenage pregnancy and retention in secondary school. Guidelines for schools on how to handle teenage pregnancy appropriately would enable young mothers to return to school and complete their education. More broadly, a deeper understanding and integration of empowerment issues – including how men and boys are involved in this debate – need to be included in policy dialogues and implementation strategies.

There is a need to develop a greater focus on equity-based programming in order to tackle differing degrees of vulnerability faced by marginalised groups (whether on the basis of gender, income, residence, religion, ability or access to basic services – see Appendix 2) through the identification of catalytic forces for the effective delivery of a holistic child welfare model, as depicted in Figure 16.

7.3 OVERARCHING RECOMMENDATIONS

- **ESTABLISH AND FULLY IMPLEMENT AN INTEGRATED EARLY CHILDHOOD DEVELOPMENT (ECD) POLICY FRAMEWORK:** Developing children’s potential starts in early childhood. The first 1,000 days of a child’s life are crucial to building good nutrition, while early cognitive development is important in preparing children for primary school. ECD goes beyond pre-primary education and includes health, nutrition and protection. As such it is important to establish an integrated ECD policy framework that is adequately funded and monitored. The integrated policy should aim to improve the enabling environment for ECD to ensure that Ugandan children get the best start in life.
- **PRIORITISE CHILD SENSITIVE SOCIAL PROTECTION POLICIES AND PROGRAMMES:** Uganda faces widespread child poverty and deprivation with many children facing specific vulnerabilities. Children with disabilities, for example, often find themselves cut off from education and other social services. Adolescent girls are highly vulnerable to dropping out of school, teenage pregnancy, early marriage and exposure to risky behaviours. Such dynamics bring a lifetime of consequences which affect them and the future generation. Child-sensitive social protection policies and programmes can help address child poverty and reduce the vulnerabilities children face. Evidence shows that social protection programmes can improve education, health and nutrition outcomes, and in some cases prevent risky behaviour in adolescents. Uganda needs to expand social protection and ensure that programmes are designed to reach the poorest and most vulnerable children and adolescents.
- **STRENGTHEN PUBLIC FINANCE FOR CHILDREN:** This involves increasing the visibility and enhancing monitoring efforts for programmes affecting children in the national budget. The latter is a crucial tool for the fulfilment of children’s rights as budgetary decisions can affect child poverty, education, health, nutrition and protection. With over 50% of the population below the age of 18, children’s cognitive development represents Uganda’s greatest natural resource. Mainstreaming of investments in children into fiscal policy through a transparent and participatory budgetary process stands a necessary precondition for Uganda to reap full benefits from the demographic dividend and achieve Vision 2040.

- **INSTITUTIONALISE CHILD INDICATORS IN NATIONAL STATISTICS, SURVEYS, AND POLICY DOCUMENTS SUCH AS THE NATIONAL DEVELOPMENT PLAN:** Child-specific indicators are necessary to monitor and assess progress in children's wellbeing. The indicators should be disaggregated by socioeconomic characteristics to measure disparities in child wellbeing within the country. The overall policy framework should aim to eliminate inequalities in access to services, opportunities and outcomes for children. This can only be achieved if child-focused indicators are regularly collected and monitored, and national policy includes specific goals to improve children's wellbeing.
- **DEVELOP A NATIONAL CHILD PARTICIPATION STRATEGY:** Child participation remains characterised by fragmented and time-limited initiatives. Developing a national child participation strategy to serve as an action plan with main interventions, timeframes, targets, key institutions and their specific roles and expected outcomes is a critical step towards establishing a better enabling environment for child participation in Uganda. Anchored on Uganda's constitution and legal framework, and firmly harnessed on the UNCRC, this strategy can pave the way for sustainable avenues for children to participate in discussions around issues that affect them at the national and local level.

7.4 SERVICES AND SECTORS: CHALLENGES AND RECOMMENDATIONS

7.4.1 The right to survival

CHALLENGES

The Government has committed to a number of national and international goals related to health-service provision and sanitation, with respective targets for 2015, 2017, 2025 and 2040. While it is unlikely to meet all its health and sanitation targets by 2015, the country has made steady progress, particularly in reducing HIV and AIDS, especially mother-to-child transmission.

Given that poverty, gender, health and hygiene are interlinked, improvements in social norms, women's empowerment, economic empowerment, education and access to WASH facilities all positively impact on health outcomes. However, there is limited adherence to national guidelines, clinical protocols and proven strategies such as integrated community case management (iCCM) and integrated management of childhood illness (IMCI). Many rural health facilities are geographically inaccessible and there are inadequate referral systems. Clinics are housed in inadequate buildings, with a lack of skilled workers and equipment, and frequent medicine stock-outs.

Financing is a key constraint to effective health sector development in Uganda. According to the National Budget Framework Paper FY 2014/15 – FY 2018/19 (MoFPED, 2014) and the Budget Speech FY 2014/15 (State House of Uganda, 2014), in FY 2014/15 the health sector share of the total budget was reduced from 8.6% to 8%. Uganda is therefore yet to comply with the Abuja Declaration to assign 15% of national budgets to health care by 2015 (Kagumire, 2010).

As well as addressing gaps in service provision, the Health Service Strategic and Investment Plan (HSSIP) requires greater investment in preventive interventions. In the longer term, this has the capacity to change behaviour to prevent illnesses (or pregnancies) arising and reduce the strain on health facilities. While there has been steady progress in reducing HIV and AIDS and in eliminating mother-to child transmission (eMTCT), increasing HIV infections, especially among adolescents, and the limited coverage of eMTCT services are of concern. Policies that monitor the implementation of eMTCT will benefit the reversing trend of HIV infections and commitments to global initiatives such as Family Planning 2020 demonstrate that Uganda will persevere past 2015 to keep women’s reproductive health on the government health agenda.

Finally, understanding of the mutual advantages that child-sensitive social protection and child protection system strengthening bring to child survival outcomes is making progress. The Social Protection Sector Review (MoGLSD, 2014b) provides relevant insights relating to child survival by focusing on the non-contributory dimensions of social security (direct income support) as well as some elements of social care and support services. The issue of child-friendly governance systems can also be promoted by using participation as a critical modality through which survival-orientated services can gain efficiencies.

RECOMMENDATIONS

- **Harness women’s voices and include men in health-seeking behaviour for children** by funding communication interventions and implementing technical training on knowledge, attitude and practice surveys and associated M&E systems.
- **Address the evolving and special needs of adolescents**, especially adolescent girls, through mainstreaming adolescent health programming and strengthening the capacity for implementation of a comprehensive HIV/AIDS response.
- **Focus efforts in stunting reduction and child development** through strengthening the Office of the Prime Minister’s capacity to coordinate and lead a multisectoral response, rolling out the ‘1,000 Days’ programme and improving the scale and quality of community-based management of acute malnutrition, jointly with parental education about infant and young child feeding.
- **Strengthen intersectoral collaboration** regarding water and sanitation and ensure accountability of relevant sectors through: scaling up community-led total sanitation and WASH in schools and health facilities; fostering public/private partnerships for innovative sanitation technologies and maintenance of WASH facilities.

- **Strengthen institutional leadership and coordination** to effectively implement the Reproductive, Maternal, Newborn and Child Health (RMNCH) 'Sharpened Plan' and address income disparities that reduce user access in pursuing RMNCH outcomes.
- **Expand social protection and equity-focused approaches**, e.g. eliminate informal user fees at health facilities and improve monitoring of health expenditure. Implementation of the National Health Insurance Policy (NHIP) should be harmonised with wider social protection systems to ensure that the interests of poor families and the needs of children are met.
- **Strengthen linkages across the continuity of care across all levels and involve the community across the full continuum of care.** This should include a consultative processes to identify health funding priorities that cater for both prevention and response-oriented activities and will require investments in social accountability mechanisms at sub-national level.
- **Improve capacity to cope with diverse emergency contexts.** Creation of a multisectoral and strategic approach to disaster risk reduction (DRR) that includes better risk assessment and planning, must be prioritised in order to achieve sustainable development. In terms of drought impact reduction, strengthening early warning systems (and the related Integrated Food Security Phase Classification - IPC), dissemination of appropriate dry-land farming practices, rangeland management, and improved soil and water management will be crucial. Integrated watershed management, forestry management (including community forestry), soil and water conservation practices will need to be strengthened.

7.4.2 The right to education and other developmental rights

CHALLENGES

Since the inception of universal primary education (UPE) in 1997 and universal secondary education in 2007, the Government has been committed to extending education to all Ugandan children. As a result, education sector expenditure has increased substantially at an average of 17% of yearly government expenditure in real terms and, with the introduction of Universal Post Primary Education and Training (UPPET) in 2006, by 33% over two financial years (ODI, 2008, cited by Ezati, 2011). Despite this increase, over the last 12 years education spending declined as a share of government expenditure from 24% in 1997/98 to a projected figure of approximately 15% (excluding external financing) in 2015/16 (MoFPED, 2014).

The profile of expenditures in the pre-primary/primary and secondary sub-sectors targeting child development indicate that spending on primary education accounted for 42% of the total education in 2013/14 and is expected to account for 50.4% of the education budget

in 2014/15. However, primary teacher salaries account for over 82% of the total expenditure in the sub-sector. This means that Uganda cannot adequately meet other inputs into primary or secondary education. While a conducive and comprehensive policy environment exists as reflected in the Education Sector Strategic Plan (2007–15), the National Development Plan 1 and 2 and the Global Partnership for Education (GPE), and while a number of policies and strategies have been introduced since 2000 including the 2008 Education Act, the implementation of these policies and strategies continues to face significant challenges. Regarding school attendance, the factor that is most consistently related to low school enrolment and high dropout rates is low household income. The most direct avenue in which to promote school enrolment and attendance (at least at primary level) is therefore to ensure that schooling really is free – including formal and informal fees, costs related to uniforms, meals and materials, transport and school facilities – and to consider financial incentives for parents to prioritise these services. Child sensitive social protection mechanisms that reduce the opportunity costs to households of children attending school should also be a focus.

Other challenges pertain to the quality of education available. High pupil/teacher and low classroom/pupil ratios, teacher absenteeism, outdated teaching methods, a curriculum that is not relevant to children’s current and future lives, and corporal punishment and abuse contribute to absenteeism and poor learning outcomes.

RECOMMENDATIONS

- **Support the approval and implementation of the Uganda Integrated Early Child Development Policy and ensure that it is sufficiently financed and targets those who are most vulnerable.** ECD interventions should also be proposed as part of a broader national social protection initiative via the Expanding Social Protection Secretariat and the Ministry of Finance, Planning and Economic Development, as well as part of discussions on the role of the private sector.
- **Invest in teacher training and familiarisation on new curriculums.** Pre-primary, primary, as well as both the new O-level curriculum (2017) and the current Post O-Level Education And Training (UPOLET) initiative, should be supported through adequate training outreach to teachers to ensure familiarity on changes in the education system, as well as best practice on skillsets that maximise learning outcomes for children.
- **Invest in adolescent girls.** This has an intrinsic rights component in addressing major inequalities and will also deliver longer-term gains in terms of girls’ labour market participation, and broader development and wellbeing. A new approach is needed that addresses economic strengthening, social norms and service constraints.
- **Eliminate all informal schooling costs to reduce school dropout.** Effectively eliminate all school-related costs, particularly PTA fees and uniform costs, so that the cost of going to school is not a barrier to children’s enrolment and attendance. In

addition to increasing the budgetary resources available to primary and secondary education, it is crucial to foster greater transparency and efficiency in the use of these resources.

- **Support the implementation of the Special Needs Education Policy.** Children with disabilities should receive better support to enrol and continue going to school. Access and transport should be improved and sensitisation towards children with disabilities should be included in teacher training and the curriculum in order to create a safe environment in both mainstream and special schools.
- **Strengthen social protection/safety net mechanisms for poor and vulnerable households to promote education service uptake.** This could be particularly useful to support the education of children with disabilities, orphans and other vulnerable children. Improved monitoring and evaluation should take into account equity dimensions at national and district level.
- **Promote opportunities for young mothers to continue their education.** Young mothers should be given flexible options to continue schooling, if necessary outside the formal school system.
- **Strengthen vocational and technical training opportunities for adolescents through implementing the Skilling Uganda Strategy.** Options for vocational and technical studies should be offered to both adolescent girls and boys, with specific attention to developing locally demanded trades that provide income opportunities.

7.4.3 The right to protection

CHALLENGES

Child protection is firmly embedded in a number of national policies and strategies such as the National Development Plan, the National Action Plan on Elimination of the Worst Forms of Child Labour and the National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children. The Government is also developing a National Gender-based Violence Policy and a cohesive child protection strategy to tackle ongoing coordination challenges.

However, limited implementation of these policies has perpetuated a continuation of violence and abuse against children. Other structural deficiencies are found in the legal system, including laws that do not define explicit criminal liabilities and sanctions of abuse. These gaps hinder prosecutions for violations such as child labour, corporal punishment, child marriage and mutilation. Moreover, 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.

The proposed national child protection strategy is expected to expand support for the justice and law and order sector (JLOS) to move away from punitive measures for children in contact with the law and fill gaps in current survivor and witness support facilities. Part of the policy challenge will be enabling an integrated child protection system to adequately cater for an evidence-based approach to address discriminatory social norms such as violence against children and gender-based violence. In addition there is a lack of skilled staff, largely due to the limited budget attributed to this sector (0.4% of GDP). At county level, support to probation officers has been replaced with community-development officers who lack the skills and time to adequately meet child protection demands.

Lack of awareness about protective legislation by children and their caregivers and fear of authorities (whose responses in some cases favour the accused) reduces incentives to report and seek legal recourse. This points to important weaknesses in the judicial system, from its communication of rights principles to citizens to developing trust in judicial institutions (including local police and family support units).

Child labour – including its most hazardous forms – is on the rise across all regions in Uganda and requires specific policies and guidelines to ensure strong law enforcement and punishment for those who employ children in hazardous working conditions.

Notably, child-sensitive social protection can help address the age-sensitive and multidimensional vulnerabilities of children while also strengthening capabilities of families and households to care for their children. Evidence from other east and southern African countries shows that child-sensitive social protection programmes, including income support and cash transfers, can help help families and children to overcome financial and social barriers and break the intergenerational transfer of poverty (Transfer Project, no date). Direct income support to families improves children’s nutrition, access to healthcare, and education, and reduces negative coping mechanisms such as pulling children out of school to contribute to family income, reducing their diets, engaging in child labour and living on the street. Social protection in the form of access to free or affordable high-quality services can also maintain family stability and promote child protection.

Making social protection more child-sensitive has the potential to benefit whole families, communities and national development as a whole. It can address chronic poverty, social exclusion and external shocks that can irreversibly affect children’s lifetime capacities and opportunities. Child-sensitive social protection can address the risk of exclusion that is intensified for children in marginalised communities and for those who are additionally excluded due to gender, disability, HIV and AIDS, and other factors such as harmful socio-cultural norms that can impinge on the fulfilment of their rights.

RECOMMENDATIONS

- **Strengthen the national strategy to eliminate child labour and adopt a more programmatic response.** This should be directed towards three broad groups of children: (1) those at risk of involvement in child labour; (2) those already harmed by exposure to child labour; and (3) those in the worst forms of child labour requiring immediate and direct action. Direct government action with the support of NGOs is needed to rescue children in the worst forms of child labour, including trafficked children, children subjected to commercial sexual exploitation and those involved in illegal activities. There is also an urgent need to share best practices in withdrawal, rehabilitation and integration, and to commit resources to support affected children and their caregivers.
- **Promote child-sensitive social protection in order to reduce household economic vulnerability and resulting child protection deficits.** These measures should include community-based social safety mechanisms such as micro health insurance plans, community saving groups, and micro-credit initiatives targeting the poorest families. Child-friendly social protection mechanisms can improve school attendance and retention, which is broadly agreed to be one of the most effective ways of addressing protection issues such as child labour.
- **Strengthen awareness of juvenile justice systems and services.** There needs to be an increased focus on policy reforms that promote practices such as advertising and expanding upon promising shifts within the JLOS sector that take a less punitive and more productive approach towards children in contact with the law. Discussions around the emerging child protection strategy could be a productive convening space for linking social protection measures to children overseen by the JLOS, as well as expanding the evidence base on preventative measures for children addressed by the OVC strategy.
- **Strengthen cross-sectoral engagement in child protection law enforcement.** Multiple actors – community structures (local leadership, religious and traditional leaders), police, civil society organisations and children themselves (through participatory consultation) – should be included in policy development and implementation. Management information systems need scaling up, including integration across OVC, education and health sectors, while also taking advantage of emerging information and communication technologies such as U-report and other measures such as community child protection scorecards. Capacities of the social welfare workforce need strengthening to create functioning case management and referral mechanisms. Linking informal and formal child protection mechanisms is crucial to enhance functioning of the child protection system at community levels where formal systems are scarcely present.

- **Improve equity-based mapping.** Include climate change/disaster risk reduction (CC/DRR) in upcoming vulnerability and capacity analysis in order to move beyond 'static' indicator assessment towards a dynamic assessment that recognises consistent low performance on impact indicators. There is also an opportunity to take advantage of Uganda's progressive refugee policies to become a beacon of learning on cross-cutting risk assessment and response.
- **Strengthen knowledge, capacity and interventions that address social norms change.** Interventions focusing on social norms change should be integrated with economic strengthening and service-based activities to ensure that progressive attitudes and behaviours are promoted and proliferated at all levels.
- **Finalise and implement a cohesive child protection strategy.** Discussions regarding a joint government strategy on child protection should take into account crucial ongoing engagements relating to child-sensitive social protection, the national strategy to eliminate child labour, policy reforms on juvenile justice, equity-based mapping, law enforcement and the linking of formal and informal systems. These focus areas, particularly the latter two, require continued support and development (including at district level) of the Child Protection Management Information System, including monitoring and evaluation indicators that are sex-disaggregated and which take into account social norms indicators.

7.4.4 The right to participation

CHALLENGES

While children's right to participation is clearly articulated in international instruments, to which Uganda is a signatory, and in several national legal frameworks and policy documents, the implementation of children's right to participate faces many challenges and gaps. In 2008, the Government developed a National Child Participation Guide explaining the UNCRC mandates around the right to participation. However, awareness of the Guide is very low due to its limited dissemination (MoGLSD et al., 2008). In addition to limited funding, other challenging factors when it comes to the realisation of children's right to participation are: societal attitudes about the status of children in society; inadequate understanding of the concept of child participation; and scepticism regarding the impact of the empowerment of children.

Where participatory initiatives have been carried out in a meaningful way the benefits of allowing children's views to be heard become clearly visible. Children and young people's participation has been shown to help ensure better protection outcomes in refugee and IDP camps, build a more complex and nuanced understanding of poverty and discrimination, and develop dialogue on conflict issues with affected communities as well as supporting the monitoring of child-related services.

RECOMMENDATIONS

- **Raise awareness about the value of child participation interventions.** The ‘value-added’ of child participation engagements – either in community, local, or national governance dialogues – will require investments in pilot activities that have robust monitoring and evaluation systems that are able to discern the cost-benefit characteristics of such engagements.
- **Support children’s participation through rights-awareness training and support for children’s activities and forums.** This requires developing the capabilities and political empowerment of children themselves as well as structures around them – including school clubs, the development of more plural and diverse school management committees, and inclusive local administration systems.
- **Invest in a community of practice to support monitoring and evaluation of child participation activities.** The data revolution, including advances in real-time monitoring (such as U-report) provides a useful entry point through which to engage children and provide immediate outputs that can assist in promoting accountability in the services that are most critical for children.

However, the development of child participation mechanisms should take into account systemic inequalities associated with such dialogues, including gender, urban and elite bias or capture. Government guidelines on child participation need to be re-promoted across ministries and re-invigorating to ensure that they are not tokenistic.

- **Develop and implement a child participation strategy.** A child participation strategy will help to articulate key interventions and mechanisms for enhancing child participation at different levels and in different spheres. It can help galvanise the efforts of different stakeholders around a common framework and sustainable avenues through which to engage children in matters that affect them. Children’s input into national surveys through child-friendly indicators and the inclusion of child-specific categories in national-level data gathering will also improve the evidence base on child wellbeing, and thereby improve targeting efficiencies.

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APPENDIX 1:

OVERARCHING FRAMEWORKS AND NATIONAL CAPACITIES RELATING TO CHILDREN'S RIGHTS

INTERNATIONAL AND NATIONAL FRAMEWORKS

UN CONVENTION ON THE RIGHTS OF THE CHILD (UNCRC)

Article 2: States parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

Article 4: Governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled. When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help families to protect children's rights and create an environment where they can grow and reach their potential. In some instances, this may involve changing existing laws or creating new ones.

Article 6: (1) States parties recognise that every child has the inherent right to life. (2) States parties shall ensure to the maximum extent possible the survival and development of the child.

Article 12: Children have the right to participate in decision-making processes that may be relevant in their lives and to influence decisions taken in their regard—within the family, the school or the community

Article 19: Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them.

Article 20: Children who cannot be looked after by their own family have a right to special care and must be looked after properly, by people who respect their ethnic group, religion, culture and language.

Article 21: Children have the right to care and protection if they are adopted or in foster care.

Article 22: Children have the right to special protection and help if they are refugees, as well as all the rights in the Convention. Article 24: (1) States parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. (2) States parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;... (d) To ensure appropriate prenatal and postnatal health care for mothers.

Article 27: Children have the right to a standard of living that is good enough to meet their physical and mental needs. Governments should help families and guardians who cannot afford to provide this, particularly with regard to food, clothing and housing.

Article 28: All children have the right to a primary education, which should be free.

Article 29.1: States parties agree that the education of the child shall be directed to: (a) the development of the child's personality, talents and mental and physical abilities to their fullest potential. ... The Committee calls on States parties to ensure that all young children receive education in the broadest sense (as outlined in Article 28), which acknowledges a key role for parents, wider family and community, as well as the contribution of organised programmes of early childhood education provided by the State, the community or civil society institutions.

Article 32: The government should protect children from work that is dangerous or might harm their health or their education.

AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF THE CHILD (ACRWC)

Every child, regardless of his or her race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status, has the right to: live; be named and registered at birth; adequate health care, nutritious food and safe drinking water; education and play. Children should be protected from all forms of economic exploitation and hazardous work and from all forms of torture, inhuman or degrading treatment, including sexual abuse. No child who is imprisoned should be tortured or otherwise mistreated. Those who are capable of communicating their views should be allowed to express their opinions freely.

UGANDA CONSTITUTION

The State shall endeavour to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that: ...all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.

Article 34 provides specifically for the following rights of children: (1) The right to know and be cared for by their parents or other people. (2) The right to basic education which must be provided by the Government and the parents of the child. (3) The right not to be denied medical treatment or any other social or economic benefits. (4) Protection from all exploitation (being taken advantage of). (5) Children who are below the age of 16 years must not be employed or do work that is harmful to their health or that interferes with their education. (6.) A child offender shall not be detained with adults. (7) Orphans and other vulnerable children must be specially protected by the laws of Uganda.

THE CHILDREN ACT

Every child has the right to education and guidance, immunisation, an adequate diet, shelter, medical attention, and to protection from violence, abuse and neglect – including social or customary practices that are harmful to their health – and not to be employed or engaged in any activity that may be harmful to his or her health, education or development.

Any member of the community who has evidence that a child's rights are being infringed or that a parent, a guardian or any person having custody of a child is able to but refuses or neglects to provide the child with adequate food, shelter, clothing, medical care or education shall report the matter to the local government council of the area.

NATIONAL CAPACITIES ON THE RIGHT TO SURVIVAL

LEGAL FRAMEWORK

The Government has decentralised health services to sub-national, district levels in accordance with the Local Government Act (1997), leaving the responsibility of policy formulation, setting standards and guidelines, supervision, monitoring and resource mobilisation with the Ministry of Health (MoH), and responsibility for service delivery to district- and regional-level leaders. Capacity in planning, management and human resource development remains weak at decentralised levels due to limited leadership, management and specialist skills (MoH, 2014b).

HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN III 2010/11–2014/15

The third Health Sector Strategic and Investment Plan (HSSIP III) was developed to operationalise the National Health Policy II and the health sector component of the National Development Plan (NDP). The main approach for achieving the sector programme goal is through implementing the Uganda National Minimum Health Care Package (UNMHCP), comprised of cost-effective health interventions to improve outcomes in key areas such as maternal and children's health or prevention and control of communicable diseases (MoH and Macro International, 2008).

The issue of informal costs and user fees in otherwise free public services is being addressed in the strategy via the development of the Medicines and Health Service Delivery Monitoring Unit (MHSDMU). This unit, which formally sits within the Office of the Prime Minister for the sake of accountability and transparency, receives numerous anecdotal reports on small-scale corruption, but is not able to respond due to a constrained monitoring envelope.

NATIONAL INTEGRATED EARLY CHILDHOOD DEVELOPMENT POLICY 2013

Previously, efforts to address early childhood development (ECD) issues have focused on education. The current policy framework aims to rectify this by coordinating and improving services, access and infrastructure (in health, safety, education, nutrition and WASH) for children aged 0–8 years. Strategies include: strengthening public health care systems such as sanitation and hygiene; equipping and empowering children's hospitals; sensitising communities and households about the importance of a clean environment and sanitation; ensuring universal immunisation coverage for all children; and ensuring access to safe and clean water in all areas of the country.

MALARIA REDUCTION STRATEGIC PLAN 2014–20

This plan was developed to provide a common framework for the nationwide scale up of evidence-led malaria reduction interventions by the Government, its development partners and the private sector. Control needs to increase if the strategy is to succeed.

REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH (RMNCH) SHARPENED PLAN

In 2013, the Government developed an evidence-based country plan to address its slow progress on MDGs 4 and 5. The ‘sharpened’ plan reviews the maternal, newborn and child mortality situation in Uganda, setting an agenda for how to accelerate progress. The plan will run until 2020, which is when the next UDHS will take place (MoH, 2013b), and involves scaling up high-impact health interventions such as promotion of breastfeeding, eMTCT services and ownership of insecticide-treated nets (MoH, 2013b). It will be implemented by numerous stakeholders including: the Government and policy-makers, the UN, parliamentarian forums, civil society organisations, the private sector, midwives’ associations and health workers.

UGANDA NATIONAL EXPANDED PROGRAMME ON IMMUNISATION (UNEPI)

This programme, aligned to the Health Sector Strategic and Investment Plan (HSSIP), has three major areas of focus: strengthening routine immunisation; conducting supplemental immunisation activities to achieve global targets of polio eradication and elimination of maternal and neonatal tetanus, and accelerated measles control; and sustaining a sensitive disease surveillance system within the Integrated Disease Surveillance and Response framework.

NATIONAL STRATEGIC PLAN (NSP) FOR HIV AND AIDS

With support from development partners, the Government initiated the programme for the elimination of mother-to-child transmission (eMTCT) of HIV in 2000 and scaled it up to all districts by 2005. Stark inequities remain most visible between urban and rural areas.

UGANDA NUTRITION ACTION PLAN (UNAP) 2011–16

Uganda’s Nutrition Action Plan (2011–16) aims to ‘reduce levels of malnutrition among women of reproductive age, infants, and young children through 2016; ensuring that all Ugandans are properly nourished will enable them to live healthy and productive lives’ (GoU,

2011: ix). The UNAP focuses on women and children, and will focus on public resources and national efforts to bring about improvements in nutrition among young children and women of reproductive age by scaling up the implementation of a package of proven and cost-effective interventions. Another component of the action plan is to operationalise the nutrition component of the NDP, as well as the Uganda Food and Nutrition Policy (UFNP) and the draft Uganda Food and Nutrition Strategy.

GOOD GOVERNANCE SUB-SECTOR WORKING GROUP ACTION PLAN FOR WATER AND SANITATION

During the 2012/13 financial year, the Good Governance Sub-sector Working Group (GGWG) of the water and sanitation sub-sector evaluated its action plan, initiated in 2009. The plan was due to run until 2014 and be measured by 11 'golden indicators', including: the percentage of people with access within 1 km (rural) and 0.2 km (urban) of an improved water source; functionality of improved water sources; percentage of people with access to handwashing facilities; percentage of actively functioning Water and Sanitation Committees (WSCs) and percentage of WSCs with women holding key positions (MWE, 2013).

NATIONAL POLICY FOR DISASTER PREPAREDNESS AND MANAGEMENT

Efforts have been made to integrate disaster preparedness and climate change adaptation into a number of national strategies and planning documents. The National Policy for Disaster Preparedness and Management, launched in 2011, aims to create an effective framework through which disaster preparedness is embedded in all aspects of development planning. It underscores the need to tackle disasters in a holistic manner with more emphasis on disaster risk reduction in line with the recommendations of the 2005 Hyogo Framework for Action.

NATIONAL CAPACITIES ON EDUCATION AND OTHER DEVELOPMENTAL RIGHTS

Legal framework

PRE-PRIMARY EDUCATION/ EARLY CHILDHOOD DEVELOPMENT (ECD)

At policy level, the implementation of ECD services remains isolated in the education sector, with various fragmented ECD-sensitive policies referenced in other sectors. Existing poli-

cies are scattered across various sectors with no effective coordination mechanism to steer common action, such as joint policy formulation, planning, implementation, pulling and leveraging resources, advocacy, research and monitoring etc. There has been limited coordinated action to assess and respond to this gap, although this is now being addressed by the development of the National Integrated Early Childhood Development policy (NIECD).

UNIVERSAL PRIMARY EDUCATION (UPE)

UPE was introduced in 1997, although primary education was not made compulsory. All formal tuition fees and parent-teacher association (PTA) charges were abolished. In order to address remaining enrolment and retention issues the Government is implementing a monitoring and evaluation framework within UPE reporting guidelines, as well as through the introduction of a theme-based curriculum focused on quality (rather than quantity issues) in educational outcomes.

QUALITY ENHANCEMENT INITIATIVE (QEI)

The QEI aims to improve the quality of primary education in 15 districts deemed the worst performing nationally. Significant progress has been made in improving and expanding school infrastructure – with key areas of improvement being teacher training and financial management and disbursement structures (MISR, 2010).

UNITED NATIONS GIRLS EDUCATION INITIATIVE (UNGEI)

Launched globally in 2000 as an initiative to address the persistent challenges to girls' education, by 2006, UNGEI had been rolled out to 14 districts and 23 sub-counties in Uganda (UNICEF, 2007, cited in Ezati, 2011). UNGEI has set up coordination and management structures at national, district and community levels. At the national level, the UNGEI umbrella covers a diverse group of donor organisations, international and national NGOs and governmental agencies.

EDUCATION SECTOR STRATEGIC PLAN (ESSP)

The ESSP 2004–15, prepared in 2003 and revised twice, is the current government strategy for education. The ESSP commits government to ensure that universal access to primary education is the highest sector priority. It targets the removal of financial impediments to that objective and focuses attention on improving regional and gender equity (Ezati, 2011).

NATIONAL CAPACITIES ON THE RIGHT TO PROTECTION

Legal framework

With the exception of the Hague Convention on Inter-Country Adoption (HCIA), Uganda has ratified and domesticated all the key international child protection legal instruments through the enactment of several child protection laws and policies, as well as several policies contextualising these. They include the National Integrated Early Childhood Development Policy 2013 (see Right to Survival section) and the following:

NATIONAL FRAMEWORK FOR ALTERNATIVE CARE (2014)

The main goals of this framework, which takes into account the UN Guidelines on Alternative Care, are to reduce the number of children in institutional (orphanage) care; to provide actors at different levels with clear guidelines and placement options for children in need of alternative care, based on a defined continuum of care principle; and to put in place mechanisms to support existing government structures to carry out their statutory responsibilities for overseeing the care of children in alternative care.

NATIONAL STRATEGIC PROGRAMME PLAN FOR ORPHANS AND OTHER VULNERABLE CHILDREN (NSPPI-2)

Uganda's national response to HIV dates back to 2001/02 when the MoGLSD commissioned a study into the situation of orphans in the country. The 2010 evaluation of the first NSPPI revealed that a number of strategies, guidelines and systems were developed to guide stakeholders in providing comprehensive and high-quality services to orphans and other vulnerable children (OVC) to improve socio-economic security, food and nutrition security, health issues such as treatment for HIV, education, legal protection services for children as a result of the Children Act (previously known as the Children Statute), and the needs of children affected by war. In 2011, a revised document (NSPPI-2) was drafted to address the gaps made evident from the previous evaluation (MoGLSD 2012d). Moreover, the NSPPI-2 emphasises economic strengthening of OVC households. According to NSPPI-2, children are categorised as critically or moderately vulnerable (Box 8).

BOX 8: CRITERIA FOR VULNERABLE CHILDREN ACCORDING TO NSPPI-2**Critically vulnerable**

- Orphans who are living in extremely difficult circumstances and are exposed to risks
- Children infected and affected by HIV/AIDS
- Children with disabilities living in extremely difficult circumstances who are exposed to risks
- Children in worst forms of child labour (e.g. sex workers, bonded labour, illicit activities, work that stops school attendance, cattle rustling, and other intolerable forms of work)
- Children experiencing various forms of abuse and violence (e.g. survivors of sexual violence, children in abusive homes or institutions)
- Street children/abandoned children/neglected children
- Children in contact with the law
- Children from child-headed households
- Children who are engaged in armed conflict as captives or child soldiers

Moderately vulnerable children

- Out-of-school children; teenage mothers
- Children in poverty stricken (impoverished) households
- Children involved in hazardous work (other than worst forms of child labour)
- Children living with elderly persons
- Children in hard-to-reach areas
- Children in fishing communities

NATIONAL CAPACITIES ON THE RIGHT TO PARTICIPATION

Legal framework

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD (UNCRC)

Article 12 of the UNCRC states that children have the right to participate in decision-making processes that may be relevant in their lives and to influence decisions taken in their regard – within the family, the school or the community. Participation is incorporated in a number of other articles, along with basic principles such as non-discrimination, honouring the best interests of the child and dedication to realising all of the UNCRC provisions. As a signatory to the UNCRC, Uganda pledged to implement the provisions of the Convention to its fullest by putting in place administrative and institutional measures for the realisation of these commitments.

AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF THE CHILD (ACRWC)

The ACRWC was adopted by the Organisation of African Unity (OAU) in 1990 to localise the provisions of the UNCRC in Africa. As in the UNCRC, the Charter recognises child participation as a means to ensuring that all actions and decisions by individuals or authorities are taken in the best interests of the child. The main articles that provide for the participation of children are 4 and 7.

CHILDREN ACT, CAP 59

The Children Act (Cap 59) has provisions to uphold the right to participation on issues that affect children's survival and development. The act aims to ensure that the child participates and provides evidence in situations where a matter is reported to the probation office. A secretary for children's affairs in each local council is responsible for ensuring that children's voices are heard.

LOCAL GOVERNMENTS ACT, CAP 243

Section 8 of the third schedule (1) (a) of the Local Governments Act states that 'A Councilor shall maintain close contact with the electoral area, and consult the people on issues to be discussed in the council where necessary'. Sub-section (1) (b) goes on to provide for sharing views from the electorate with the council by requiring the councillor to present views, opinions and proposals to the council. Sub-section (d) provides for councillors to meet with the electorate on a regular basis; and (e) requires one to report to the electorate the general decisions of the council and the actions it has taken to solve problems raised by the residents in the electoral area. Councils are obliged to consult with their constituencies, including children, and to provide feedback on what occurs in their sessions.

APPENDIX 2: STATISTICAL ABSTRACT

SITUATION ANALYSIS OF CHILDREN IN UGANDA 2015

For children, equity refers to the equal opportunity to survive, develop and reach their full potential without discrimination, bias or favouritism, including children in the most disadvantaged segments of society. This appendix provides a statistical overview of some of the inequities that affect the wellbeing of children in Uganda. The aim is to identify key priority areas of intervention in the national development agenda to influence more equitable programming, policy advocacy and research initiatives aimed at improving the lives of all children in Uganda.

In order to get the actual numbers of individuals who have not been reached by a service, the Uganda Bureau of Statistics (UBOS) and UNICEF went beyond the averages that the indicators give us. For example, for each region or district (depending on the level of disaggregation of the available data) as well as at national level, calculations were made of the number of pregnant women who did not attend a fourth antenatal visit or receive a second dose of intermittent preventive treatment for malaria; or in the case of children, the number of children who did not receive all basic vaccinations or who did not get malaria treatment the same or next day after onset of symptoms.

In addition to providing the size of each gap in service delivery (numbers of individuals not receiving a service), the analysis demonstrates that the biggest numbers of unreached people are not always living within the poorest performing indicator areas – although there are overlaps for some indicators. This is because the population of the age group for each indicator naturally contributes to the gap size leading to regions/districts with low population sizes and poor performance indicator levels having low gap numbers compared to regions/districts with high population sizes. The results provide evidence that for development programmes to effectively take positive action that enhances the fulfilment of children's rights, development resources should be focused on both geographical areas with poorest performing indicator levels and also those with the highest numbers of people whom service delivery has not reached.

The appendix covers the demographic profile of the country's children – their right to an adequate standard of living, in relation to the right to survival and health; the right to education; and the right to protection and an identity. Most of the data is derived from the 2011 Uganda Demographic and Health Survey (UDHS) (UBOS and ICF International, 2012), the 2012/13 Uganda National Household Survey (UNHS) (UBOS, 2014a), and sector databases and reports. Information on the indicators, which cover the full spectrum of a child's continuum of care and development, was compiled for each region and used to estimate the number of children who are not receiving the service represented by each indicator. All the selected indicators are sourced from lists of priority indicators of the strategic planning documents of the public institutions responsible for each area of service delivery.

METHODOLOGY

The selected 43 indicators were grouped under ‘impact’ and relevant children’s rights as follows:

1. Impact Indicators (7)
2. The right to an adequate standard of living (1)
3. The right to survival and health (28)
 - 3.1 Maternal and neonatal health (6)
 - 3.2 Child health (9)
 - 3.3 HIV and AIDS (4)
 - 3.4 Nutrition (6)
 - 3.5 Water, sanitation and hygiene (WASH, 3)
4. The right to education (3)
 - 4.1 Early childhood development (1)
 - 4.2 Basic education (2)
5. The right to protection and identity (4)

SUMMARY

THE RIGHT TO AN ADEQUATE STANDARD OF LIVING

This is assessed on the basis of two measures – income-based poverty (whether a household’s income, structure and number of members placed it below the poverty line) and deprivation-based poverty (where a child is deprived in at least two out of seven children’s rights dimensions – health, water, sanitation, education, shelter and information).

- Northern and eastern regions have the largest proportion of children living in poverty.

THE RIGHT TO SURVIVAL AND HEALTH

Seven impact indicators (e.g. Under-five mortality) and 28 other indicators under maternal and neonatal health (e.g. percentage of women attending four or more antenatal visits during their pregnancy), child health (e.g. percentage of children aged 12–23 months who received all basic vaccinations), HIV/AIDS (e.g. percentage of pregnant women receiving ARVs for eMTCT), nutrition (e.g. children aged 6–23 months who receive a minimum acceptable diet) and water, sanitation and hygiene (e.g. households using an improved sanitation facility).

- Child mortality rates are higher in rural areas and in Karamoja, South-West, West Nile regions.
- Rural children and children living in Karamoja region are more likely to be stunted and underweight.
- Births in Karamoja are the least likely to be assisted by a skilled attendant.
- Mothers living in rural areas and South-West region, those with no education and those in the lowest wealth quintile are least likely to get a postnatal check-up.

- Children living in rural households, East Central region, areas surrounding Kampala and those born to mothers without an education are least likely to be fully immunised.
- The use of insecticide-treated nets against malaria is lowest in East Central and South-West regions.
- The use of zinc supplements to treat diarrhoea in under-fives is lowest in rural areas, in Western and Karamoja regions and among mothers with no education.
- Children living in East Central and Karamoja regions in a household in the lowest wealth quintile or whose mothers have at most primary education are least likely to be given antibiotics for respiratory infections.
- Children aged under 15 years who are HIV-positive and living in Karamoja are least likely to receive ART.
- Babies in Karamoja and East Central, and those born into the highest wealth quintile, are more likely to have been breastfed in the first hour.
- Karamoja and East Central have the highest prevalence of anaemia in children.
- Less than one household in every 100 in the northern part of the country have a handwashing facility with soap and water.

THE RIGHT TO EDUCATION

Indicators: access to early childhood development (ECD) facilities and enrolment and retention rates at primary and secondary schools.

- The net attendance rate of three to five-year-olds in pre-primary schools is lowest for children living in rural areas, in West Nile, Karamoja and North regions, and in households in the lowest wealth quintile.
- Secondary school attendance rates are lowest in Karamoja and North regions and in rural areas.

THE RIGHT TO PROTECTION AND AN IDENTITY

Indicators: birth registration rates, early pregnancy, and physical or sexual violence against girls and women.

- Karamoja, South-West, West Nile and Western regions have the lowest birth registration rates.
- Teenage girls born to mothers with no education and in households in the lowest quintile are more likely to start child bearing early.
- Women living in the Eastern, North and East Central regions are most likely to have recently experienced physical or sexual violence.

The following pages provide a detailed analysis of equity patterns across Uganda.

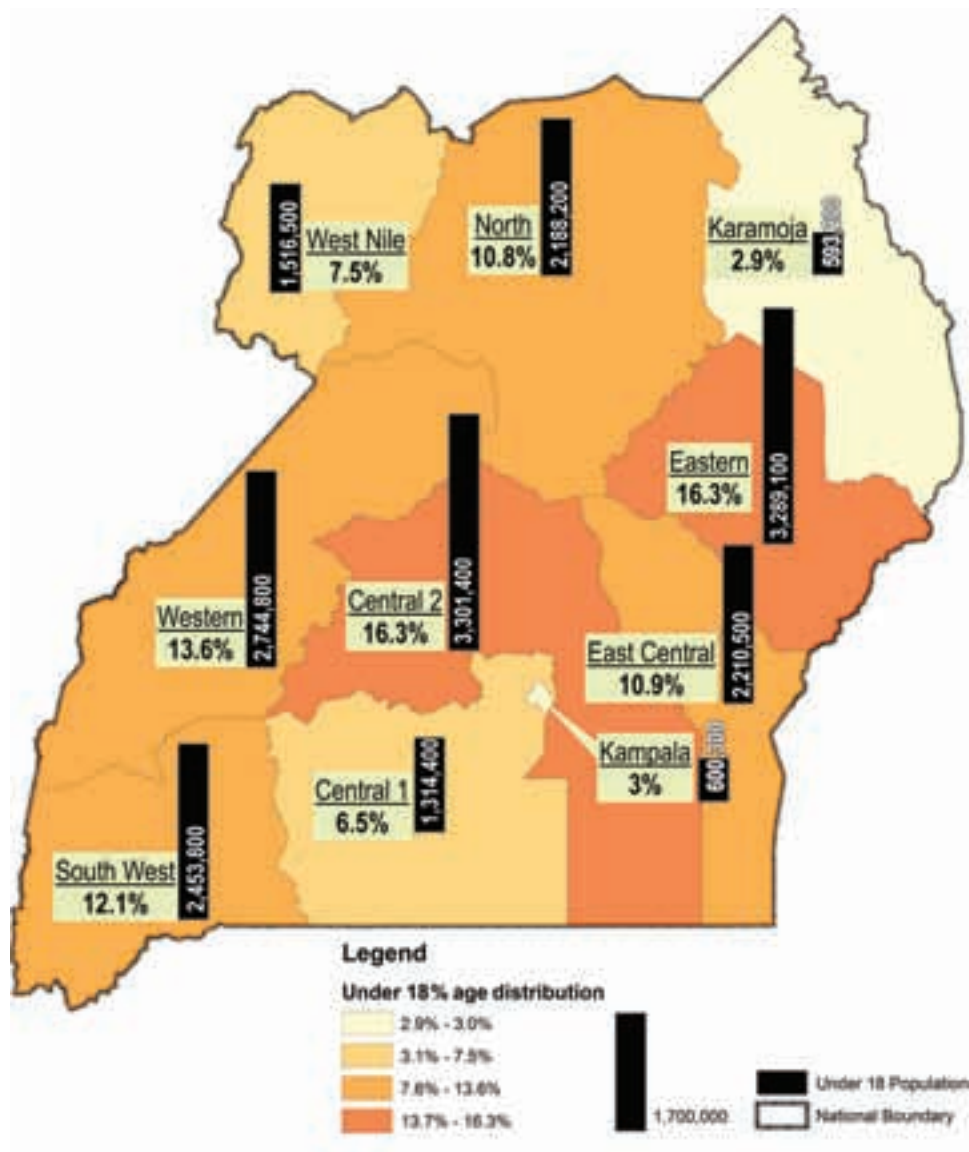
THE DEMOGRAPHY OF UGANDA'S CHILDREN

Uganda has 20,212,200* children.

- 6,630,500 (19% of the population) are under the age of five years.
- The majority of children (58%) live in Eastern, Central 2, Western and South-West regions.

NUMBER AND PERCENTAGE DISTRIBUTION OF CHILDREN BY REGION

Children 0–17 years by Region (Provisional Population 2014)



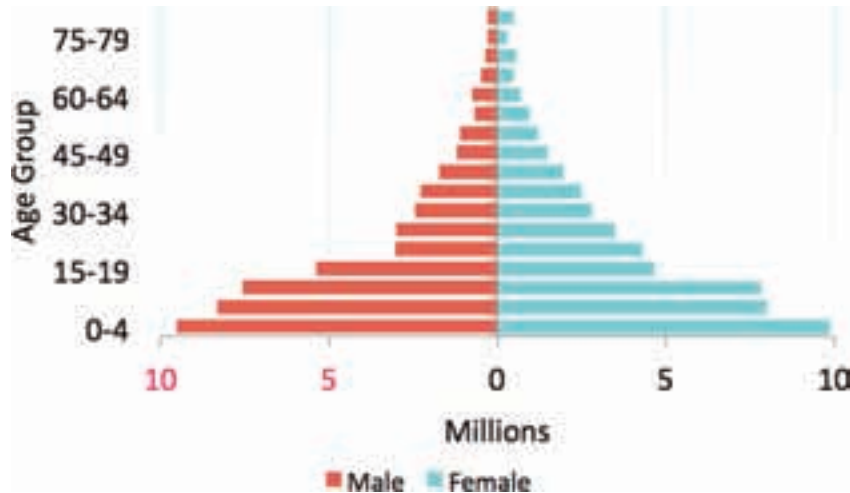
Source: UBOS, 2014b

*According to provisional results from the 2014 census (UBOS, 2014b), detailed data from which are yet to be published and were not available during the drafting of the situation analysis which makes up the main body of this report.

Uganda has a predominantly young population.

- Three in every four people are under 30 years of age.
- Children comprise 56% of the population.

POPULATION PYRAMID 2012/13

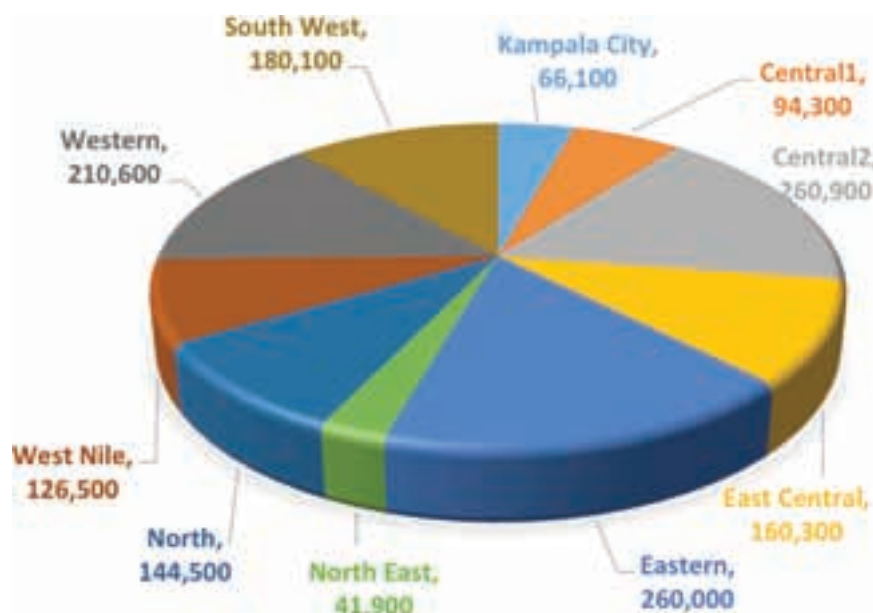


Source: UBOS, 2014a

A total of 1.5 million children were estimated to have been born in 2014.

- Four regions contributed 58% of the births – Eastern, Central 2, Western and South-West.

NUMBER OF BIRTHS BY REGION IN 2014



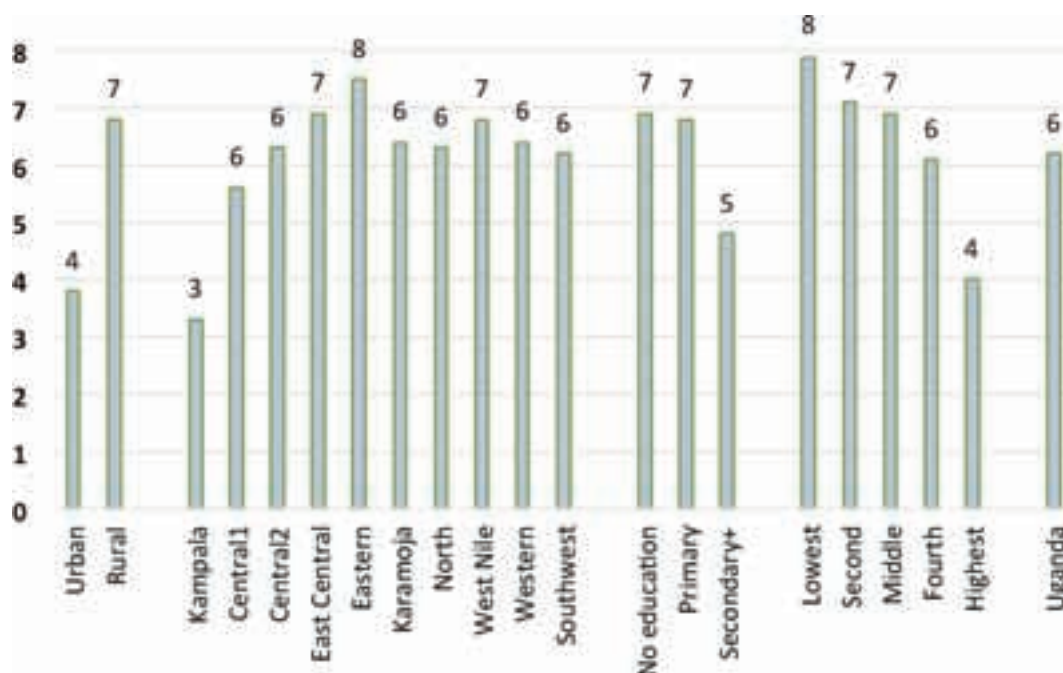
Source: UBOS, 2014b



With a fertility rate of 6.2 children per woman, Uganda has one of the highest fertility rates in the world.

- On average women in Kampala have 3.3 children, while in Eastern region they have 7.5.
- Rural women have almost twice as many children as urban women.

TOTAL FERTILITY RATE FOR THE THREE YEARS PRECEDING THE SURVEY, 2011



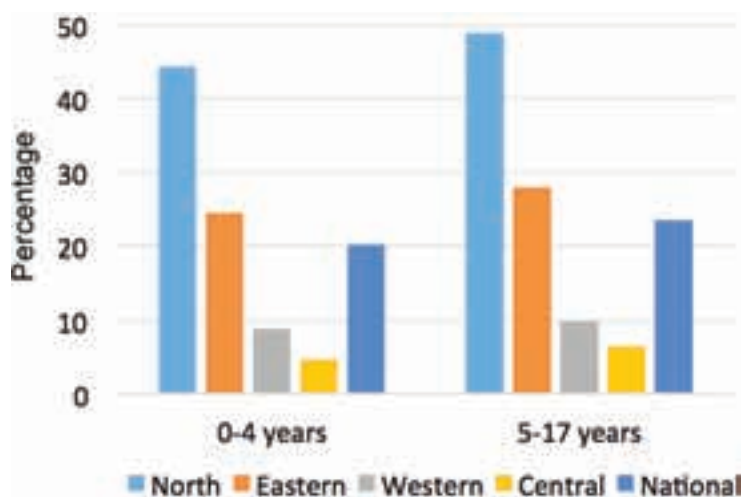
Source: UBOS and ICF International, 2012

THE RIGHT TO AN ADEQUATE STANDARD OF LIVING: INCOME AND DEPRIVATION-BASED POVERTY

4.4 million (22.1%) children live in income-poor households.

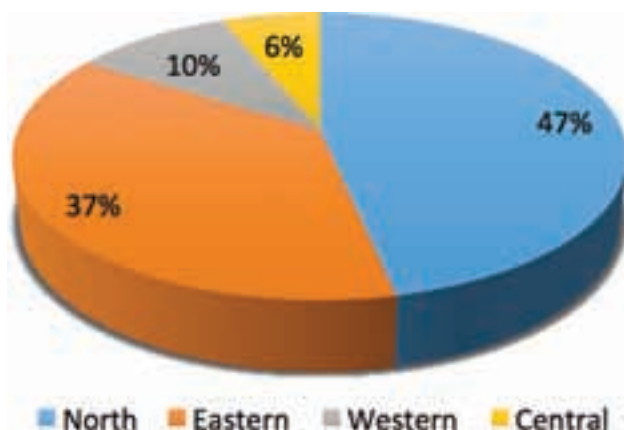
- The northern and eastern parts of the country are most affected by poverty.
- About 44% of under-fives and 49% of children aged 5–17 years in northern Uganda live in income-poor households.

CHILDREN IN EACH AGE GROUP AND REGION THAT LIVE IN INCOME-POOR HOUSEHOLDS



Source: UBOS calculations based on UBOS, 2014a

REGIONAL DISTRIBUTION OF CHILDREN (0-17 YEARS) LIVING IN INCOME-POVERTY

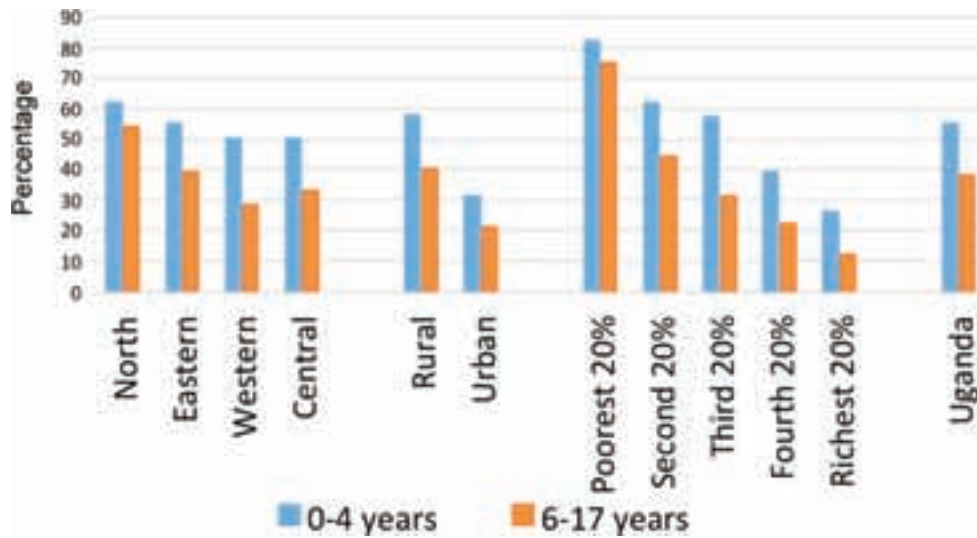


Source: UBOS calculations based on UBOS, 2014a

More than half of under-five children are deprived in at least two poverty dimensions.

- Deprivation rates are higher in rural areas (58%) than in urban areas (31%).
- Deprivation rates are highest in the north (particularly Karamoja and West Nile regions) and lowest in Central Uganda.

DEPRIVATION OF CHILDREN IN AT LEAST TWO DIMENSIONS



Source: MoGLSD et al., 2014



THE RIGHT TO SURVIVAL AND HEALTH

IMPACT INDICATORS

Indicators	1995	2001	2006	2011	Targets
1 Maternal mortality ratio per 100,000 live births	527	505	435	438	211 (2017)
2 Under-five mortality rate per 1,000 live births	147	152	137	90	53 (2017)
3 Infant mortality rate per 1,000 live births	81	88	76	54	30 (2017)
4 Neonatal mortality rate per 1,000 live births	27	33	29	27	10 (2017)
5 Low birth weight	No data	33	No data	10	9 (2016)
6 Stunting among under-fives (height for age)	No data	39	38	33	25 (2016)
7 Underweight among under-fives (weight for age)	No data	22.8	15.9	14	10 (2016)

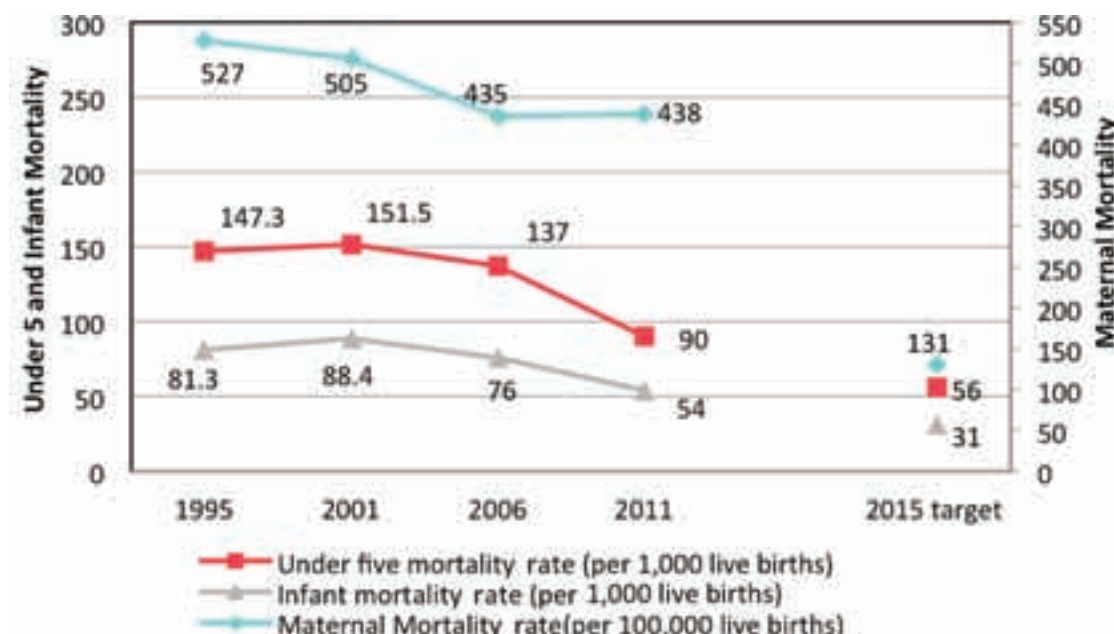
Source: UBOS and Macro International, 1996, 2000-01 and 2007; UBOS and ICF International, 2012

MATERNAL AND NEONATAL HEALTH

Maternal and children's mortality rates are going down but remain high.

- All regions have higher mortality rates than the respective 2015 targets.

MATERNAL, UNDER-FIVE AND INFANT MORTALITY RATES



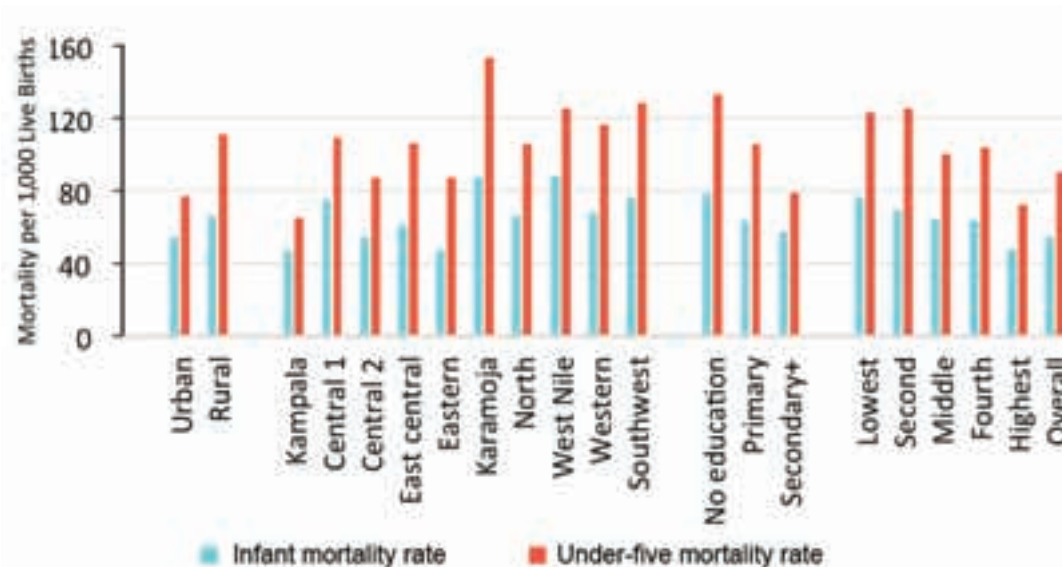
Source: UBOS and Macro International, 1996, 2000-01 and 2007; UBOS and ICF International, 2012



Mortality rates are higher in Karamoja, West Nile and South-West regions.

- They are also higher in rural areas, among children of mothers with primary or no education, and for children living in households that are in the three bottom quintiles.

INFANT AND UNDER-FIVE MORTALITY BY BACKGROUND CHARACTERISTICS, DHS 2011

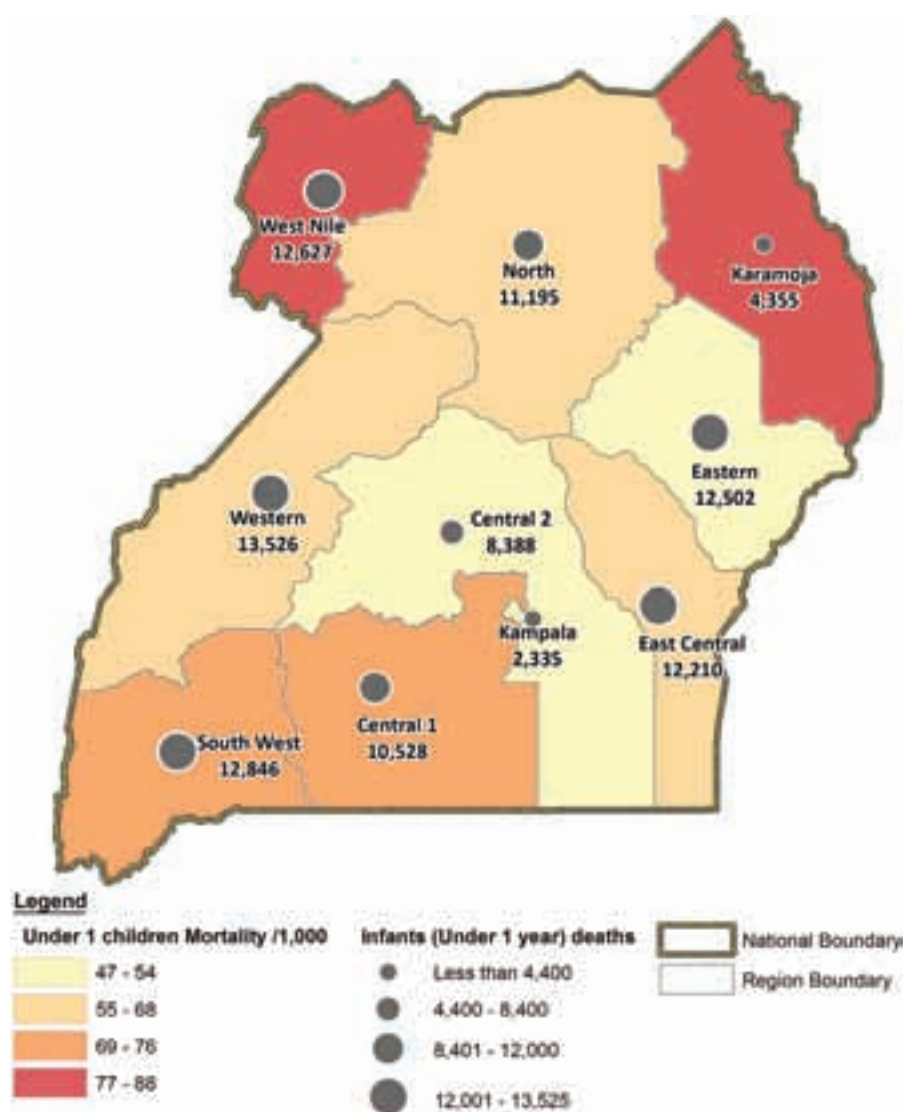


Source: UBOS and ICF International, 2012

Nationally, there are estimated to be 167,000 deaths of children aged under five and 101,000 deaths of children aged under one year annually.

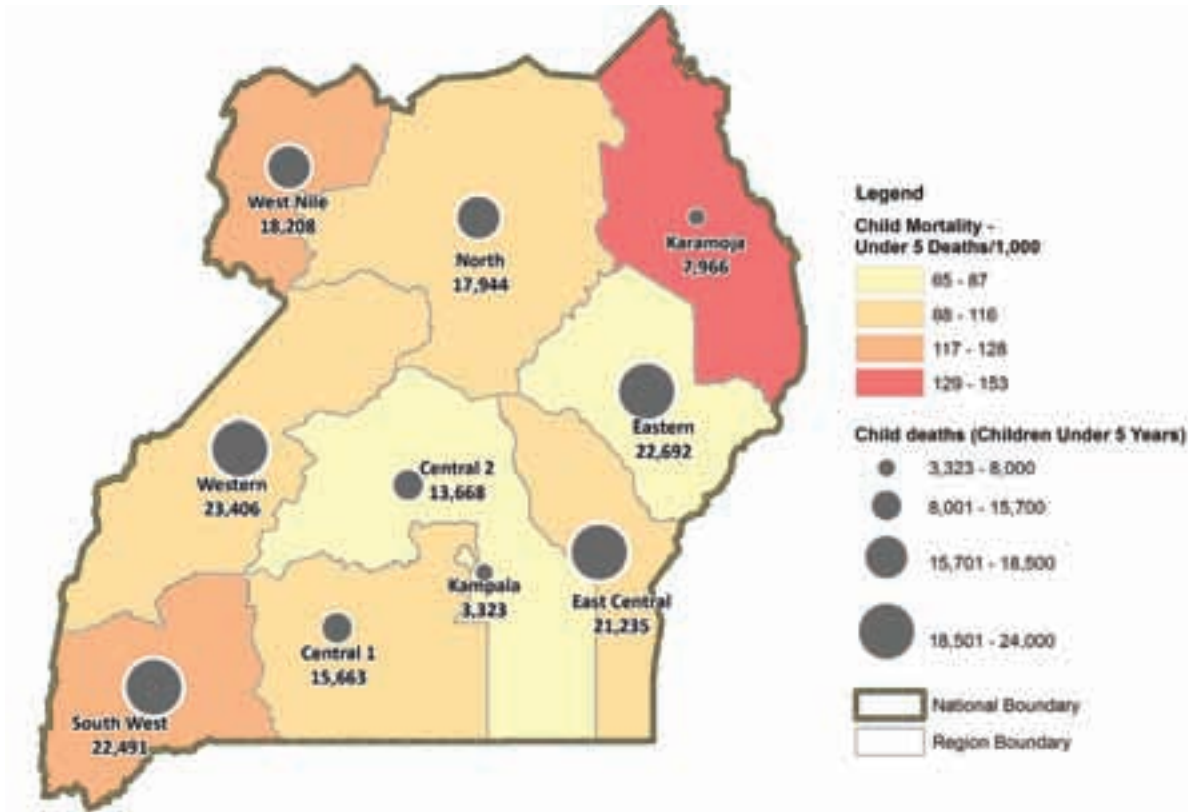
- Karamoja has the highest under-one and under-five mortality rates, with 87/1,000 live births and 153/1,000 respectively.
- Karamoja's under-five mortality rate is more than twice as high as Kampala's (65/1,000).
- Western region has the estimated highest number of deaths of both under five and under one-year-olds (with 14,000 and 23,000 respectively).

INFANT MORTALITY



Source: Mortality rates: UBOS and ICF International, 2012; Absolute deaths estimates: UNICEF calculations

UNDER-FIVE MORTALITY

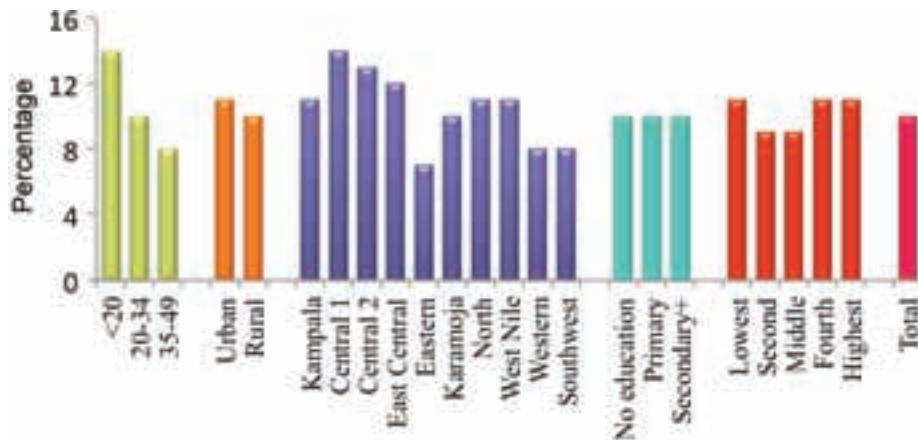


Source: Mortality rates: UBOS and ICF International, 2012; Absolute deaths estimates: UNICEF calculations

Teenage mothers are more likely to produce low birthweight (less than 2.5 kg) babies than other age groups.

- The prevalence of low birth weight is highest in Central 1 and Central 2 regions (14% and 13% respectively).

DISTRIBUTION OF BIRTHS WITH A REPORTED BIRTH WEIGHT OF LESS THAN 2.5 KG ACCORDING TO BACKGROUND CHARACTERISTICS

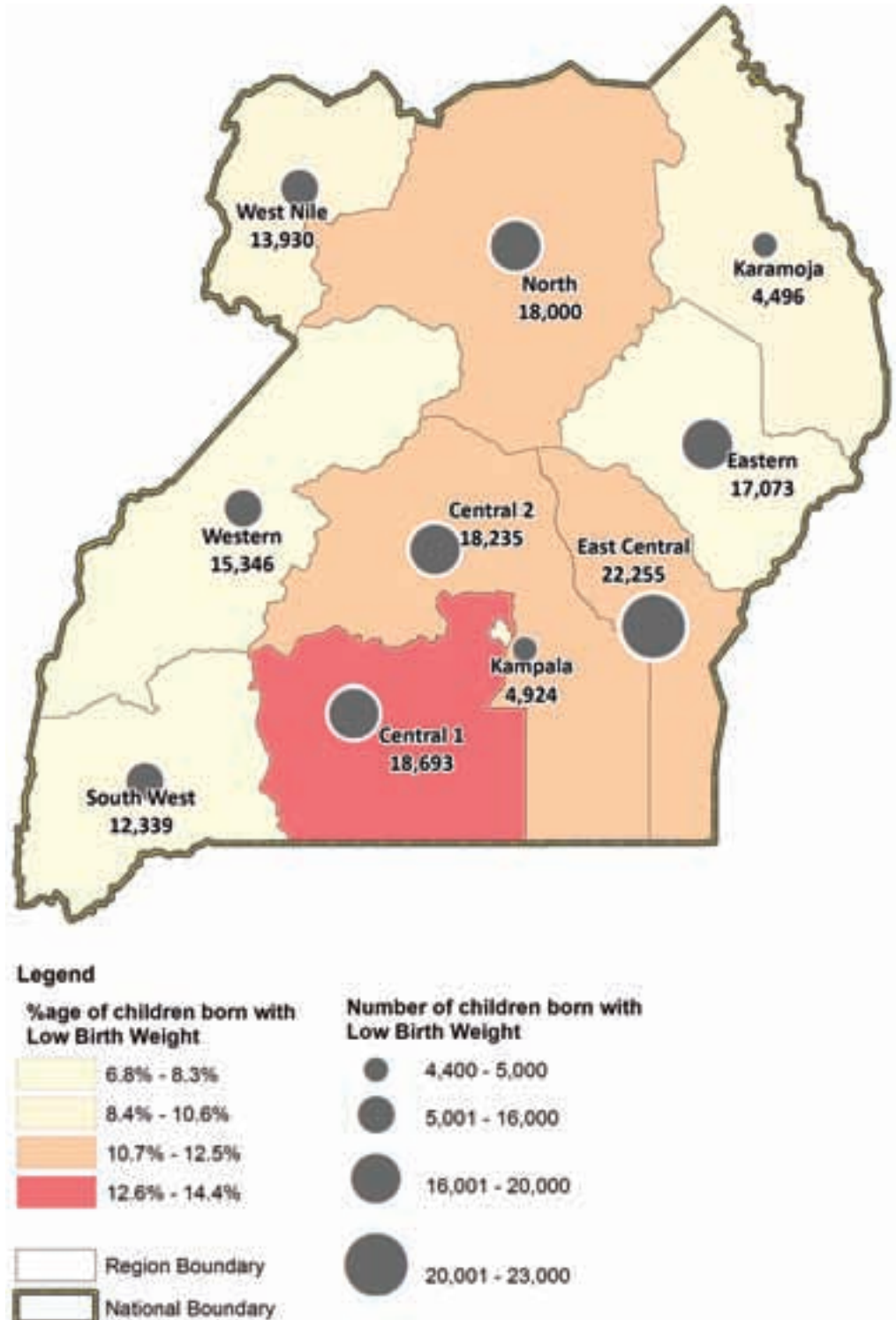


Source: UBOS and ICF International, 2012

More than 145,000 newborn babies have a low birth weight.

- East Central has the greatest number (over 22,000).

CHILDREN BORN WITH LOW BIRTH WEIGHT



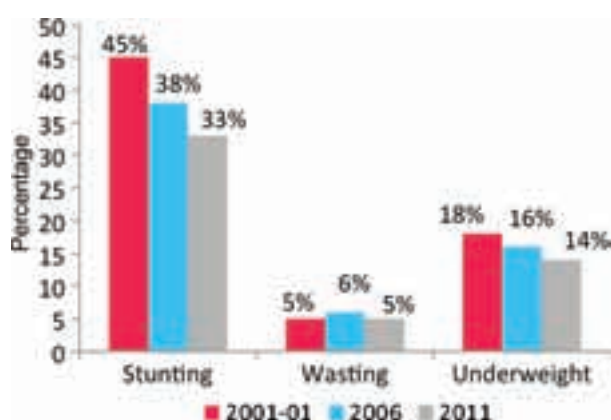
Source: Low birth prevalence rates: UBOS and ICF International, 2012;
Absolute number of low birth estimates: UNICEF calculations

NUTRITION

One in three children under-five is stunted and 14% are underweight.

- Stunting and underweight are more prevalent among rural children (36% and 15% respectively) than urban children (19% and 7% respectively).
- There was minimal improvement in the nutritional status of children over the decade 2000/01 to 2011.

TRENDS IN NUTRITIONAL STATUS OF CHILDREN UNDER FIVE YEARS

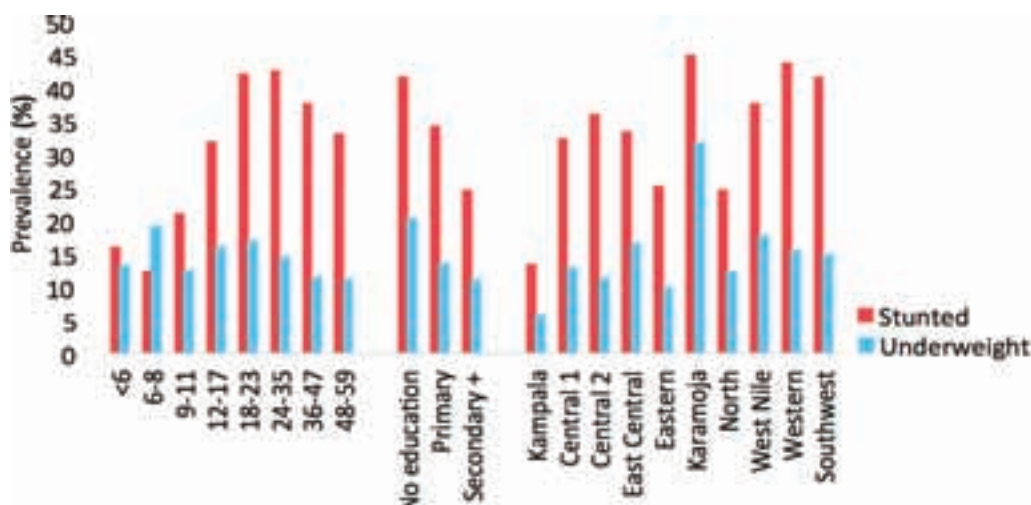


Source: UBOS and Macro International 2000/01 and 2007; UBOS and ICF International, 2012

Mothers who have no education give birth to higher proportions of stunted and underweight children.

- Under-five children in Karamoja are more likely to be stunted or underweight than those in other regions.

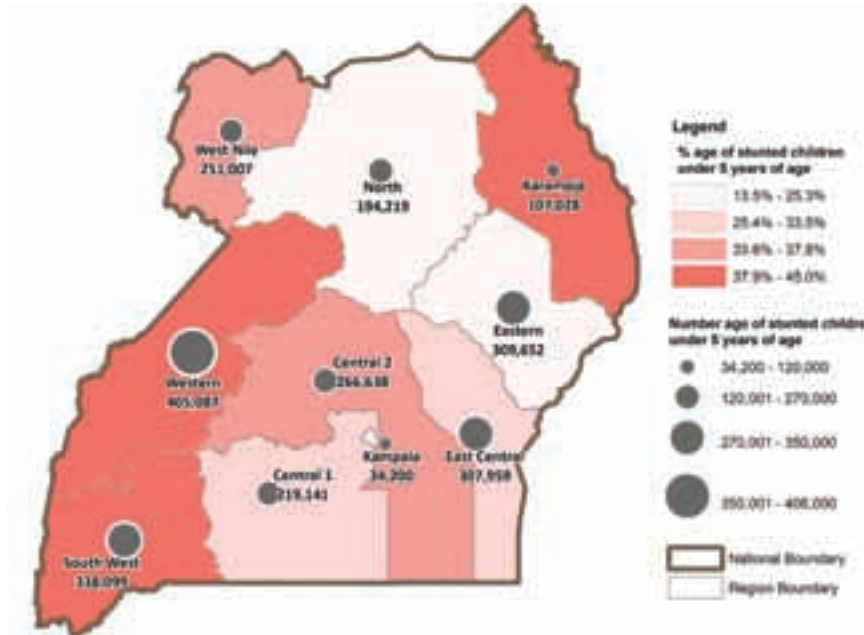
CHILDREN UNDER FIVE YEARS CLASSIFIED AS STUNTED OR UNDERWEIGHT BY MOTHER'S EDUCATION LEVEL, RESIDENCE, REGION AND WEALTH QUINTILE



Source: UBOS and ICF International, 2012

Over 2.4 million children are stunted; the highest number is in Western region.

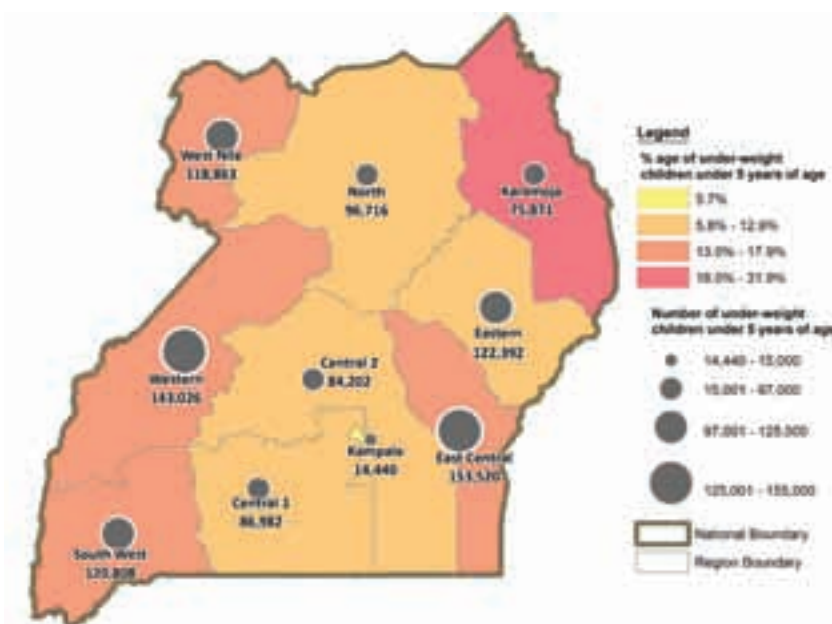
UNDER FIVE STUNTING BY REGION



Source: Stunting prevalence rates: UBOS and ICF International, 2012; Number of stunted children under five estimates: UNICEF calculations.

Over 1 million children are underweight; one in every three underweight children is in East Central or Western regions.

UNDERWEIGHT CHILDREN OVER FIVE YEARS OF AGE



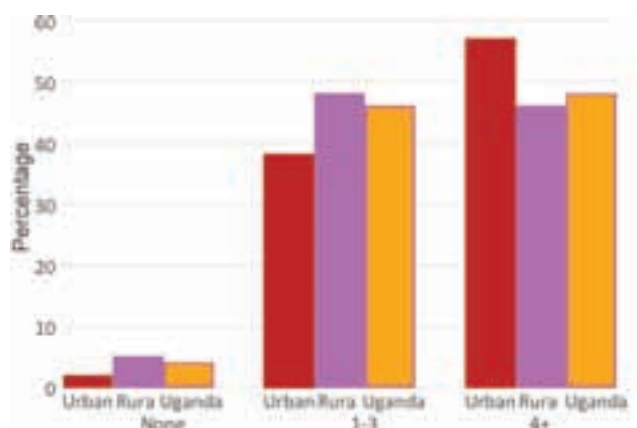
Source: Underweight prevalence rates: UBOS and ICF International, 2012; Number of underweight children under five estimates: UNICEF calculations

ANTENATAL CARE (ANC)

Overall 48% of pregnant women make the recommended four or more ANC visits during their entire pregnancy.

- Urban women (57%) are more likely to have attended four or more ANC visits than rural women (46%).

DISTRIBUTION OF WOMEN AGED 15-49 BY NUMBER OF ANC VISITS FOR THE MOST RECENT LIVE BIRTH

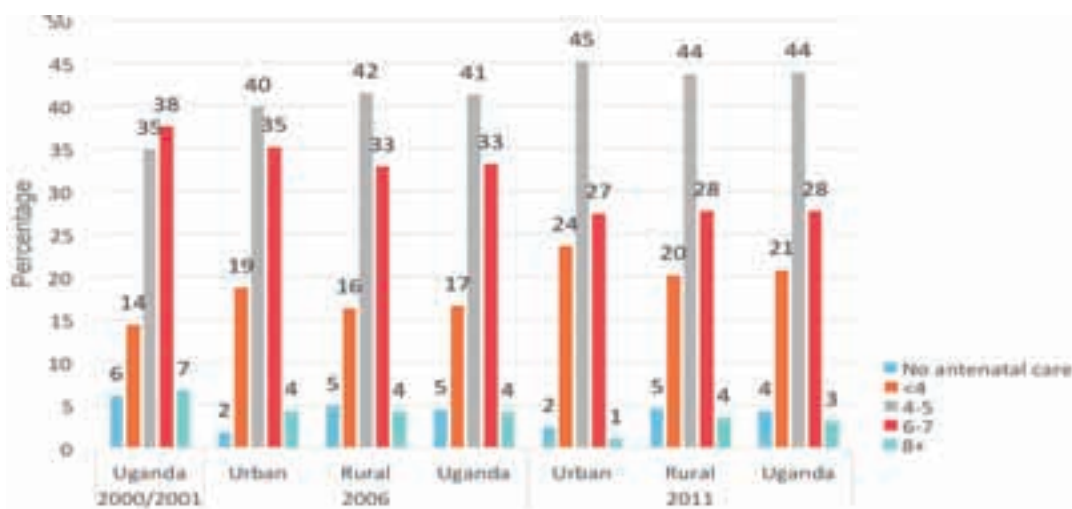


Source: UBOS and ICF International, 2012

Only 21% of women make their first ANC visit before the fourth month of pregnancy, an insufficient improvement from 17% in the UDHS 2006 survey.

- The majority of pregnant women undertake their first ANC visit during the fourth to fifth month (44%) instead of the recommended first trimester, which leaves insufficient time for four ANC visits.

WOMEN AGED 15-49 BY NUMBER OF MONTHS PREGNANT AT THE TIME OF THE FIRST ANC VISIT



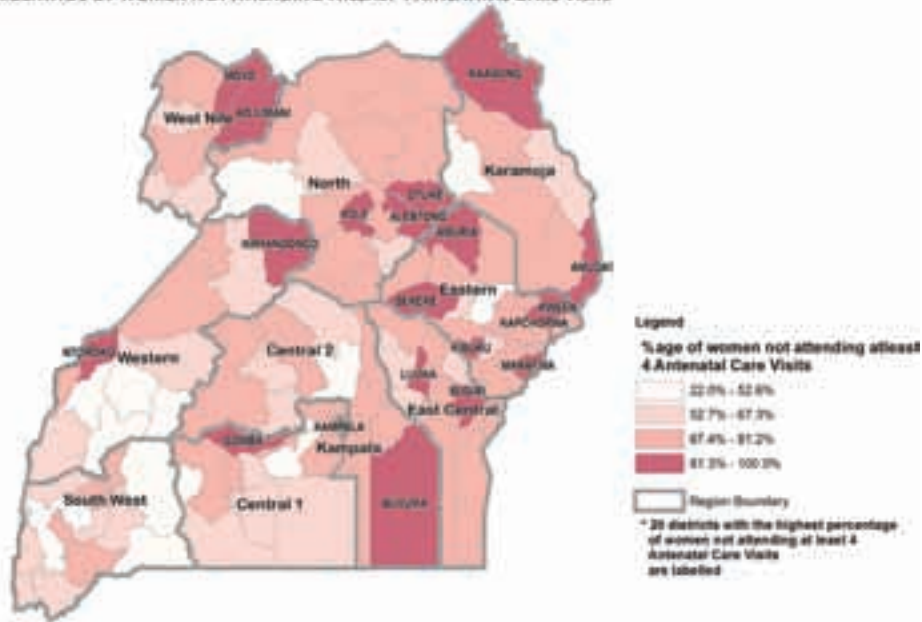
Source: UBOS and ICF International, 2012

Most districts are performing poorly on ANC, and in the worst 24 districts, less than one in every five women are attending their fourth ANC visit.

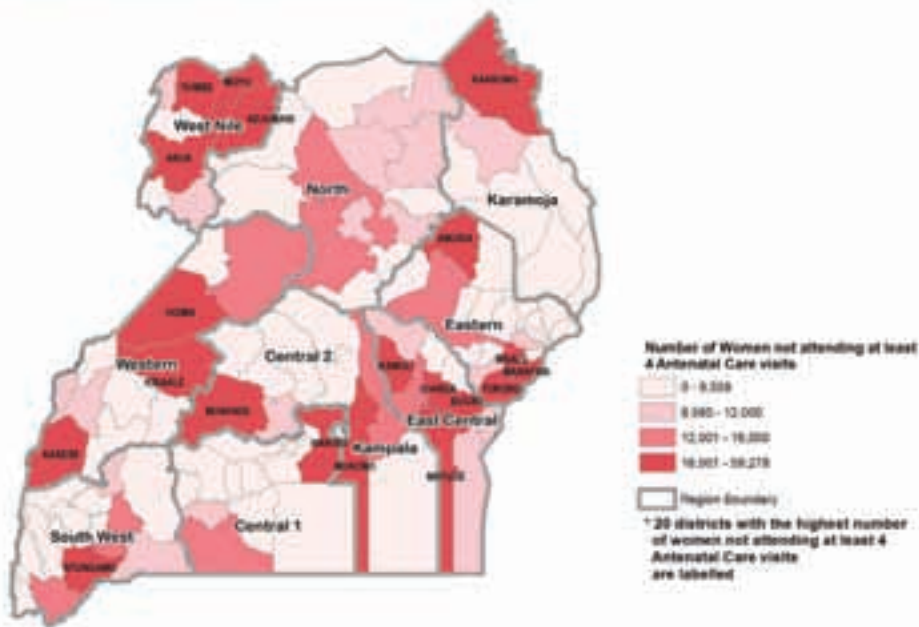
- The number of pregnant women not attending four ANC visits is estimated at over 1 million.
- Only 12 districts have at least one in every two women making four ANC visits.

PREGNANT WOMEN NOT ATTENDING AT LEAST FOUR ANTENATAL CARE VISITS

PERCENTAGE OF WOMEN NOT ATTENDING AT LEAST 4 ANTENATAL CARE VISITS



NUMBER OF WOMEN NOT ATTENDING AT LEAST 4 ANTENATAL CARE VISITS

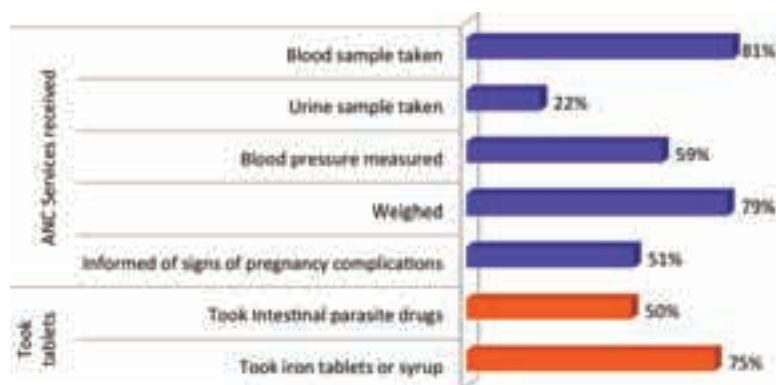


Source: ANC 4 prevalence rates: MoH, 2013c; Number of pregnant women not attending ANC4: UNICEF calculations

The quality and reach of ANC services needs to be improved.

- Only one in every two women making ANC visits were informed of signs of pregnancy complications, and only one in every five had their urine samples taken.

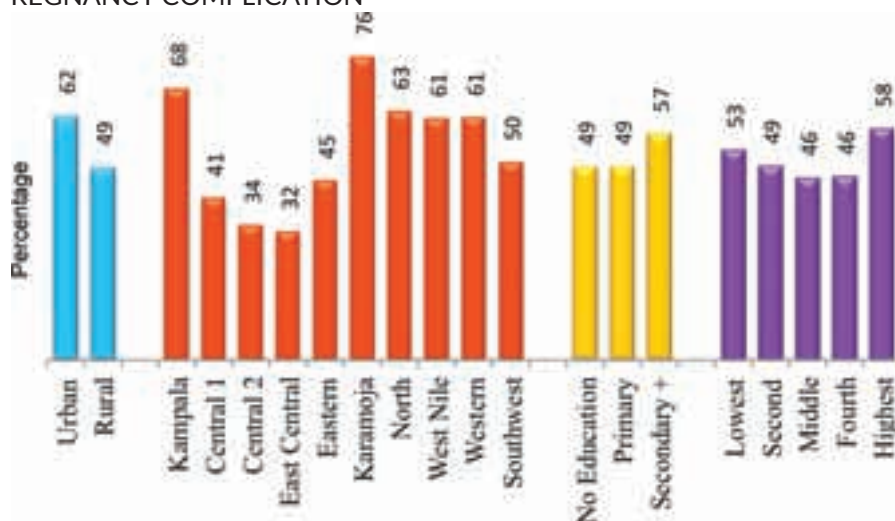
AMONG WOMEN AGED 15-49 WITH A LIVE BIRTH IN THE FIVE YEARS PRECEDING THE SURVEY – THE PERCENTAGE WHO TOOK IRON TABLETS AND DRUGS FOR INTESTINAL PARASITES DURING THE PREGNANCY OF THE MOST RECENT BIRTH, AND AMONG WOMEN WHO RECEIVED ANTENATAL CARE FOR THEIR MOST RECENT BIRTH IN THE PAST FIVE YEARS, THE PERCENTAGE WHO RECEIVED SELECTED SERVICES



Source: UBOS and ICF International, 2012

- Rural-based pregnant women making ANC visits are less likely (49%) to be given information on signs of pregnancy complications than are urban (62%) women.
- East Central (32%) and Central 2 (34%) had the lowest percentage of women who were given information on signs of pregnancy complications while Karamoja had the highest percentage (76%).

AMONG WOMEN WHO RECEIVED ANTENATAL CARE FOR THEIR MOST RECENT BIRTH IN THE PAST FIVE YEARS – THE PERCENTAGE WHO WERE INFORMED OF SIGNS OF PREGNANCY COMPLICATION



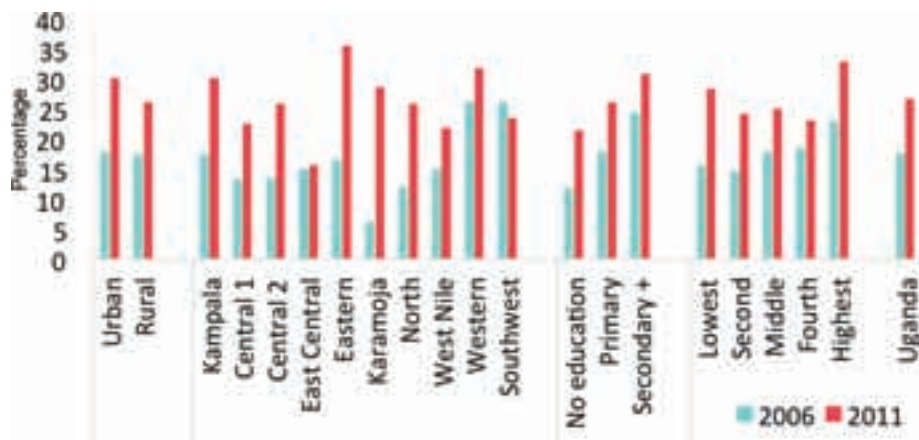
Source: UBOS and ICF International, 2012



Fewer than one in every three women receive two or more doses of intermittent preventive treatment (IPT2).

- At the national and sub-national level, there has been an improvement in IPT2 uptake for malaria. Nationally the level has gone up from 16% in 2006 to 27% in 2011.
- There are disparities among pregnant women on the basis of residence (rural women are less likely to get IPT2 than urban); the regions (women in East Central are less than half as likely to get IPT2 as those in other regions).
- A woman’s likelihood of having received IPT2 increases as her level of education increases, with those having at least some secondary education being 1.5 times more likely to have received IPT2 (29%) than those with no education (20%).

WOMEN AGED 15–49 WITH A LIVE BIRTH IN THE TWO YEARS PRECEDING THE SURVEY WHO, DURING THE PREGNANCY PRECEDING THE LAST BIRTH, TOOK 2+ DOSES OF SP/ FANSIDAR

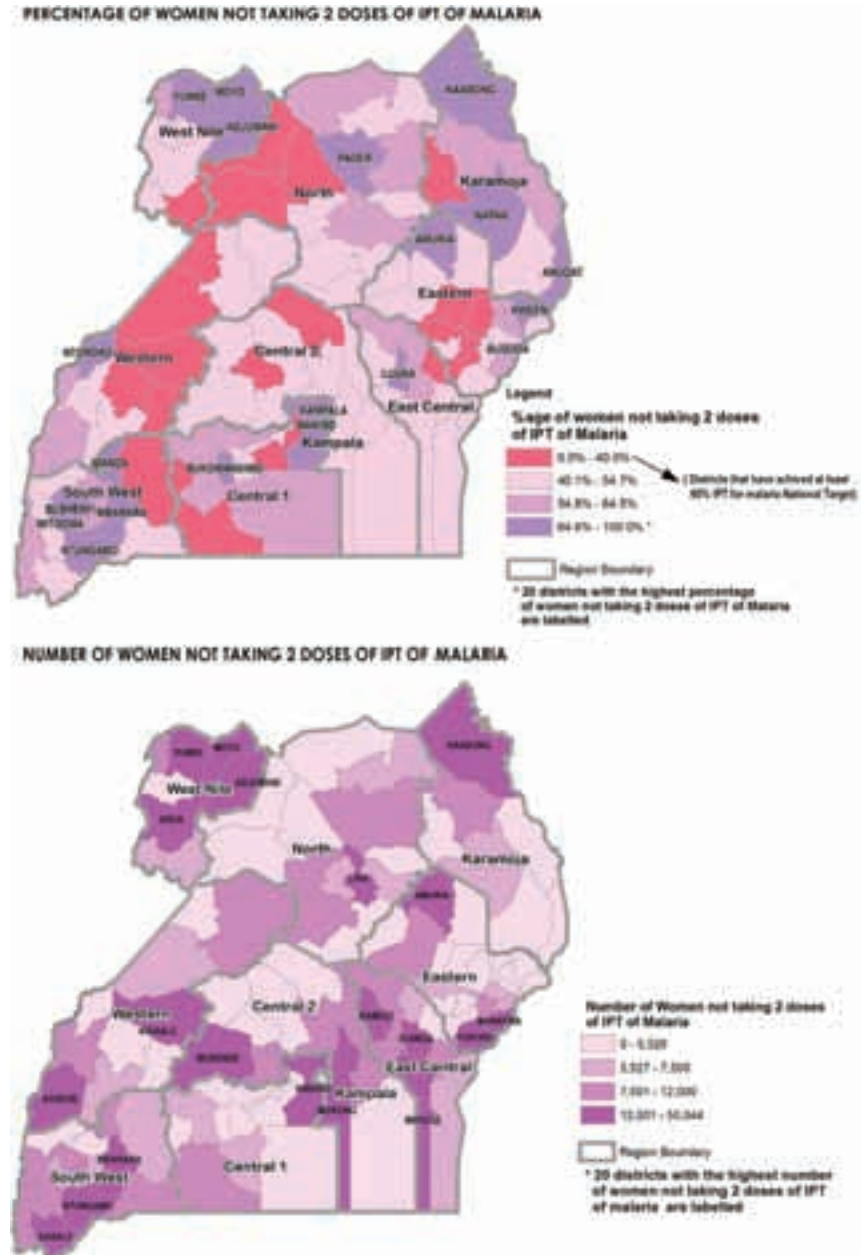


Source: UBOS and ICF International, 2012

The number of women not receiving preventive treatment against malaria at least twice (IPT2) is 877,460.

- Only 23 districts have achieved the Government's target of 60% of pregnant women receiving IPT2.
- Only 44 districts have at least half of pregnant women receiving IPT2.

PREGNANT WOMEN NOT TAKING TWO DOSES OF INTERMITTENT PREVENTATIVE TREATMENT (IPT) OF MALARIA



Source: IPT2 prevalence rates: MoH, 2013c; Number of pregnant women not taking IPT2: UNICEF calculations

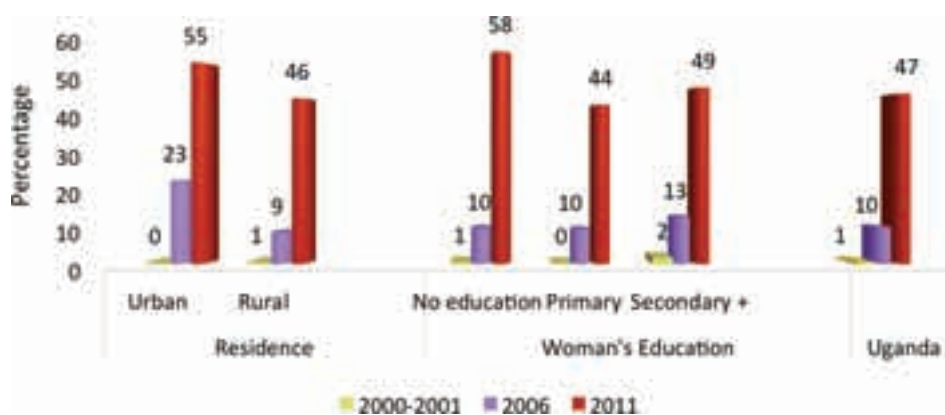
- There is an issue of continuity of use, with 62% of pregnant women reporting that they took antimalarial drugs (any type) for malaria prevention during pregnancy BUT only 27% of women reporting taking 2+ doses of SP/Fansidar as recommended.

PREGNANT WOMEN SLEEPING UNDER AN INSECTICIDE TREATED NET (ITN)

There has been marked increase in the use of ITNs by pregnant women, from 1% in 2000/01 to 47% in 2011 due to the distribution of free ITNs to some communities.

- Rural women seem to be less likely to use an ITN during pregnancy than urban women.

AMONG PREGNANT WOMEN AND 15-49, PERCENTAGE WHO SLEPT UNDER AN ITN THE PREVIOUS NIGHT OF THE SURVEY

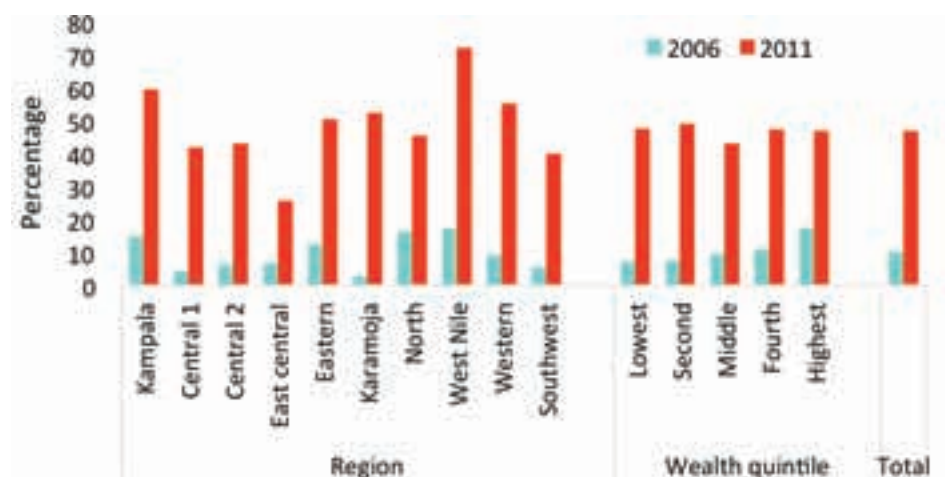


Source: UBOS and Macro International, 2000-01 and 2007; UBOS and ICF International, 2012

No region has achieved the Government target of 80%; the closest is West Nile (72%) and Kampala 60%.

- East Central (26%), South-West (40%), and Central 1 and 2 require prioritised support.

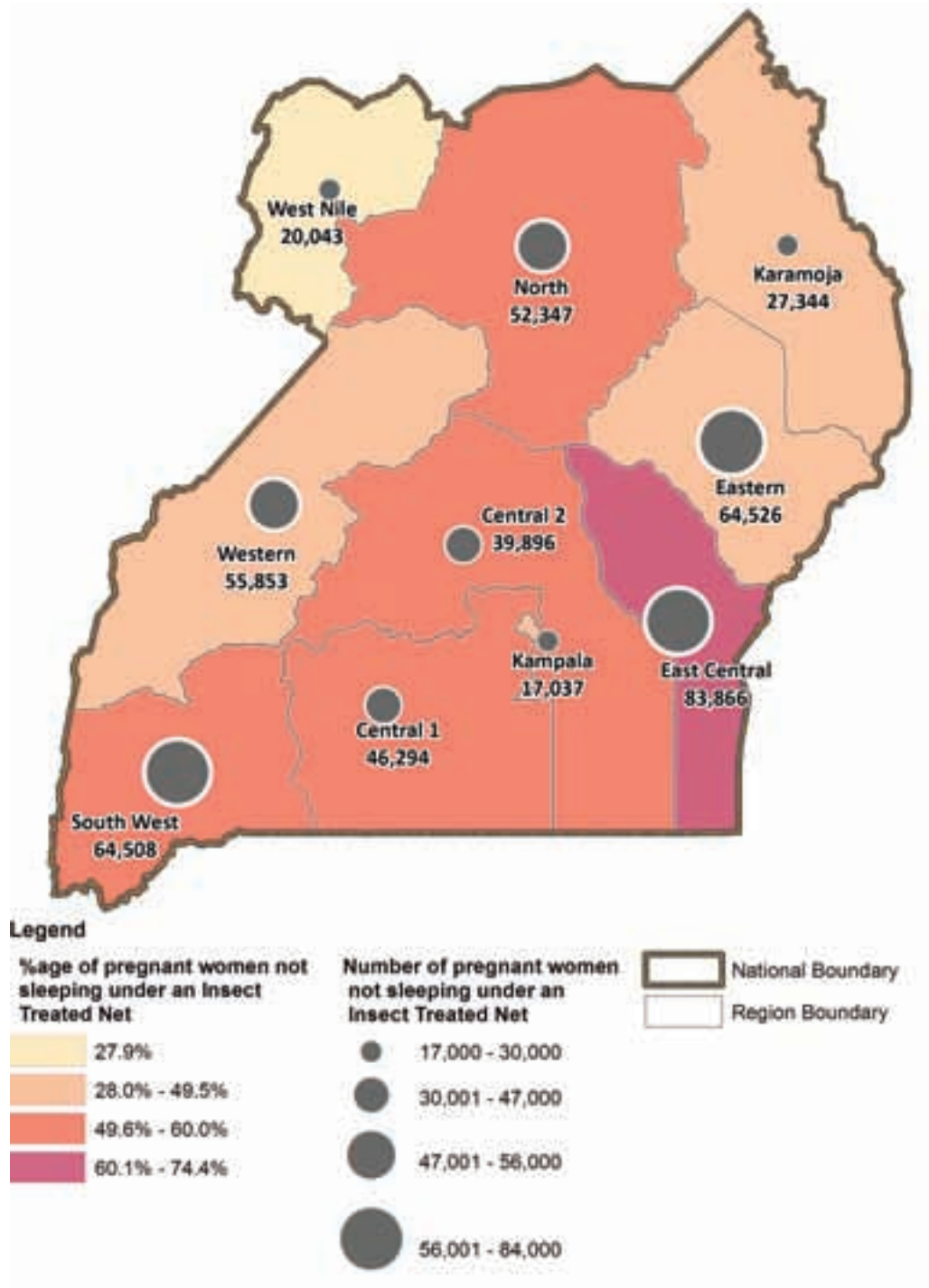
AMONG PREGNANT WOMEN AGED 15-49, PERCENTAGE WHO SLEPT UNDER AN ITN BY BACKGROUND CHARACTERISTICS, 2011



Source: UBOS and ICF International, 2012

Of the 472,000 pregnant women who are not sleeping under an ITN, the majority (45%) reside in East Central, Eastern and South-West regions.

PREGNANT WOMEN NOT SLEEPING UNDER AN ITN



Source: Pregnant women sleeping under an ITN prevalence rates: UBOS and ICF International, 2012;
 Number of pregnant women not sleeping under an ITN estimates: UNICEF calculations

BIRTHS ASSISTED BY A SKILLED PROVIDER

Nationally, 58% of births are attended by a skilled health service provider. The Government target is 70%.

- There was improvement over the decade 2000/01 to 2011 from 39% to 58% at the national level but it was not equitably spread.
- Only Kampala (93%) is above the national target. Karamoja has the lowest rate (31%).
- In rural areas 53% of births are assisted by a skilled provider compared with 89% in urban areas. Three out of five of births (62%) to women with no education were not attended by a skilled provider compared with one out of five of births (19%) among women with secondary and higher education.
- More than five in every ten women in the bottom wealth quintile (55%) are not assisted by a skilled health service provider during childbirth; the same ratio is one in ten for women in the highest wealth quintile.
- Traditional birth attendants are still delivering one in every five babies (18%).
- One in every five women (19%) in the South-West region give birth without anyone providing assistance.

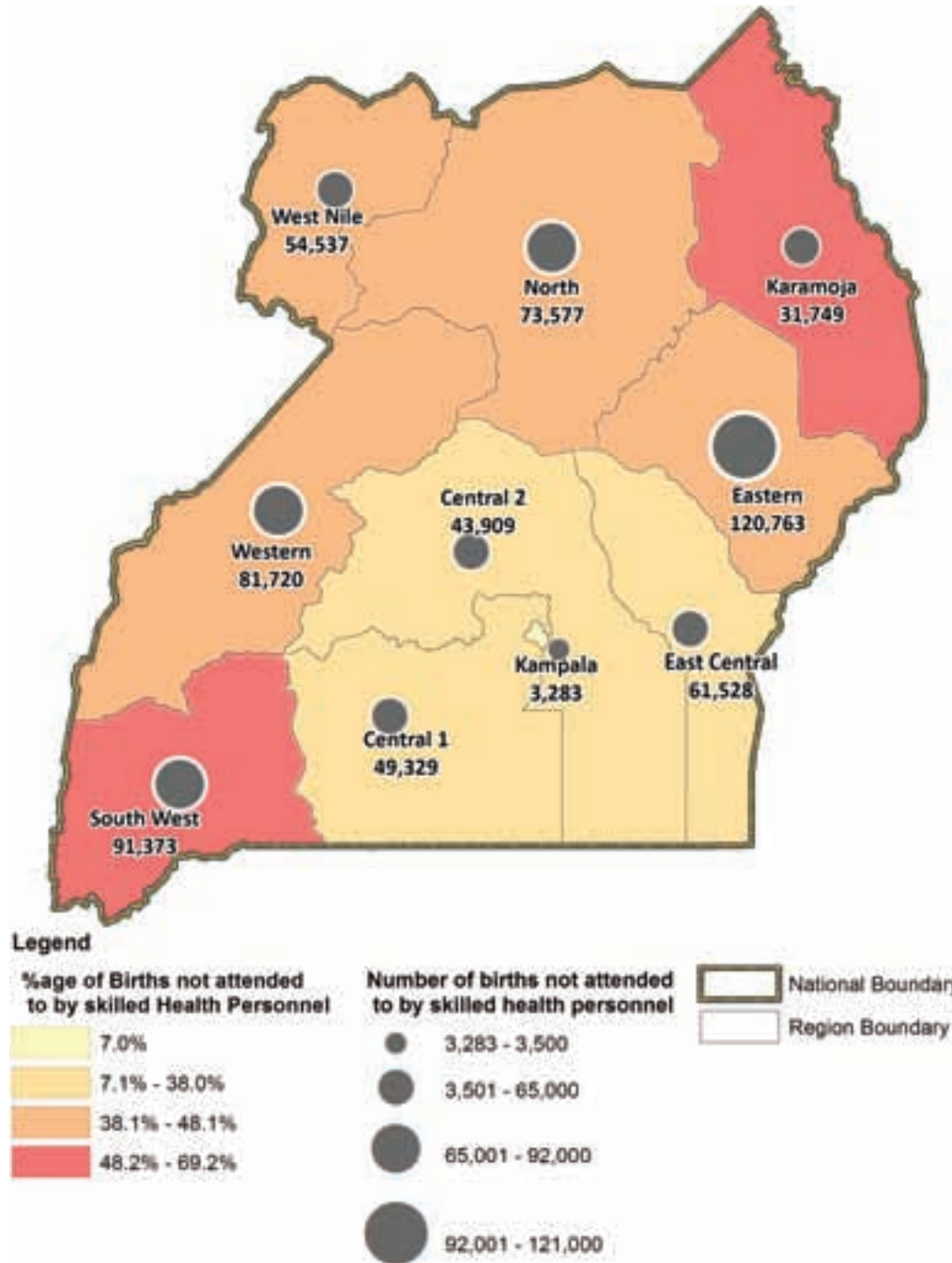
DISTRIBUTION OF LIVE BIRTHS ASSISTED BY A SKILLED PROVIDER BY BACKGROUND CHARACTERISTICS



Source: UBOS and Macro International, 2000–01 and 2007; UBOS and ICF International, 2012

The number of women not attended by skilled health personnel during childbirth is estimated at 612,000.

BIRTHS NOT ATTENDED BY SKILLED HEALTH PERSONNEL



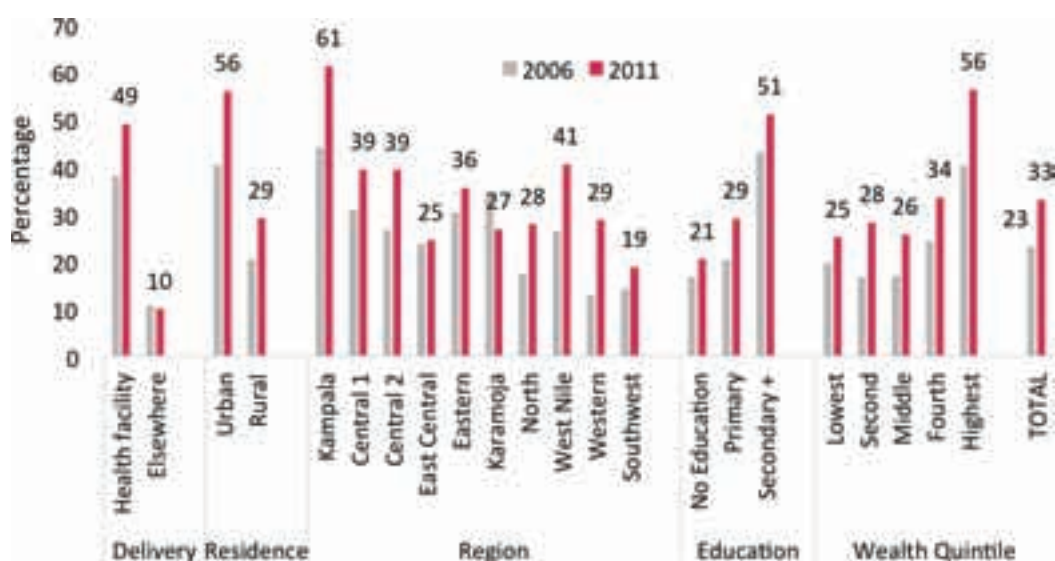
Source: Births attended by skilled health personnel prevalence rates: UBOS and ICF International, 2012; Number of births not attended by skilled health personnel estimates: UNICEF calculations

POSTNATAL CARE

Two out of every three mothers are not receiving postnatal care within 48 hours of giving birth.

- Seven in every ten rural mothers are not getting a postnatal check-up (compared with four in every ten urban mothers).
- Only Kampala (61%) is close to the national target (70%) for postnatal visits within 48 hours.
- All other regions are at 40% or below; South-West is the lowest (19%).
- Mothers in South-West region are twice as likely as mothers in Kampala not to get a check-up.
- Four in every five mothers who have no education are not getting a postnatal check-up (compared to two in every five mothers with at least a secondary school education).
- Almost eight in every ten mothers in the lowest quintile are not getting a postnatal check-up (compared with three in every 10 in the highest quintile).

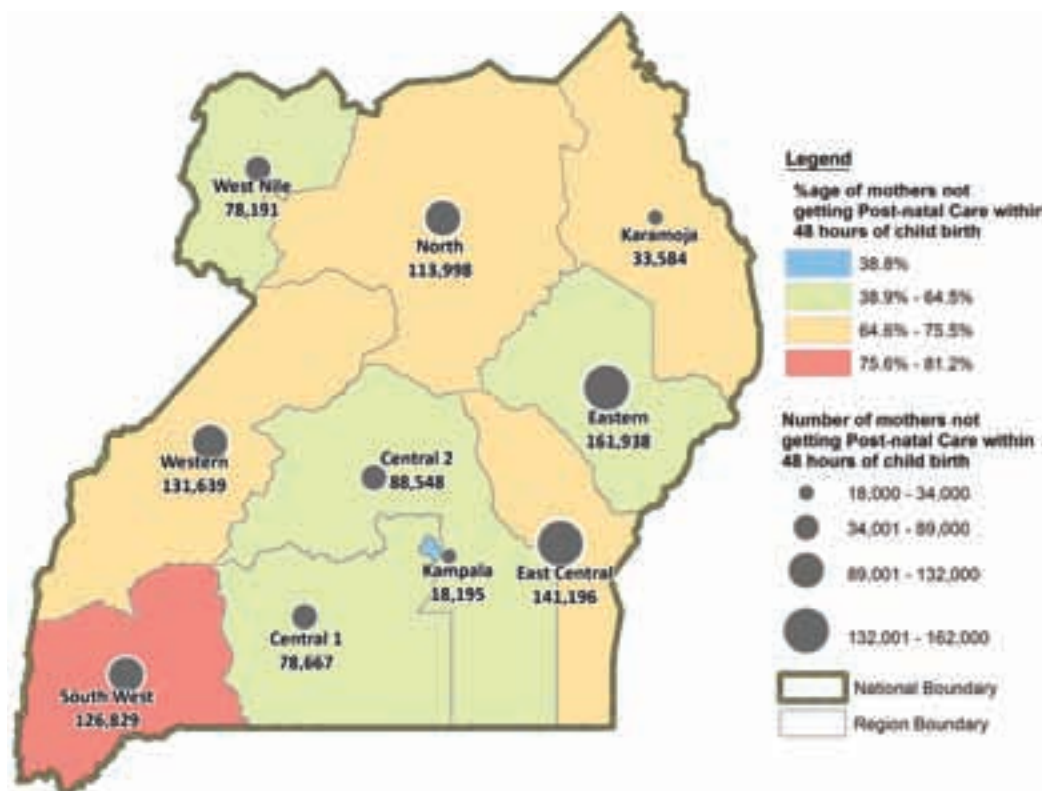
AMONG WOMEN AGED 15–49 GIVING BIRTH IN THE TWO YEARS PRECEDING THE SURVEY, THE PERCENTAGE THAT RECEIVED POST-NATAL CHECK-UP IN THE TWO DAYS AFTER GIVING BIRTH



Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

The number of women not getting postnatal care within 48 hours of giving birth is estimated at over half a million (601,143).

MOTHERS NOT GETTING POSTNATAL CARE WITHIN 48 HOURS OF CHILDBIRTH

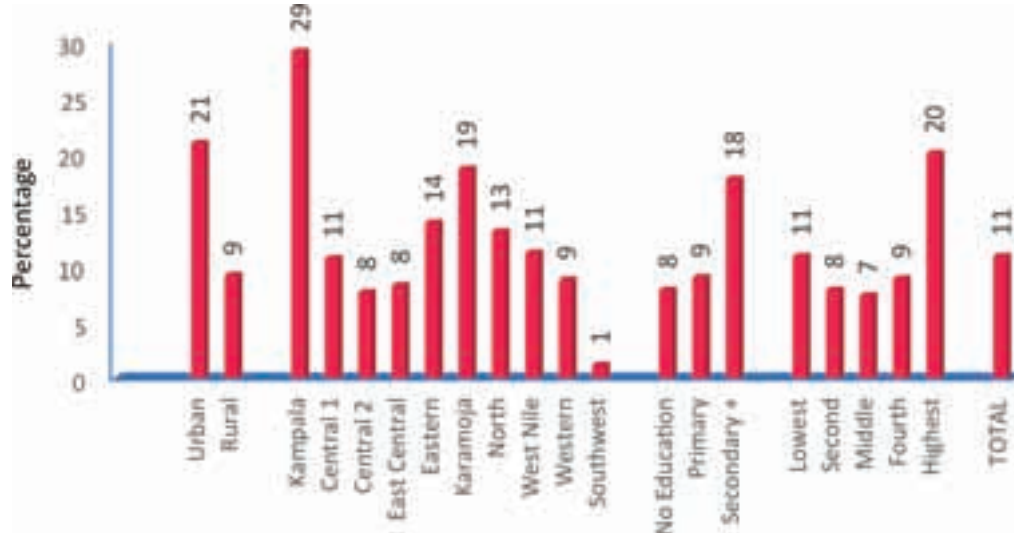


Source: Percentage of mothers not getting postnatal care within 48 hours rates: UBOS and ICF International, 2012;
Numbers of mothers not getting postnatal care within 48 hours estimates: UNICEF calculations

Only one in 10 babies gets a postnatal checkup within 48 hours of being born, far below the national target of seven in every 10.

- Babies born in rural areas are half as likely as those in urban areas to get a postnatal check-up within 48 hours.
- Babies born in households in the lowest quintile are half as likely as those from the highest quintile.
- Babies born to mothers with no education are half as likely as those born to mothers with at least a secondary school education.
- Babies born in Kampala region are 29 times as likely as those born in the South-West region to get a check-up within 48 hours.

AMONG WOMEN AGED 15–49 GIVING BIRTH IN THE TWO YEARS PRECEDING THE SURVEY, THE PERCENTAGE THAT RECEIVED A POSTNATAL CHECK-UP FOR THEIR NEWBORNS IN THE TWO DAYS AFTER GIVING BIRTH

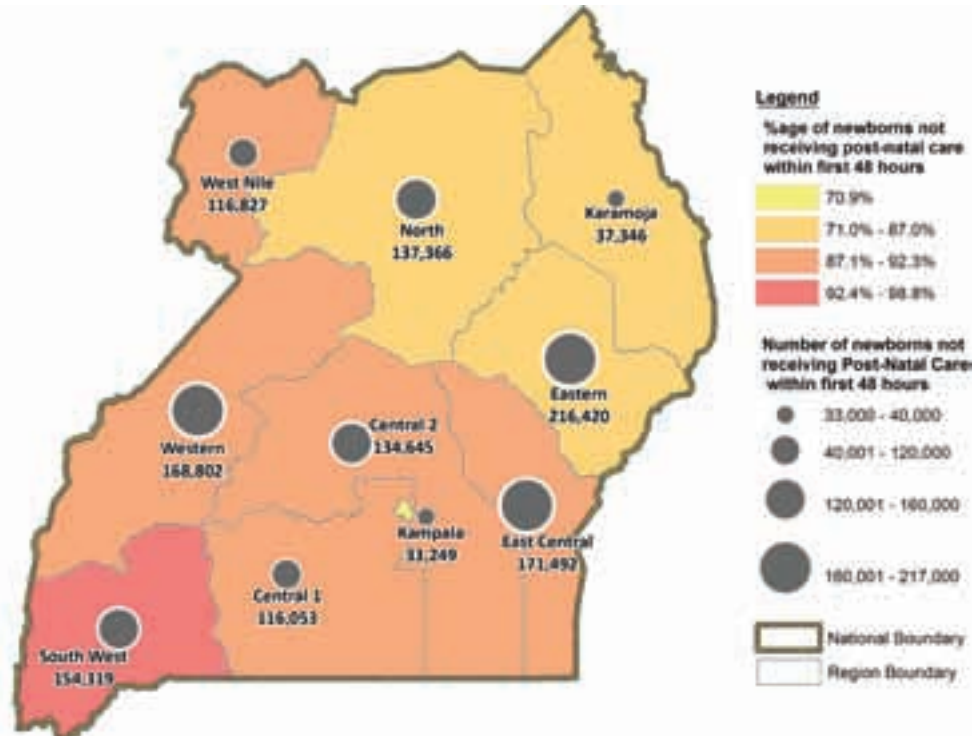


Source: UBOS and ICF International, 2012

About 1.3 million babies do not get a postnatal check-up within 48 hours of being born.

- Of these, 43% are born in East Central, Eastern and Western regions.

NEWBORNS NOT RECEIVING POSTNATAL CARE WITHIN THE FIRST 48 HOURS



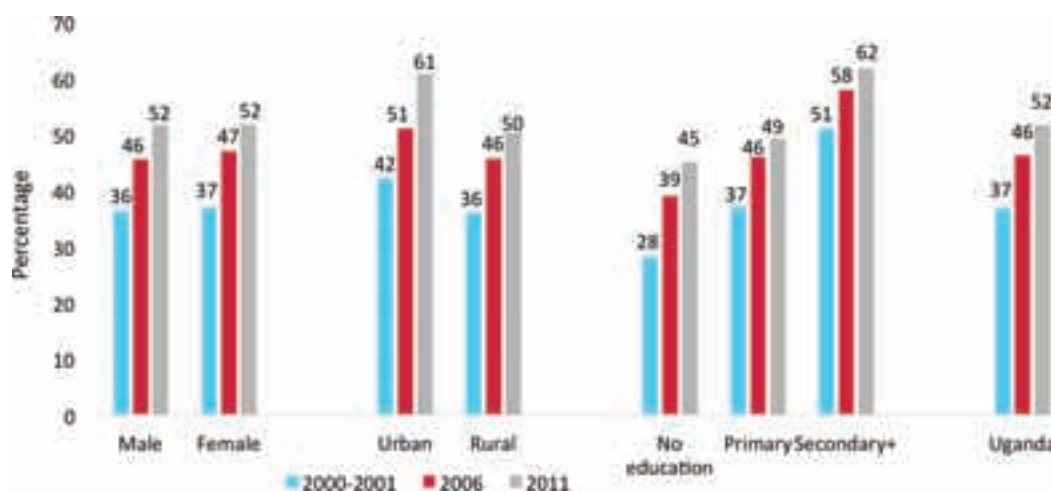
Source: Newborn postnatal care within 48 hours prevalence rates: UBOS and ICF International, 2012; Number of newborns not receiving postnatal care within 48 hours estimates: UNICEF calculations

CHILDREN'S HEALTH

One in every two children aged 12–23 months has received all vaccinations. From 2000/01 to 2011, the proportion rose from 37% to 52%.

- Urban children (61%) are more likely than those living in rural area (50%) to be fully vaccinated.
- Vaccination coverage increases with educational attainment of a child's mother, from 45% for children whose mothers have no education to 62% among children of mothers with secondary or higher education.
- Only 4% of children aged 12–23 months had not received any vaccinations.
- There are no disparities between the sexes, and relatively minor disparity between urban and rural.

CHILDREN AGED 12–23 MONTHS WHO RECEIVED ALL THE BASIC VACCINATIONS

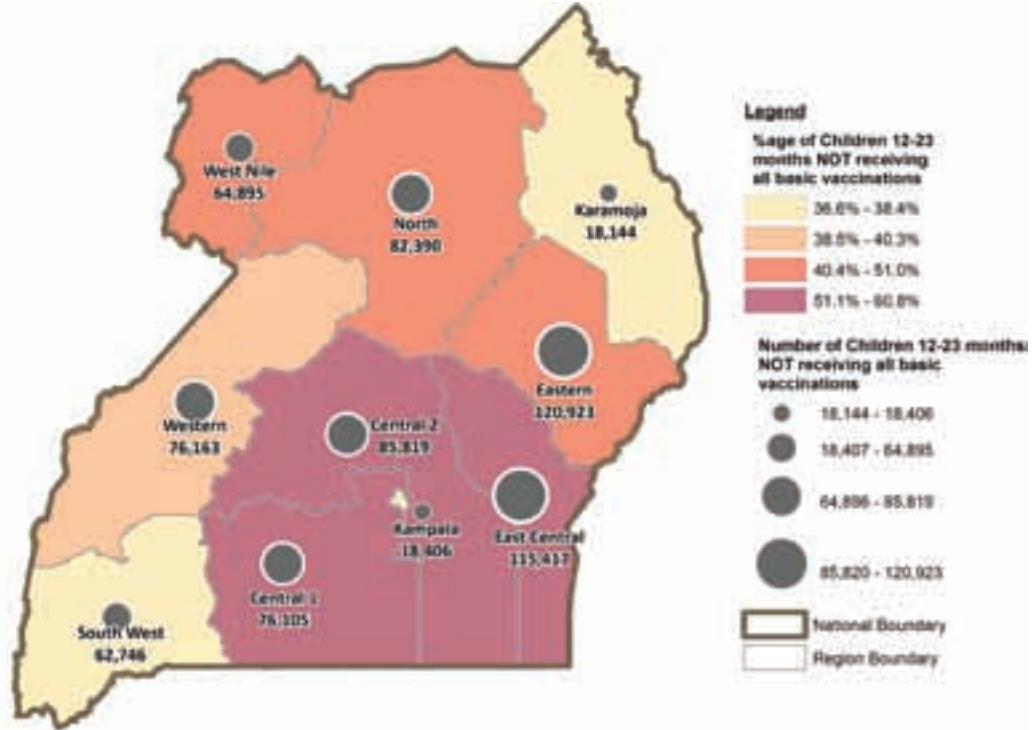


Source: UBOS and Macro International, 2000–01 and 2007; UBOS and ICF International, 2012

The number of children 12–23 months old who have not received all basic vaccinations is estimated at 721,000.

- Two regions, East Central and Eastern, have the highest numbers of children aged 12–23 months who have not received all basic vaccinations (over 236,000; 33%).

CHILDREN AGED 12–23 MONTHS NOT RECEIVING ALL BASIC VACCINATIONS

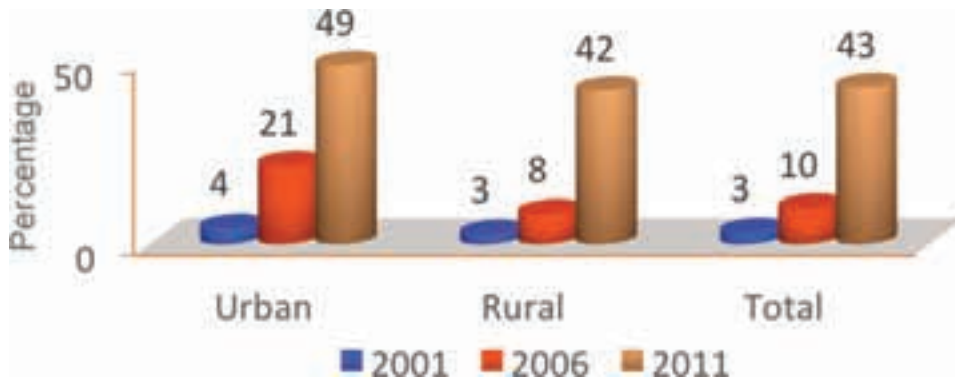


Source: Children 12–23 months not receiving basic vaccinations rates: UBOS and ICF International, 2012; Number of children 12–23 months not receiving basic vaccinations estimates: UNICEF calculations

Slightly over four in ten children aged under five sleep under an ITN.

- This is a sharp increase from just 3/100 in 2000/01.

PERCENTAGE OF CHILDREN UNDER AGE FIVE IN ALL HOUSEHOLDS WHO SLEPT UNDER AN ITN

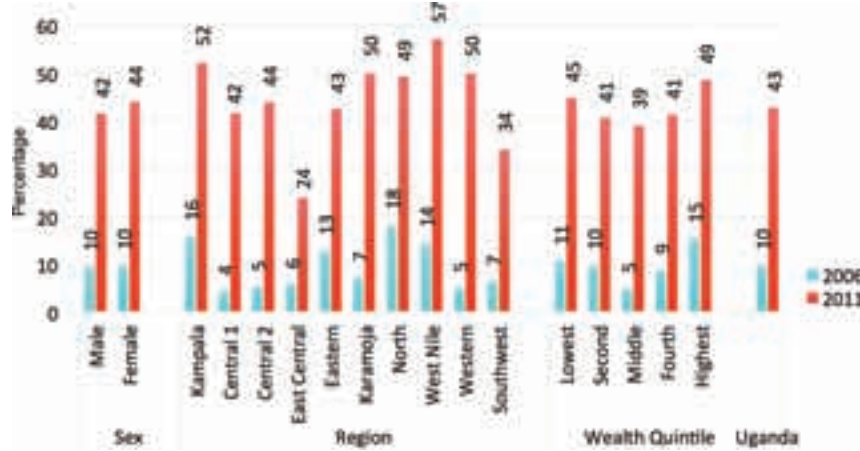


Source: UBOS and Macro International, 2000–01 and 2007, UBOS and ICF International, 2012

Only one in every four under-fives in East Central region sleep under an ITN compared with one in every two in West Nile and Kampala.

- There is no distinct wealth level-related disparity pattern between the five wealth groups.

CHILDREN UNDER AGE FIVE IN ALL HOUSEHOLDS WHO SLEPT UNDER AN ITN BY SEX, REGION AND WEALTH QUINTILE

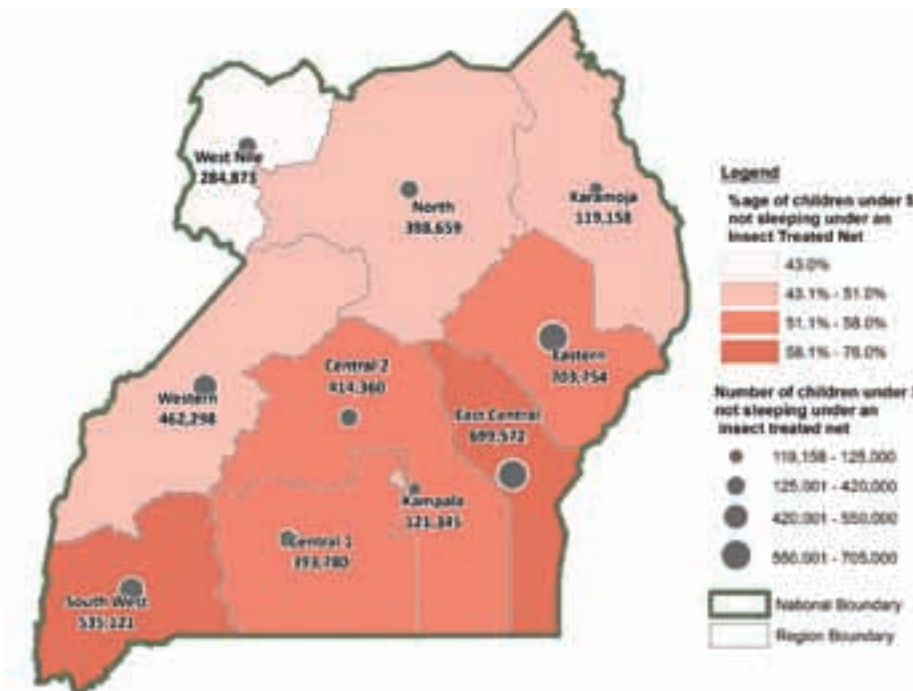


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

A total of 4.1 million children are not sleeping under an ITN.

- Three regions (East Central, Eastern and South-West) contribute over 1.9 million (47%) to that total, and each one has more than half a million children not sleeping under an ITN.

CHILDREN UNDER FIVE NOT SLEEPING UNDER AN ITN



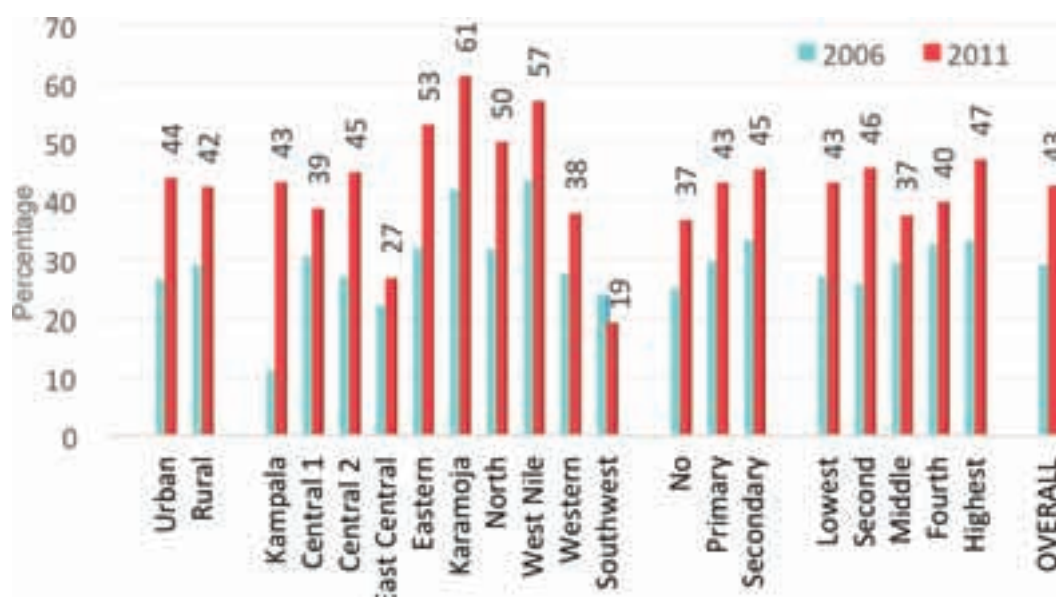
Source: Children under five years not sleeping under an ITN rates: UBOS and ICF International, 2012; Numbers of children under five years not sleeping under an ITN estimates: UNICEF calculations

TREATMENT OF MALARIA

The percentage of under-fives with fever who took malaria treatment the same or next day has gone up from 29% in 2006 to 43% in 2011, but is still far below the national target of 80%.

- A child in Karamoja is three times as likely (61%) as a child in South-West region (19%) to get treatment.
- There is no significant difference between rural and urban proportions and no definite pattern between the different wealth groups.

AMONG CHILDREN UNDER AGE FIVE WITH FEVER, THE PERCENTAGE WHO TOOK ARTEMISININ-BASED COMBINATION THERAPY (ACT) THE SAME OR NEXT DAY FOLLOWING THE ONSET OF FEVER

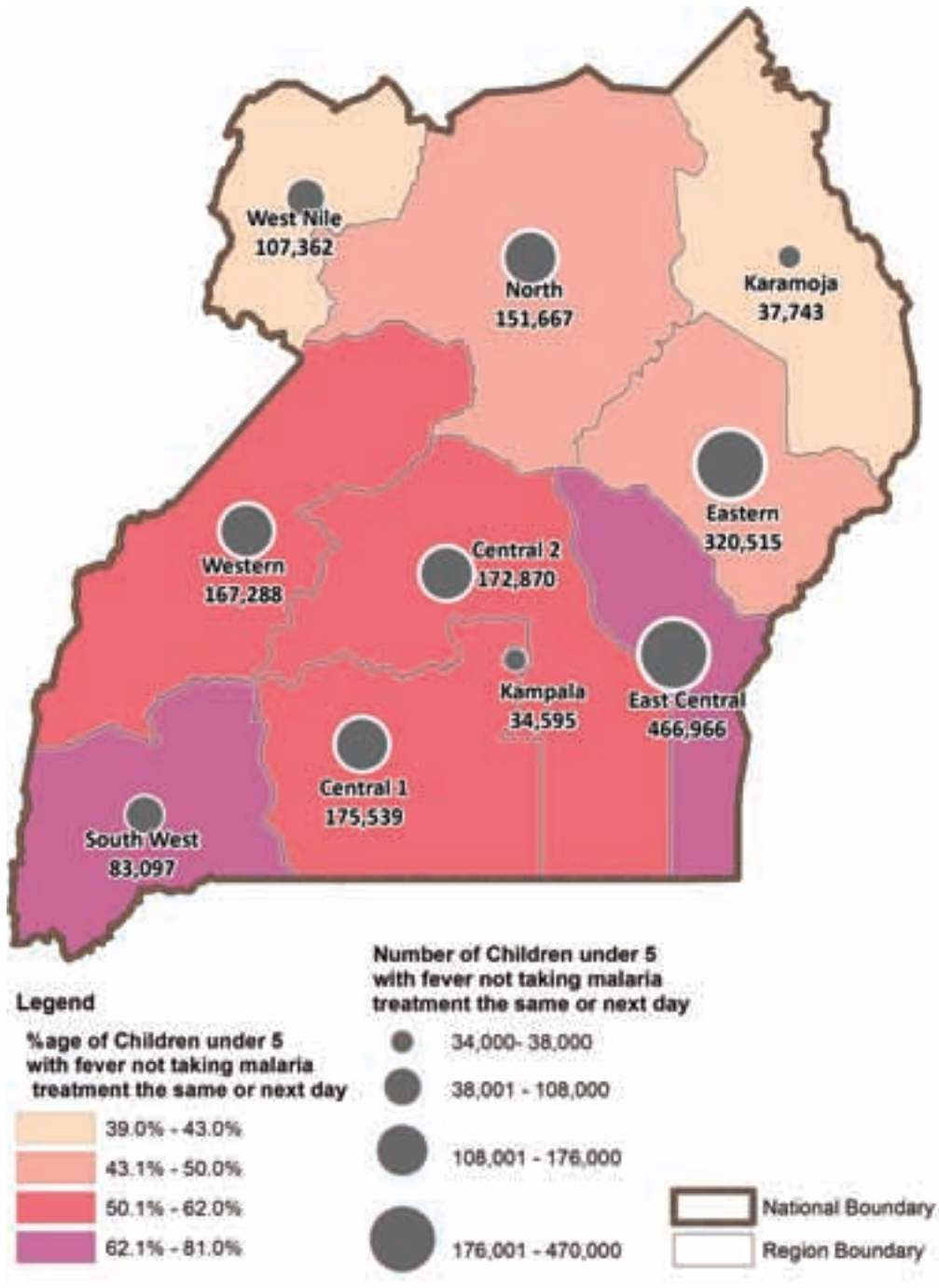


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

An estimated 1.7 million under-fives with fever did not take malaria treatment the same or next day following the onset of fever.

■ About 787,000 (46%) of those children were in Eastern Central and Eastern regions.

CHILDREN UNDER FIVE WITH FEVER NOT TAKING MALARIA TREATMENT THE SAME OR NEXT DAY



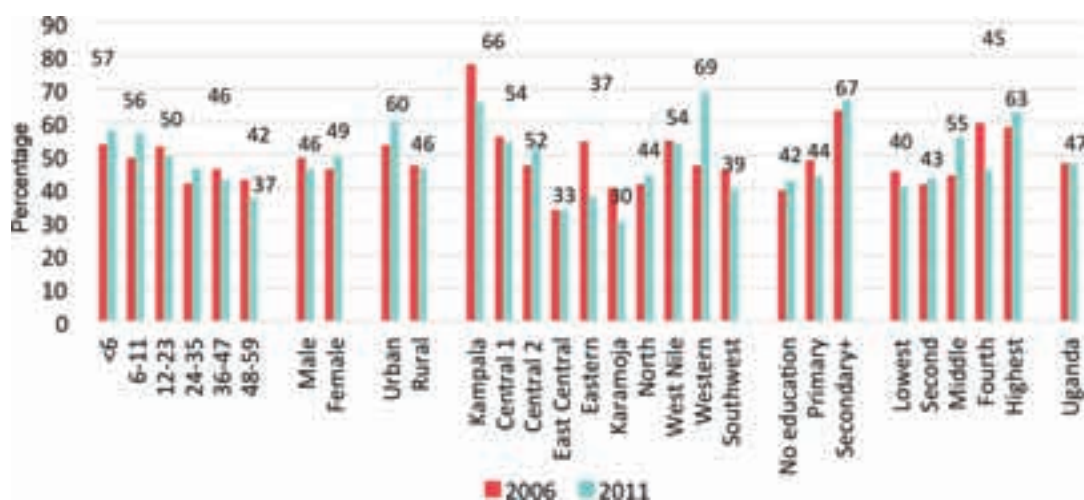
Source: Under-fives with fever who did not take malaria treatment the same or next day rates: UBOS and ICF International, 2012; Numbers of under-fives with fever who did not take malaria treatment the same or next day estimates: UNICEF calculations

INFECTION (ARI)

The percentage of children aged under five with symptoms of ARI who were given antibiotics has remained stagnant at 47% since 2006 – just over half the national target of 90%.

- Karamoja has the lowest proportion, with only three in every ten children receiving treatment.
- Under-fives in rural areas are less likely to receive antibiotics for ARI than their urban counterparts.
- The likelihood of getting antibiotics for symptoms of ARI decreases as the child's age increases, while it goes up as the mother's educational level increases.

AMONG CHILDREN UNDER FIVE WITH ARI, PERCENTAGE THAT RECEIVED ANTIBIOTICS

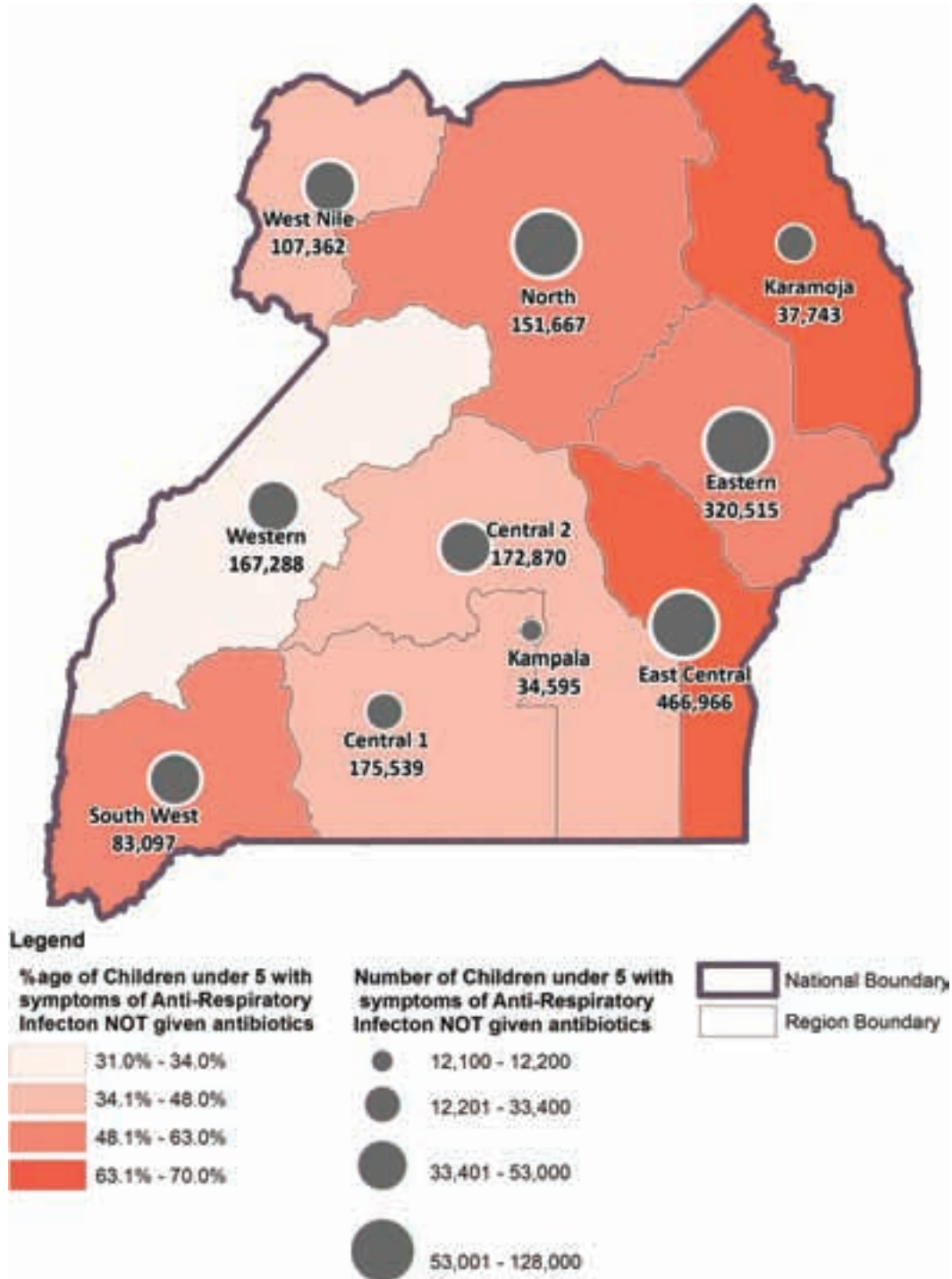


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

Around 580,000 under-fives with symptoms of ARI did not get antibiotics.

- An estimated 128,000 of these children live in Eastern region.

CHILDREN UNDER FIVE WITH SYMPTOMS OF ARI NOT GIVEN ANTIBIOTICS



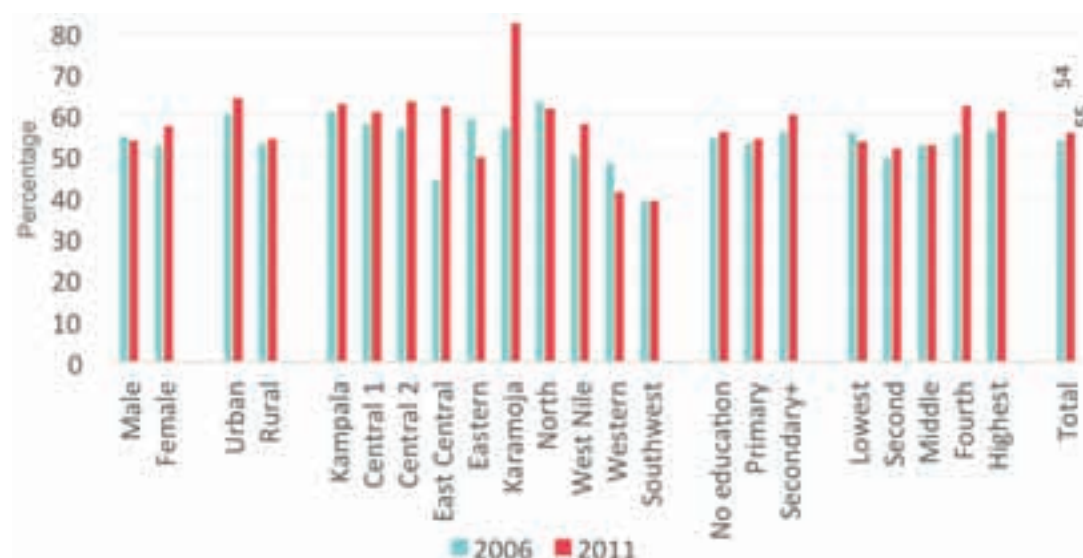
Source: Under-fives with symptoms of ARI who were not given antibiotics rates: UBOS and ICF International, 2012; Numbers of under-fives with symptoms of ARI who were not given antibiotics estimates: UNICEF calculations

TREATMENT OF DIARRHOEA

The percentage of children under five with diarrhoea receiving oral rehydration therapy (ORT)/fluids went up by just 2% between 2001 and 2011 (from 53% to 55%) – well below the national target of 90%.

- South-West region has the lowest percentage (39%) while Karamoja has the highest (82%).
- The likelihood of being given ORT/fluids when a child under five has diarrhoea decreases as the child gets older.
- No distinct pattern is observed among different wealth groups or different levels of education of the mother.

AMONG CHILDREN UNDER AGE FIVE WHO HAD DIARRHOEA IN THE TWO WEEKS PRECEDING THE SURVEY, THE PERCENTAGE GIVEN ORT OR INCREASED FLUIDS AS TREATMENT



Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

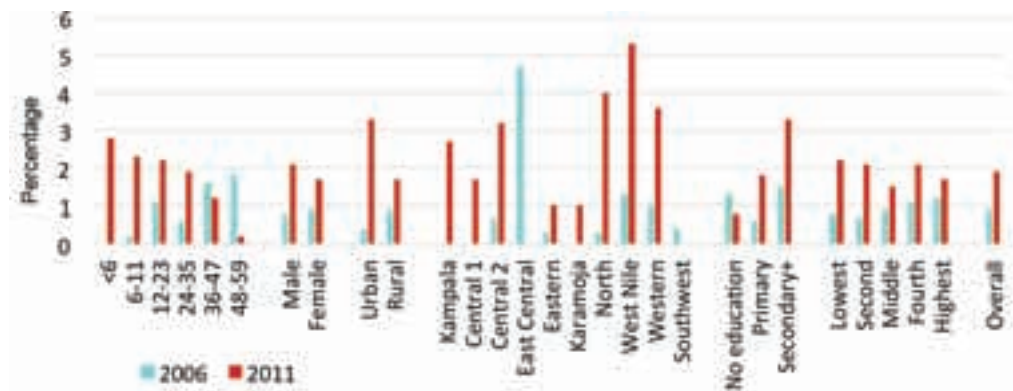
A total of 758,000 children with diarrhoea did not get ORT with increased fluids.

- Over 200,000 of these children live in Eastern region alone (27%).
- More than half (55%) of the children not getting ORT are from three regions (East Central, Eastern and Western), each of which has more than 100,000 children not getting ORT/fluids.

Only one child in 50 with diarrhoea receives zinc supplements.

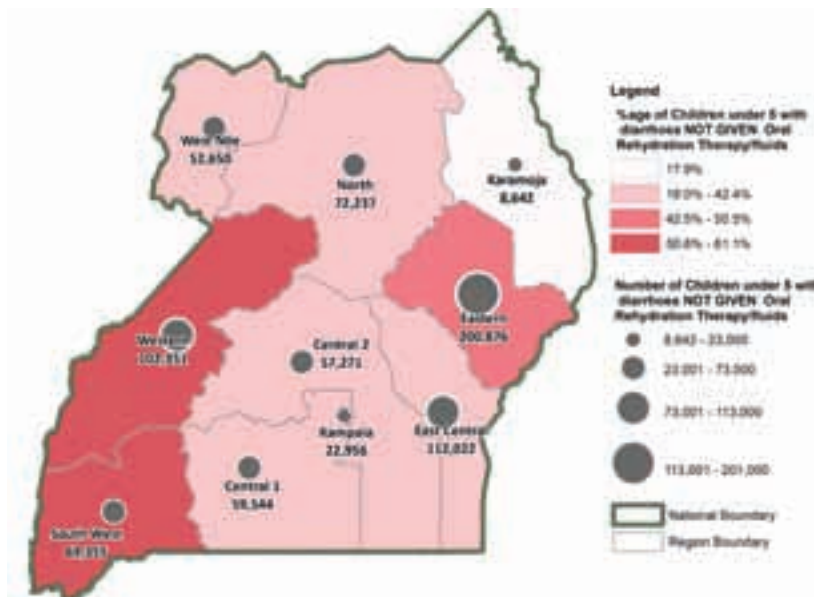
- An urban-based infant is twice as likely to be given zinc for diarrhoea as a rural infant.
- Despite the very low national levels, there are big regional disparities, with children in the South-West and East Central regions getting no zinc and more than one in every 20 being given zinc for diarrhoea in West Nile region.
- Children born to mothers with at least a secondary school education are four times as likely to get zinc for diarrhoea treatment as are children born to mothers without an education.
- Children’s likelihood of getting zinc for diarrhoea treatment decreases as they get older: for four-year-olds it is one in every 500 sick children while for children under six months it is three in every 100.
- No distinct pattern is observed among different wealth groups.

AMONG CHILDREN UNDER FIVE WHO HAD DIARRHOEA IN THE TWO WEEKS PRECEDING THE SURVEY, THE PERCENTAGE GIVEN ZINC SUPPLEMENTS AS TREATMENT



Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

CHILDREN UNDER FIVE WITH DIARRHOEA NOT GIVEN ORT/FLUIDS



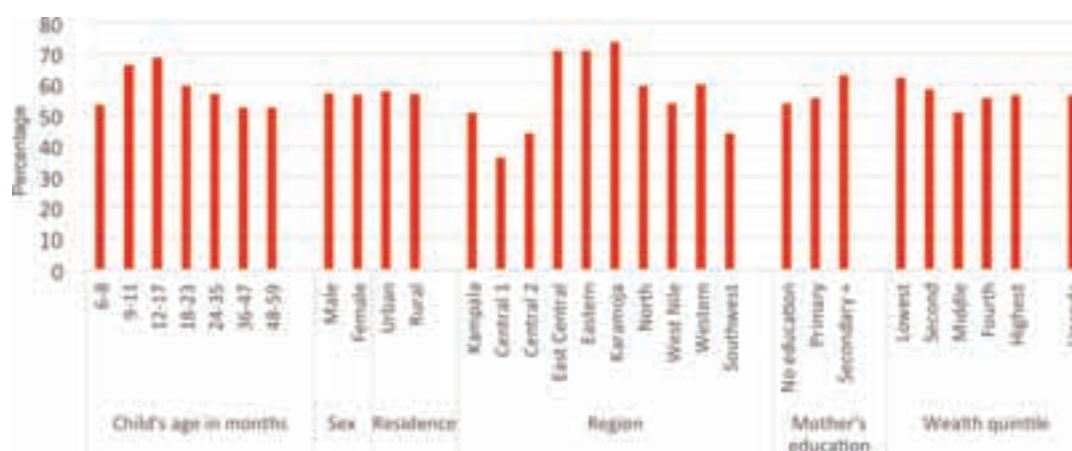
Source: Under-fives with diarrhoea who were not given ORT/fluids rates: UBOS, 2012; Numbers of under-fives with diarrhoea who were not given ORT/fluids estimates: UNICEF calculations

VITAMIN A SUPPLEMENTATION

The percentage of children under five receiving vitamin A supplements increased from 36% in 2006 to 57% in 2011.

- Almost three in every five children aged 6–59 months (57%) received vitamin A supplements in the six months preceding the 2011 UDHS.
- Vitamin A supplementation was lowest in Central 1 (36%) region followed by Central 2 and South-West (each 44%) and highest in Karamoja (74%).
- There was no significant variation in vitamin A supplementation among children on the basis of gender or residence.
- There was no definite pattern of variation in vitamin A intake between different levels of wealth group. Children in the third quintile had the least intake of vitamin A supplements (51%) compared with those in the lowest quintile (62%).
- Vitamin A supplementation increased with the mother's level of education.

CHILDREN AGE 6–23 MONTHS WHO ARE LIVING WITH THEIR MOTHER WHO WERE GIVEN VITAMIN A SUPPLEMENTS IN PAST SIX MONTHS



Source: UBOS and ICF International, 2012

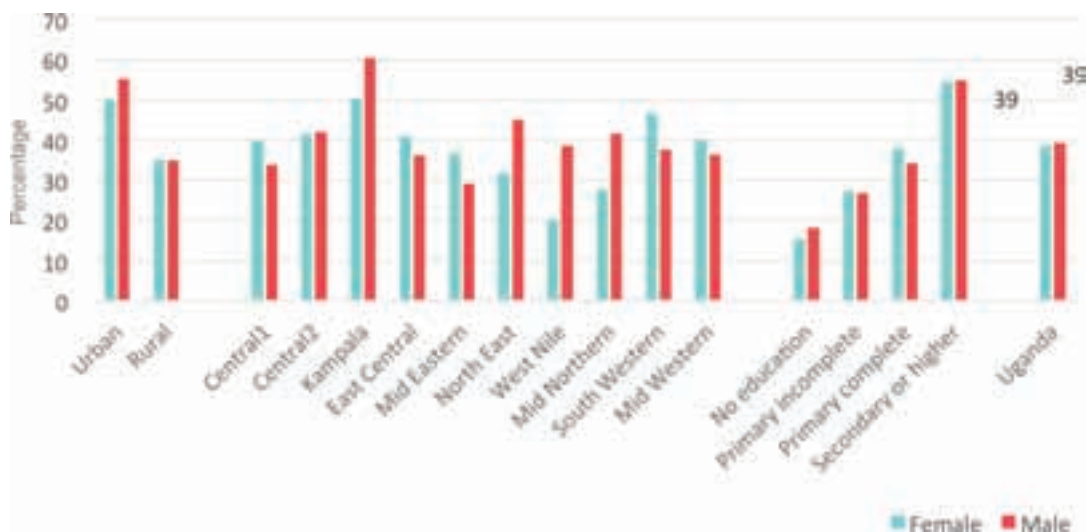


HIV AND AIDS

The percentage of young people aged 15–19 years with a comprehensive knowledge of HIV and AIDS is 36% while for those aged 15–24 years the percentage is 39%.

- Young people in urban areas are more likely to have comprehensive knowledge about HIV/AIDS (50%, female; 55%, male) than rural young people (35%, both female and male).
- Young people aged 15–24 living in Kampala region are more likely to have comprehensive knowledge about HIV/AIDS (50%, female; 60%, male) than those living in West Nile (20%, female; 39% male).
- The proportion of young people with comprehensive knowledge about HIV/AIDS increases steadily with an increase in the level of education.

WOMEN AND MEN AGED 15–24 WITH COMPREHENSIVE KNOWLEDGE ABOUT AIDS



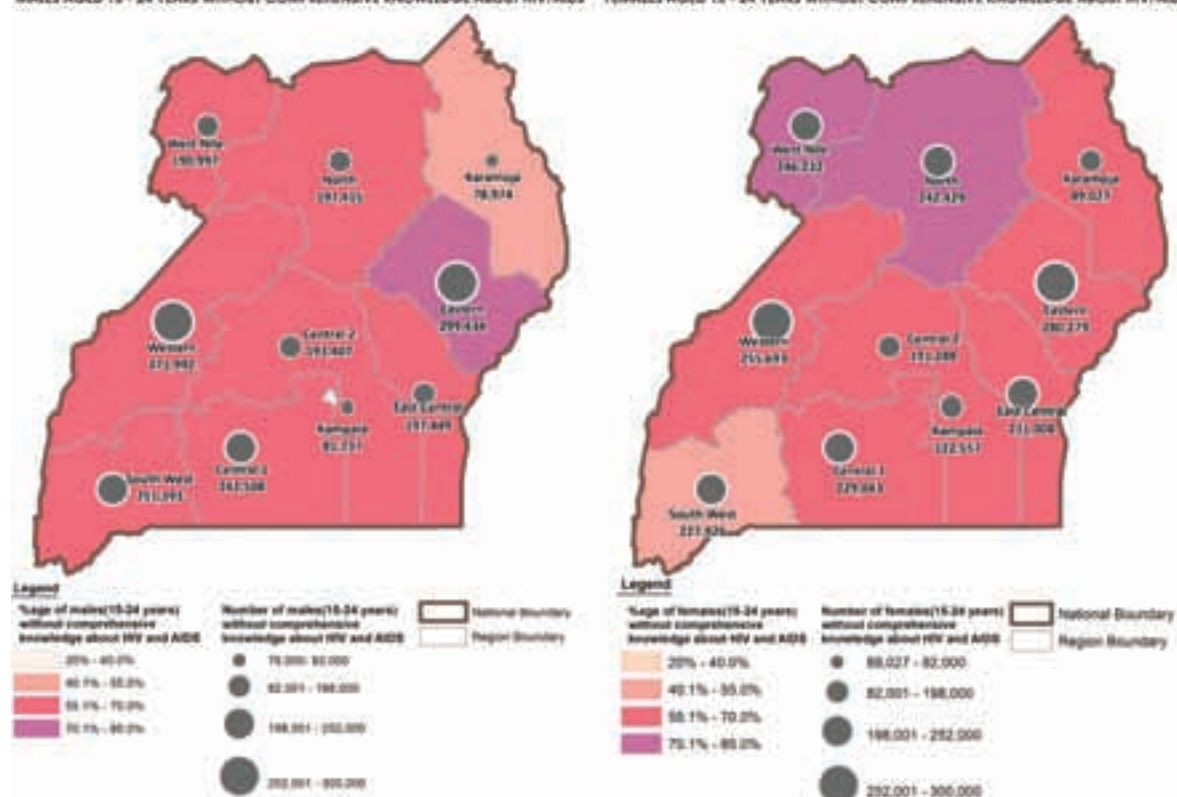
Source: Ministry of Health AIDS Indicator Survey 2011 (MoH, 2012b)

About 4 million young people lack comprehensive knowledge about HIV and AIDS.

- Only about two out of every five young women and men aged 15–24 have accurate comprehensive knowledge about HIV/AIDS, up from one in three in 2006 (UDHS and Macro International, 2007; UBOS and ICF International, 2011).
- Most young women and men aged 15–24 without comprehensive knowledge about HIV/AIDS reside in Eastern, South-West and Western regions (a total of 1.6 million, 39 % of total).

YOUNG ADULTS WITHOUT COMPREHENSIVE KNOWLEDGE ABOUT HIV/AIDS

MALES AGED 15 - 24 YEARS WITHOUT COMPREHENSIVE KNOWLEDGE ABOUT HIV/AIDS FEMALES AGED 15 - 24 YEARS WITHOUT COMPREHENSIVE KNOWLEDGE ABOUT HIV/AIDS



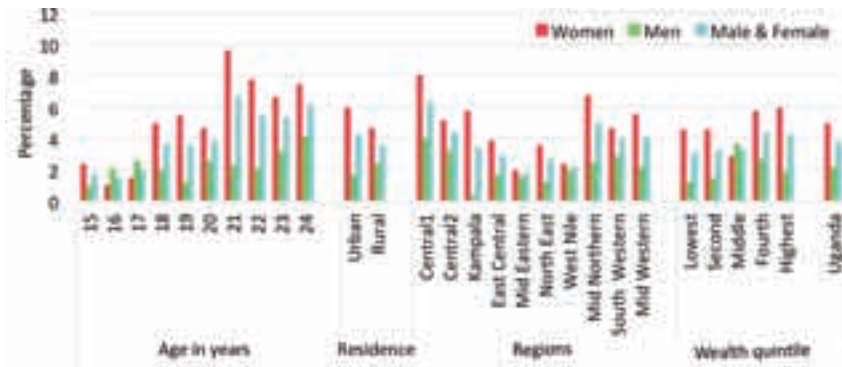
Source: Young people without a comprehensive knowledge of HIV/AIDS, MoH, 2012b; Numbers of young people without a comprehensive knowledge of HIV/AIDS, UNICEF estimates

A quarter of a million young people aged 15–24 years are HIV-positive.

- At a regional level, the estimated numbers of HIV+ 15–24-year-olds ranges from 7,000 in Karamoja to 47,000 in Central 1.
- HIV prevalence among 15–19-year-olds rose from 1.5 % in 2004/05 to 2.4% in 2011.
- Among 15–19-year-olds, HIV prevalence is higher among women (3.0%) than among men (1.7%).
- Young women aged 15–24 years are 2.5 times more likely to be HIV+ (5%) than men of the same age (2%).

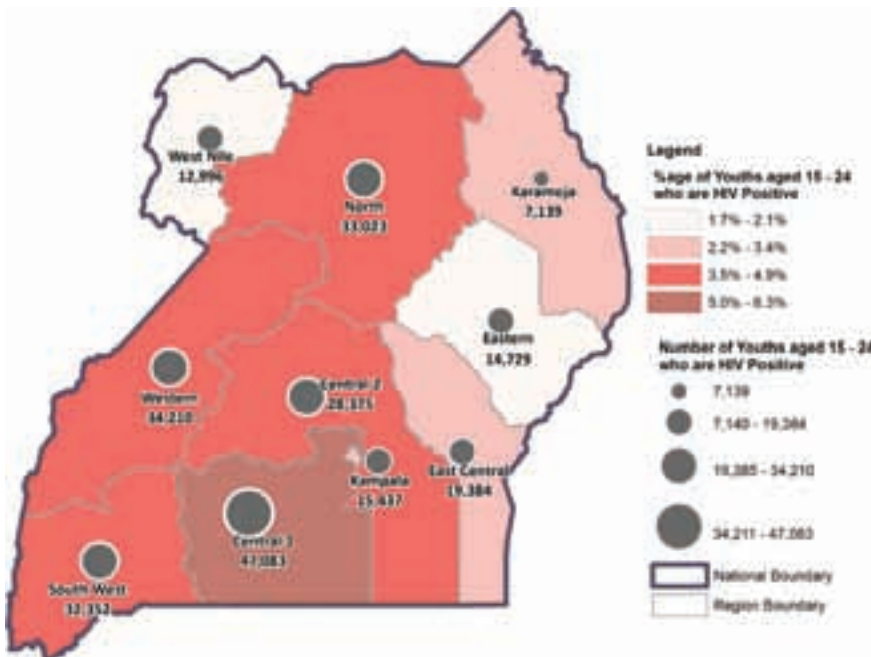
- Mid-Eastern has the lowest HIV prevalence rate for 15–24-year-olds (1.7%) and West Nile has the highest (6.3%).
- HIV prevalence among 15–24-year-old females is higher in urban areas (5.9%) than in rural areas (4.6%).
- Central 1, Central 2, Mid-Northern, Kampala and Mid-Western regions have the highest prevalence rates for women.

WOMEN AND MEN AGED 15–24 YEARS WHO ARE HIV+



Source: MoH, 2012b

HIV PREVALENCE AMONG YOUNG PEOPLE AGED 15–24 YEARS

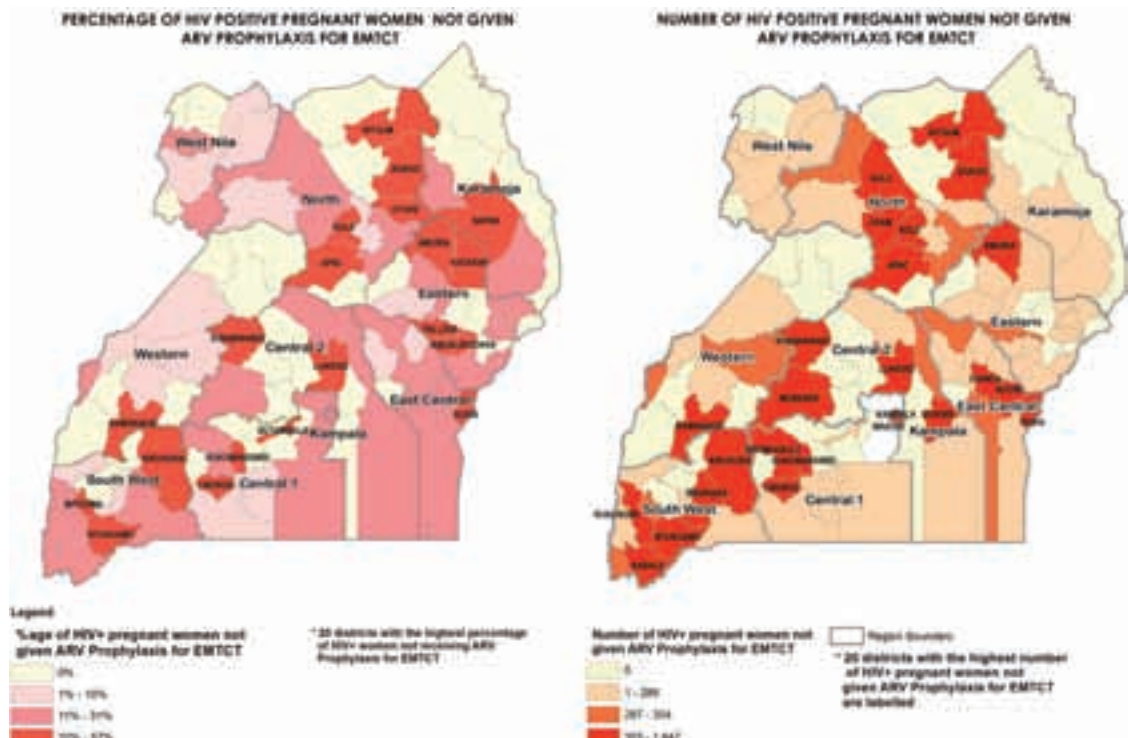


Source: UNICEF estimates based on MoH, 2012b

The number of HIV+ pregnant women being treated with antiretrovirals (ARVs) to prevent mother-to-child transmission (MTCT) is estimated to be over 21,500.

- Nationally, the proportion of women receiving ARV prophylaxis for the prevention of MTCT is 85%, while the target is 95%.
- Over 1,000 women in three districts (Kibaale, Wakiso and Kampala) who have been identified as HIV+ did not receive ARV treatment for the prevention of MTCT.
- Over half of pregnant women in four districts (Mayuge, Kaabong, Otuke and Abim) who were identified as HIV+ did not receive ARV treatment for the prevention of MTCT.
- Only in 33 districts (29% of districts) did all pregnant women identified as HIV+ receive ARV treatment for the prevention of MTCT.

HIV-POSITIVE PREGNANT WOMEN NOT GIVEN ARV PROPHYLAXIS FOR EMTCT

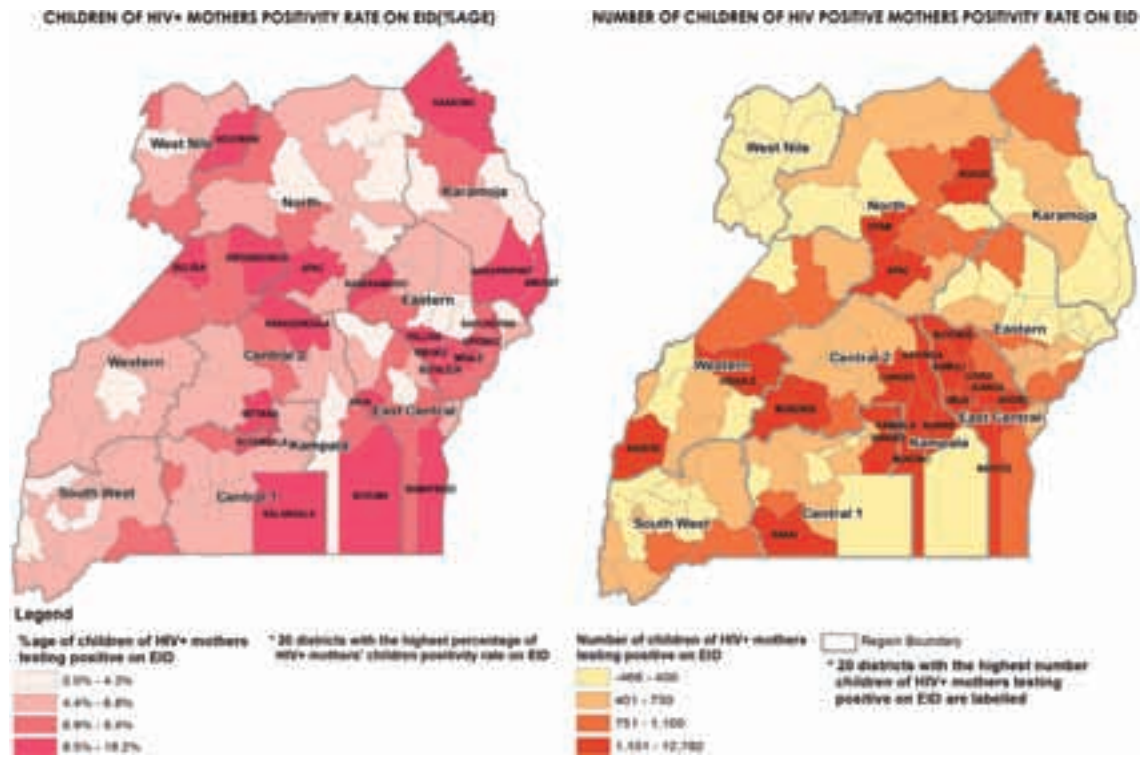


Source: MoH, 2014c

The number of children benefiting from early infant diagnosis (EID) who are nevertheless born HIV-positive is 4,185.

- The rate is below 18.2% across all districts and 22% of the districts (25) have a positivity rate of less than 5%.
- 12 districts have EID positivity rates greater than 10% (Buliisa, Kibuku, Butambala, Buvuma, Amudat, Kaabong, Butaleja, Nakapiripirit, Budaka, Jinja, Apac and Kiryandongo).
- The highest numbers of post-EID HIV+ children reside in Kampala (422), and Wakiso (201). Five other districts have over 100 post-EID HIV+ children.

CHILDREN OF HIV+ MOTHERS POSITIVITY RATE ON EARLY INFANT DIAGNOSIS

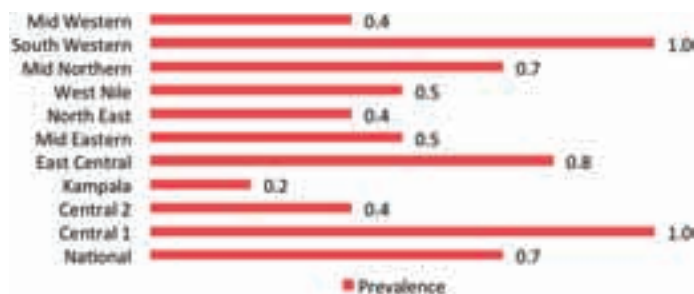


Source: MoH, 2014c

Overall, over 46,000 children under the age of five years are living with HIV.

- A child aged under five years in South-West or Central 1 regions is five times as likely to be HIV+ than a child in Kampala.

PERCENTAGE OF HIV PREVALENCE AMONG CHILDREN UNDER FIVE YEARS OF AGE

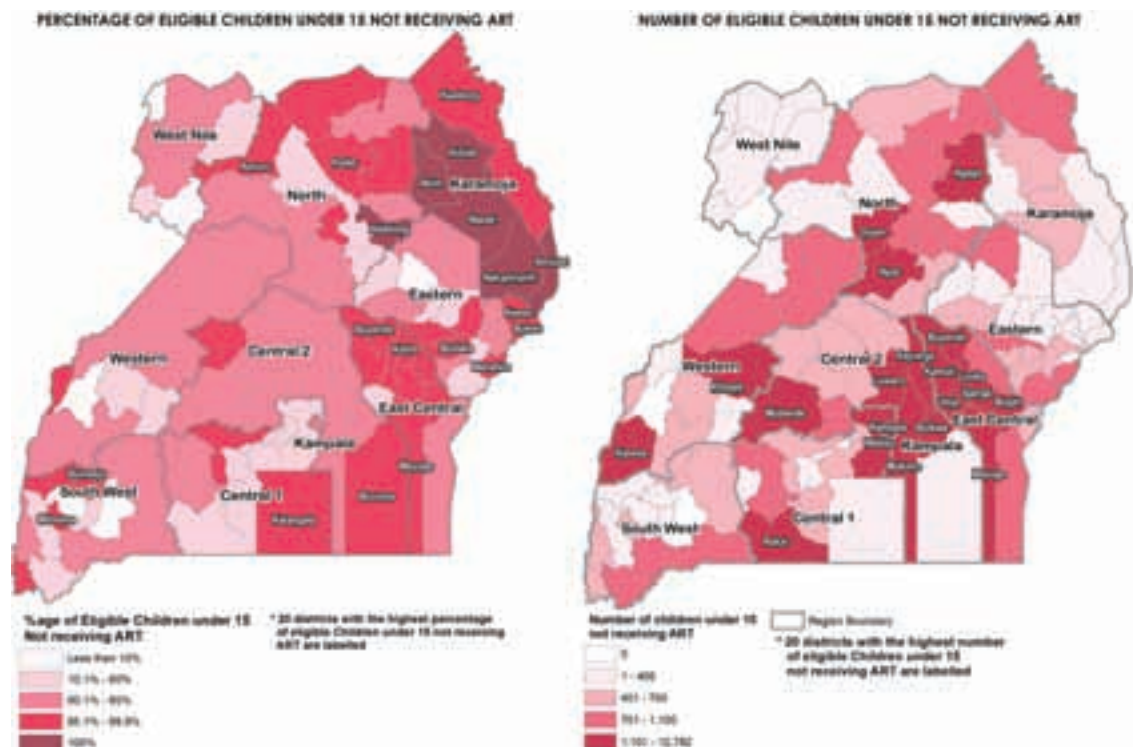


Source: MoH, 2012b

One in three HIV+ children under the age of 15 years is not getting ART.

- There are disparities in levels of access to antiretroviral therapy (ART) services between districts: in 52 of the worst performing districts, less than one in every five HIV+ children under the age of 15 are receiving ART; in 92 districts, the proportion is less than one in two HIV+ children.
- 86,652 HIV+ children under the age of 15 years are not receiving ART.
- HIV+ children who reside in five of the seven districts of Karamoja region are not receiving an ART service.

CHILDREN UNDER 15 WITH HIV NOT RECEIVING ART



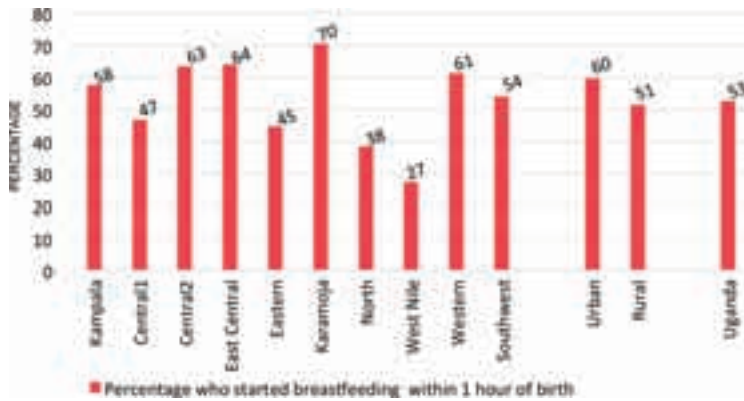
Source: MoH, Health Management Information System (HMIS): <http://health.go.ug/hmis/>

BREASTFEEDING AND INFANT FEEDING

Nationally, one in two children is breastfed within one hour of birth.

- Almost all children have benefited from breastfeeding.
- A newborn baby in Karamoja is more than twice as likely to be breastfed within one hour as a child in West Nile.

BREASTFEEDING PRACTICE AND BREASTFEEDING WITHIN ONE HOUR OF BIRTH

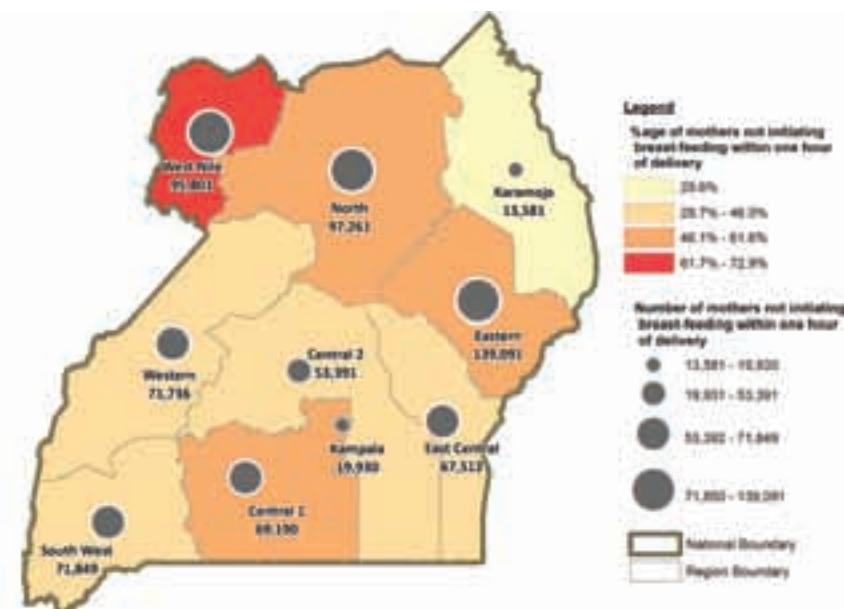


Source: UBOS and ICF International, 2012

Over 699,000 newborn babies are not breastfed within one hour of birth.

- One newborn baby in every five who is not breastfed within one hour of birth (over 139,000) is in Eastern region.

MOTHERS NOT INITIATING BREASTFEEDING WITHIN ONE HOUR OF DELIVERY

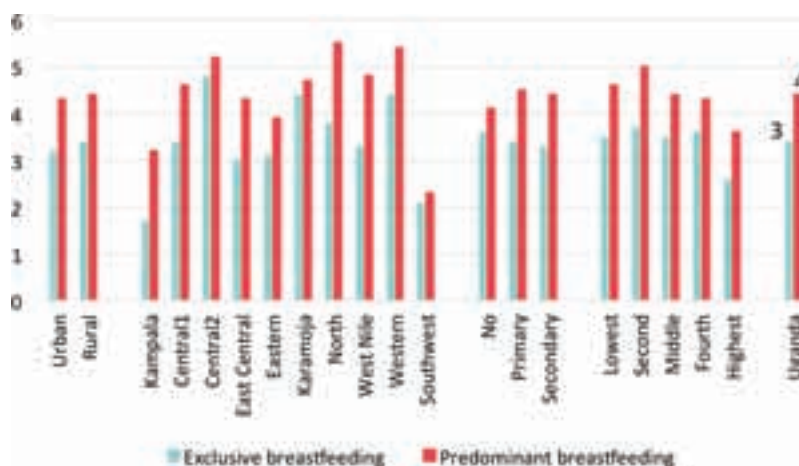


Source: Mothers not breastfeeding within one hour of delivery rates: UBOS and ICF International, 2012; Numbers of mothers not breastfeeding within one hour of delivery, UNICEF estimates

Only three in every five children (63%) are exclusively breastfed during the first six months after birth.

- Infants up to one month old are twice as likely to be exclusively breastfed (82%) as are infants aged four to five months (41%).
- Median duration of breastfeeding (exclusive or predominant) is below six months, both nationally and within all groups.

MEDIAN DURATION OF BREASTFEEDING (MONTHS)

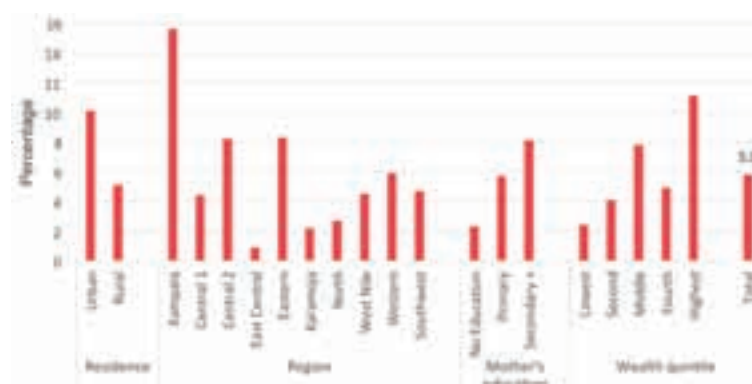


Source: UBOS and ICF International, 2012

Only three out of 50 children aged 6–23 months receive a minimum acceptable diet (5.8%).

- Less than 1% (188,000) of children in East Central region get a minimum acceptable diet.
- Rural children are less likely to get an acceptable diet (one in 20).
- Children whose mothers have a secondary education, or more, are more than three times as likely (8.2%) to receive the minimum acceptable diet than are children whose mothers have no education (2.3%).

YOUNGEST CHILDREN AGED 6–23 MONTHS WHO ARE FED ACCORDING TO THREE INFANT AND YOUNG CHILD FEEDING (IYCF) PRACTICES

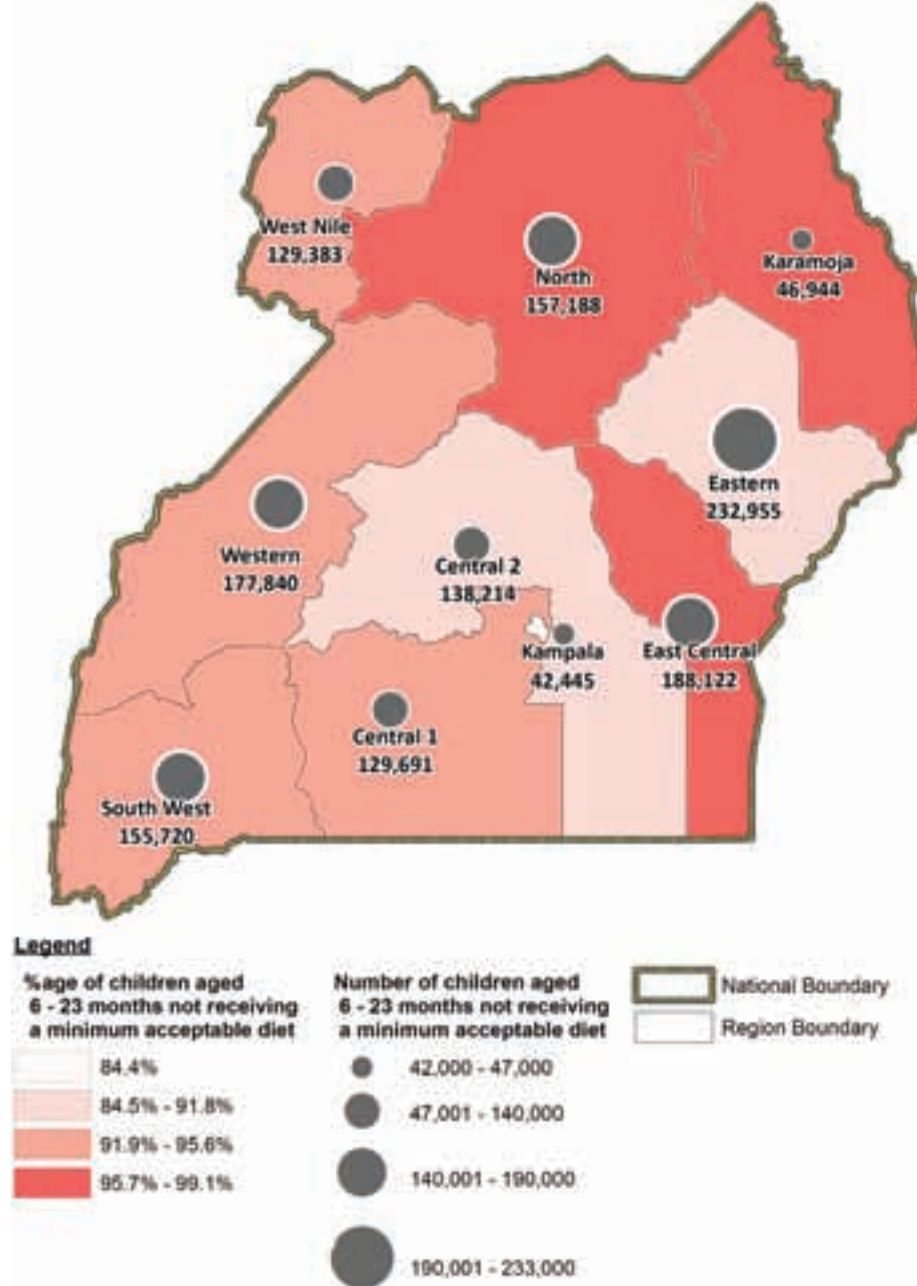


Source: UBOS and ICF International, 2012

Fewer than one in every 20 children aged 6–23 months get the minimum acceptable diet in six of the 10 regions.

- 1.4 million children are not getting the minimum acceptable diet.
- All regions have over 120,000 children not getting the minimum acceptable diet with the exception of Kampala and Karamoja (both with fewer than 50,000 children).

CHILDREN AGED 6–23 MONTHS NOT RECEIVING A MINIMUM ACCEPTABLE DIET



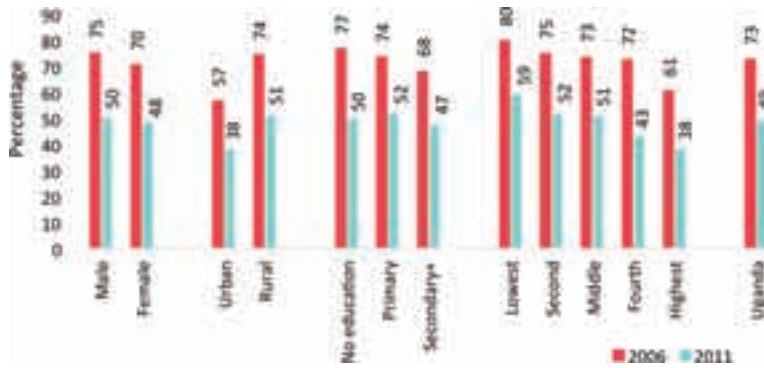
Source: Percentage of children not getting a minimum acceptable diet, UBOS and ICF International, 2012; Numbers of children not getting a minimum acceptable diet, UNICEF calculations

IRON DEFICIENCY ANAEMIA

One in every two children aged under five years suffers from iron deficiency anaemia.

- Children from households in the lowest wealth quintile are more likely to have iron deficiency anaemia (3 out of 5) than children from the highest quintile (2 out of 5).
- Children from households in rural areas are more likely to have iron deficiency anaemia (five out of 10) than children from urban areas (4 out of 10).

PREVALENCE OF ANAEMIA IN CHILDREN AGED 6–59 MONTHS BY BACKGROUND CHARACTERISTICS

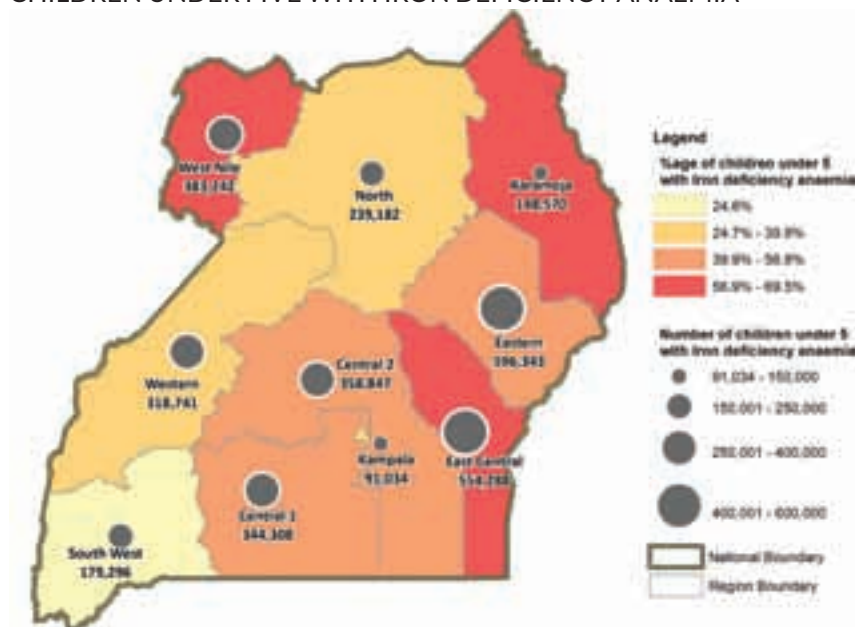


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

3.2 million children have iron deficiency anaemia.

- Together, East Central and Eastern regions have the highest number of children with iron deficiency anaemia (1.2 million, 36%).

CHILDREN UNDER FIVE WITH IRON DEFICIENCY ANAEMIA



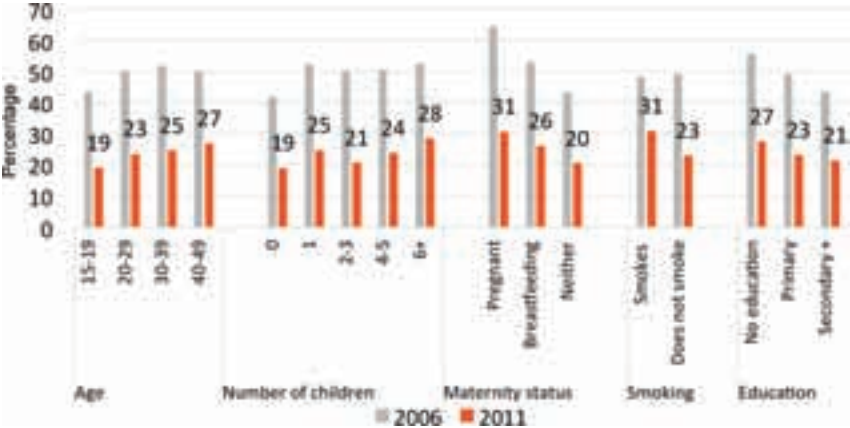
Source: Children under five years with iron deficiency anaemia rates: UBOS and ICF International, 2012; Numbers of children under five years with iron deficiency anaemia estimates: UNICEF calculations



More than three in every five pregnant women aged 15–49 years have iron deficiency anaemia.

- Highest prevalence rates for anaemia are among pregnant women and women who smoke.
- Prevalence of anaemia among women aged 15–59 years is higher among women with no education. The prevalence rate goes down as the woman’s education level rises.
- The highest levels of iron deficiency anaemia are among women from the lowest wealth quintile (29%); and the Karamoja (43%) and Central 2 regions (31%).
- Rural women are more likely than urban women to suffer from iron deficiency anaemia.

PREVALENCE OF ANAEMIA IN WOMEN AGED 15-49 YEARS

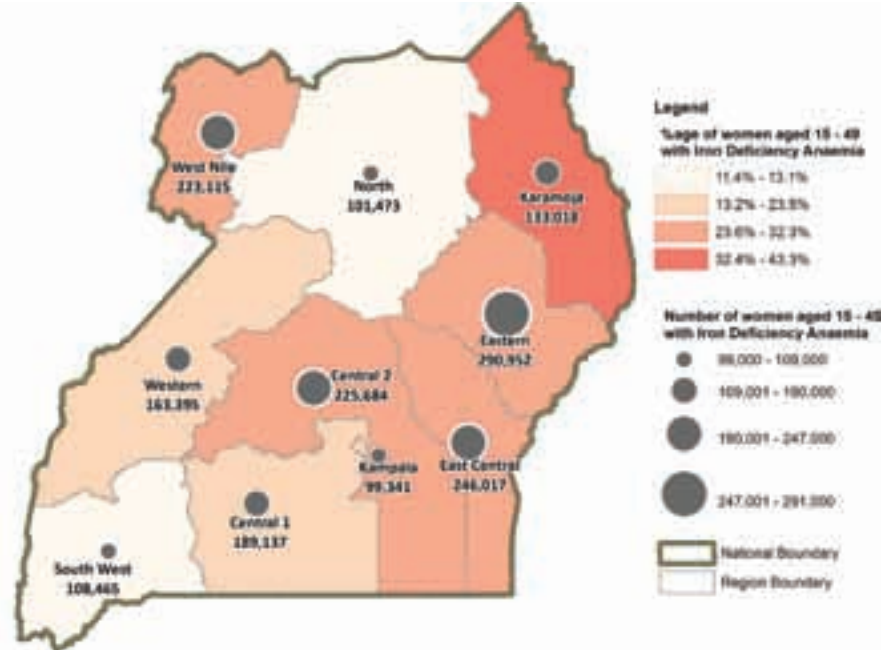


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

1.8 million women aged 15-49 have iron deficiency anaemia.

- 986,000 (55%) of affected women reside in four regions: Eastern, East Central, Central 2 and West Nile, and each region has over 200,000 anaemic women.

WOMEN AGED 15–49 YEARS WITH IRON DEFICIENCY ANAEMIA



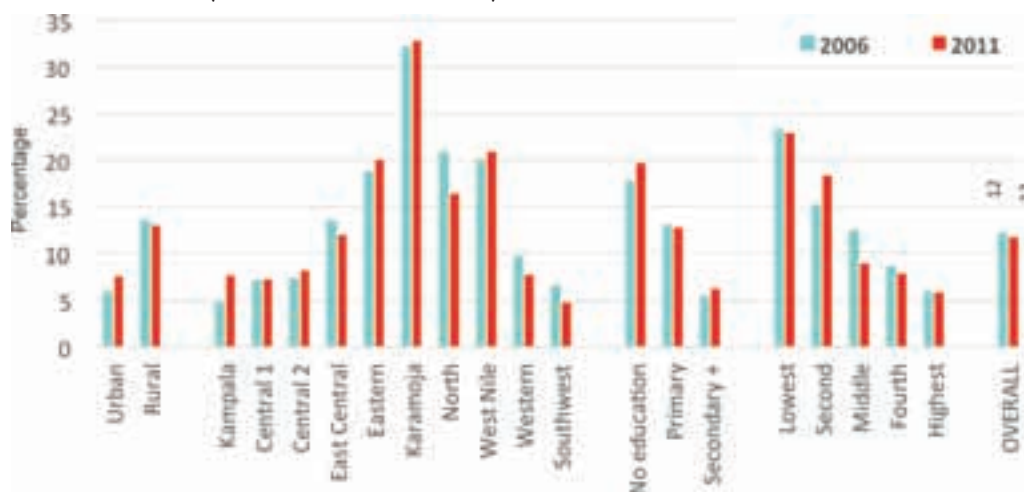
Source: Women 15–49 years with iron deficiency anaemia rates: UBOS and ICF International, 2012; Numbers of women 15–49 years with iron deficiency anaemia estimates: UNICEF calculations

Underweight among non-pregnant women

The highest prevalence of underweight among non-pregnant women aged 15–49 (BMI less than 18.5 kg/m²) is in Karamoja, where one in every three women is underweight.

- Rural women are twice as likely to be underweight as urban women.
- Women from households in the lowest quintile are four times as likely to be underweight as women from the highest quintile.

UNDERWEIGHT (LESS THAN 18.5 KG/M2) AMONG WOMEN AGED 15–49 YEARS

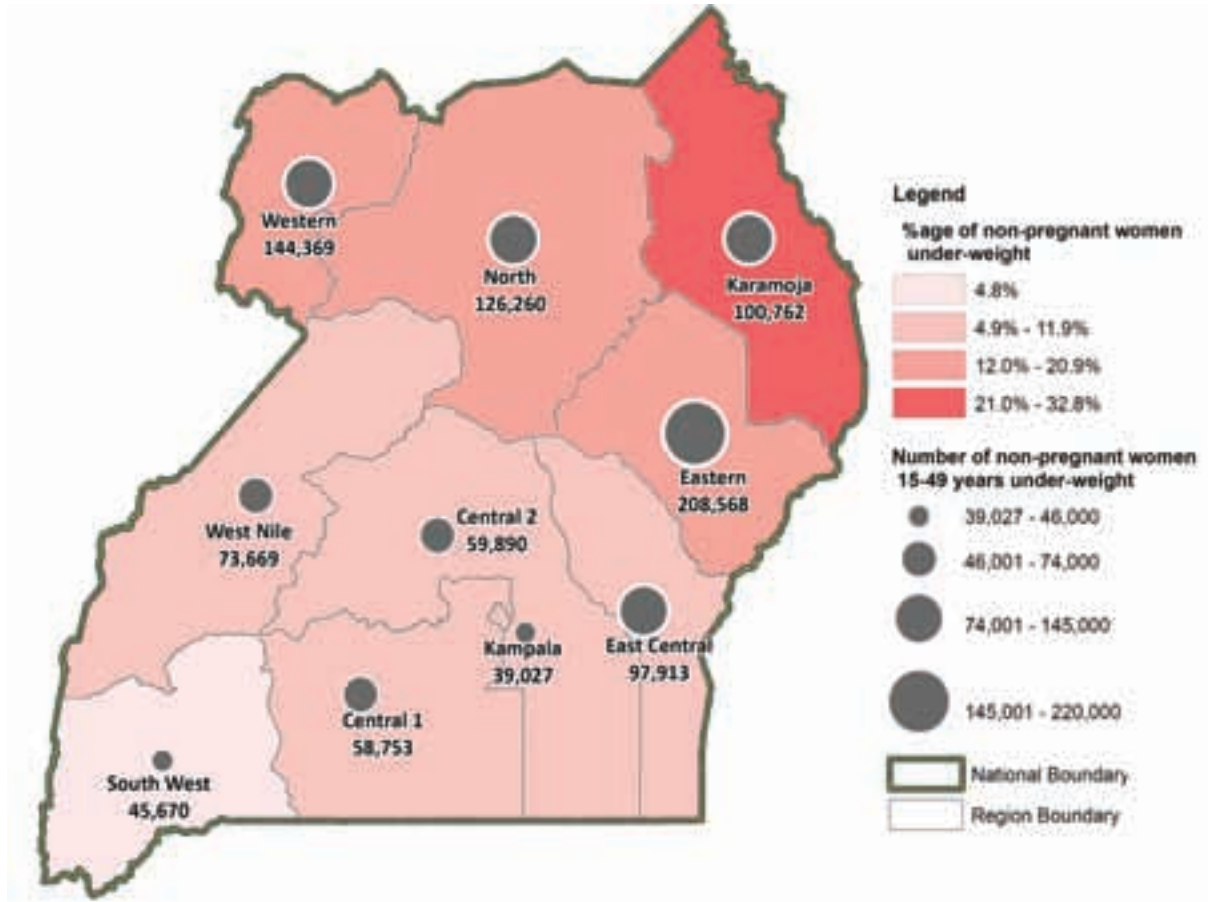


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

Nationally, approximately 955,000 women aged 15–49 are underweight.

- About 209,000 of these women (22%) reside in Eastern region.
- An additional 227,000 (24%) reside in Karamoja and North region.

UNDERWEIGHT (BMI LESS THAN 18.5 KG/M²) AMONG NON-PREGNANT WOMEN AGED 15–49 YEARS



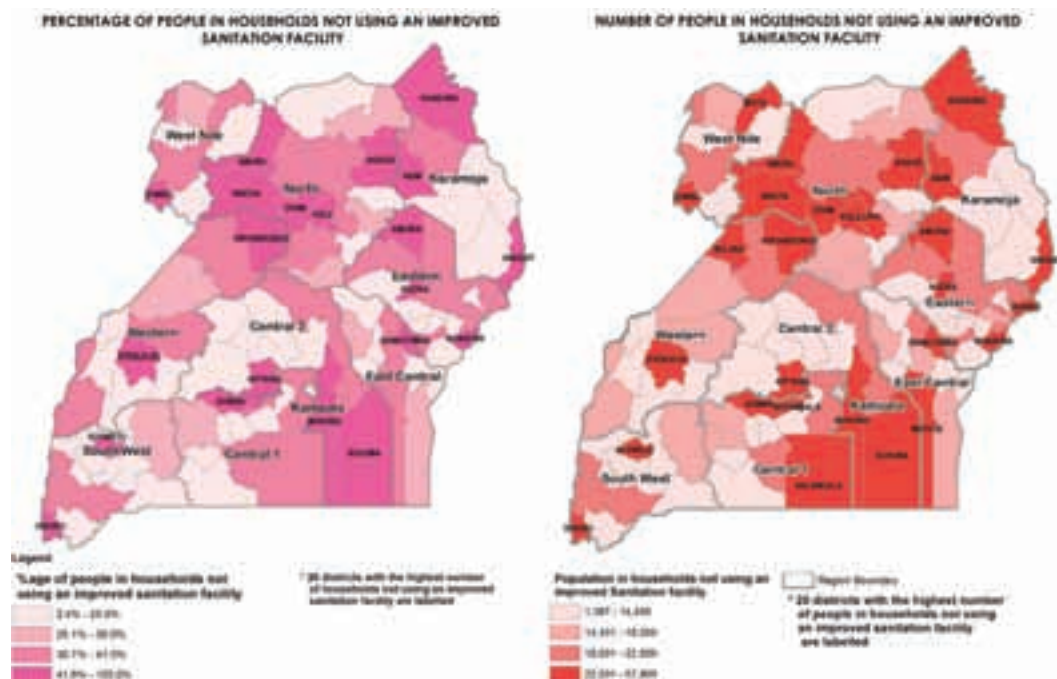
Source: Non-pregnant women 15–49 years who are underweight prevalence rates: UBOS and ICF International, 2012; Numbers of women 15–49 years who are underweight estimates: UNICEF calculations

WATER, SANITATION AND HYGIENE (WASH)

Only one in every five households has an improved, not shared, sanitation facility.

- Only seven out of every 10 households have any type of (improved and non-improved) pit latrine.
- One in every 10 people has no access to any sanitation facility.

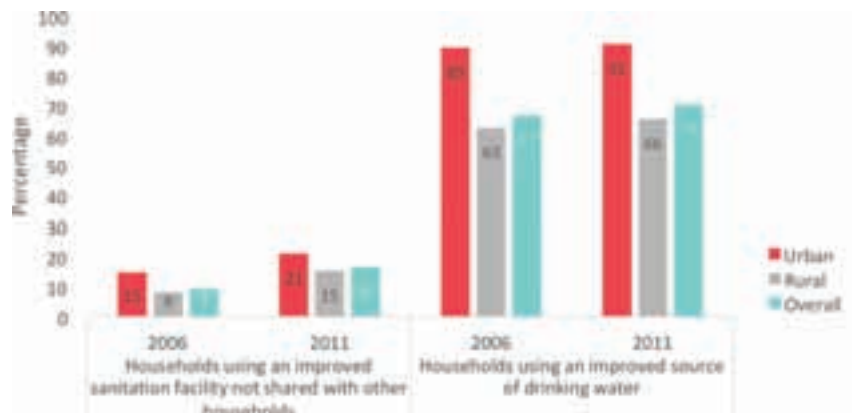
PEOPLE IN HOUSEHOLDS USING AN IMPROVED SANITATION FACILITY



Source: MoH, 2013c

There was an improvement in access to improved sanitation facilities and improved sources of water over the five years 2006–11.

HOUSEHOLDS USING AN IMPROVED SANITATION FACILITY AND AN IMPROVED SOURCE OF DRINKING WATER

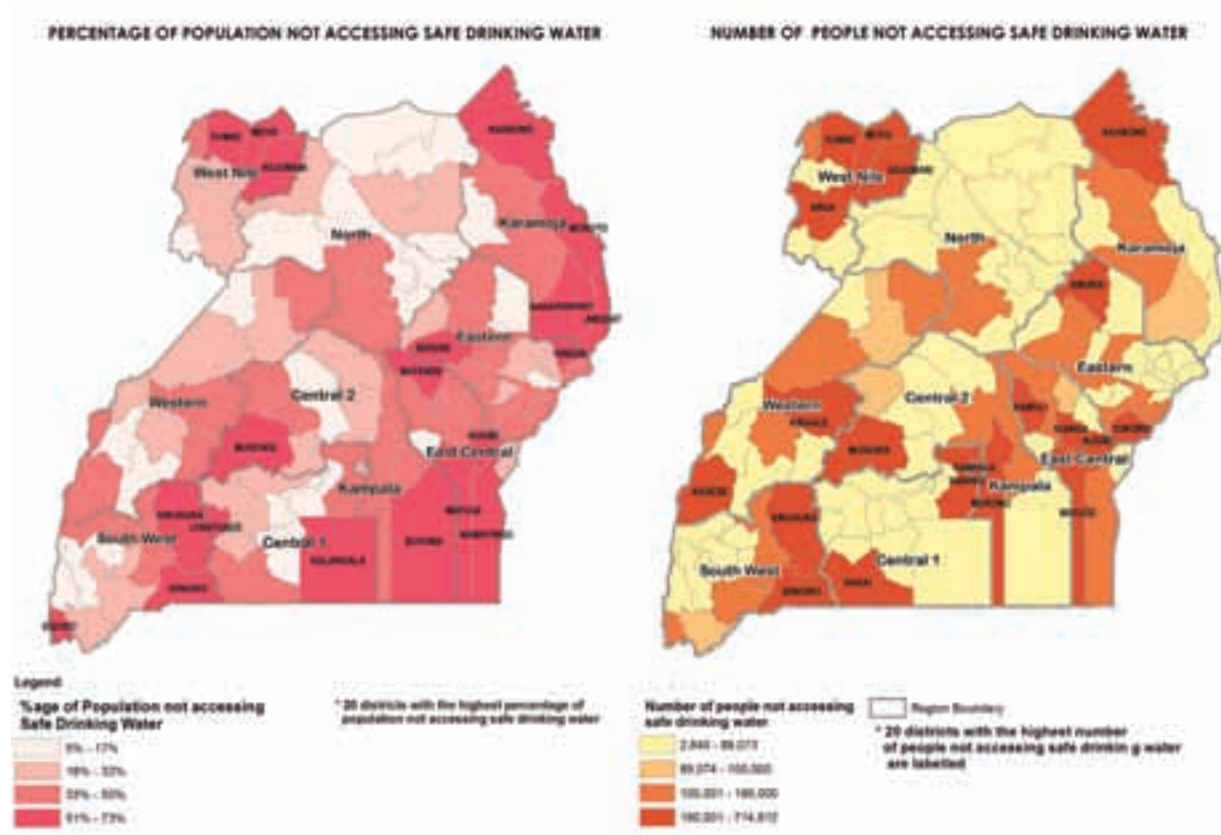


Source: UBOS and Macro International, 2007; UBOS and ICF International, 2012

Seven out of every 10 people have access to an improved water source.

- Two out of every five households boil their water prior to drinking it.
- About 12 million people do not have access to an improved water source.

POPULATION NOT ACCESSING SAFE DRINKING WATER

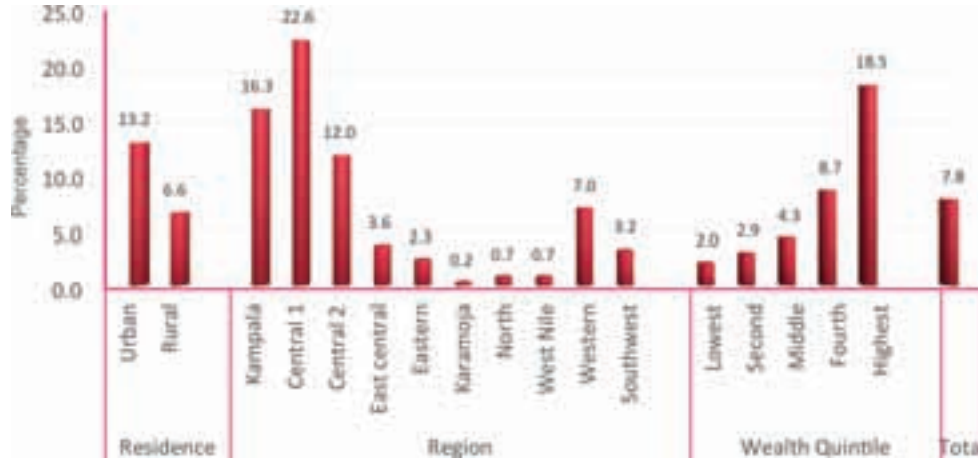


Source: MWE database: <http://ipsanad.com/>

Only four in every 50 households have a handwashing facility with soap and water.

- The presence of a handwashing facility with soap and water is associated with household wealth.
- The highest proportions of households with a handwashing facility with soap and water are in Kampala and the regions surrounding it, urban areas and the highest wealth quintile.
- The lowest levels are in the northern half of the country where less than one household in every 100 has such a facility.

HOUSEHOLDS WITH HANDWASHING FACILITIES HAVING BOTH SOAP AND WATER

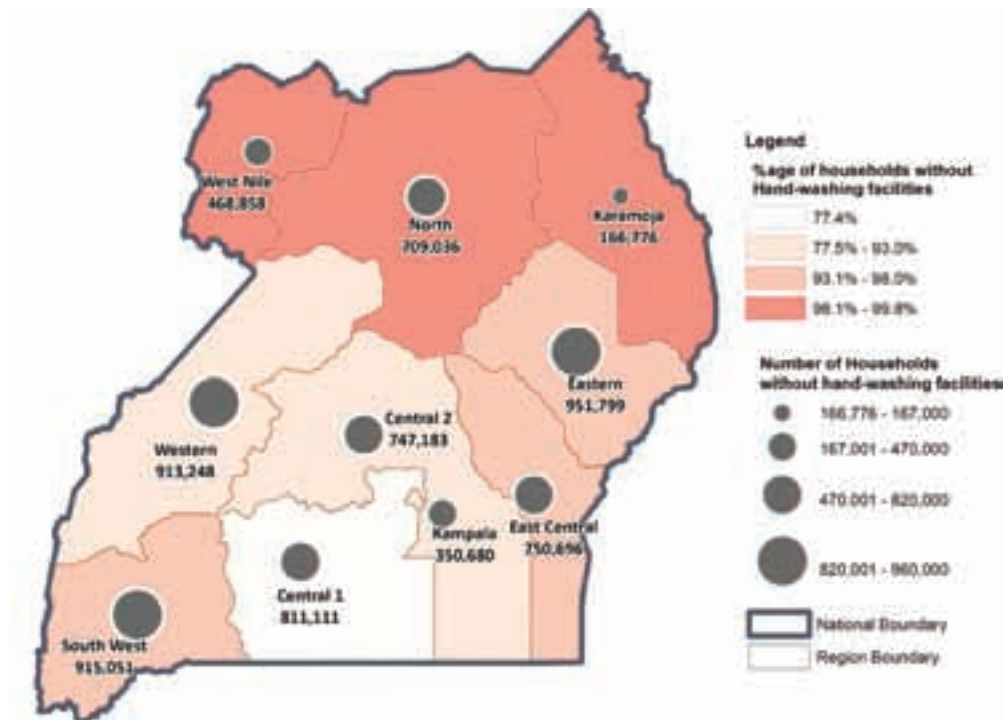


Source: UBOS and ICF International, 2012

6.8 million households do not have handwashing facilities with soap and water.

- Kampala, Karamoja and West Nile have the least number of households (below half a million) without a handwashing facility with soap and water; the rest of the regions each have over 700,000 households without a handwashing facility with soap and water
- 2.8 million (41%) of households that do not have handwashing facilities are in the Eastern, South-West and Western regions.

HOUSEHOLDS WITHOUT HANDWASHING FACILITIES, SOAP AND WATER



Source: Households without handwashing facilities rates: UBOS and ICF International, 2012; Numbers of households without handwashing facilities estimates: UNICEF calculations

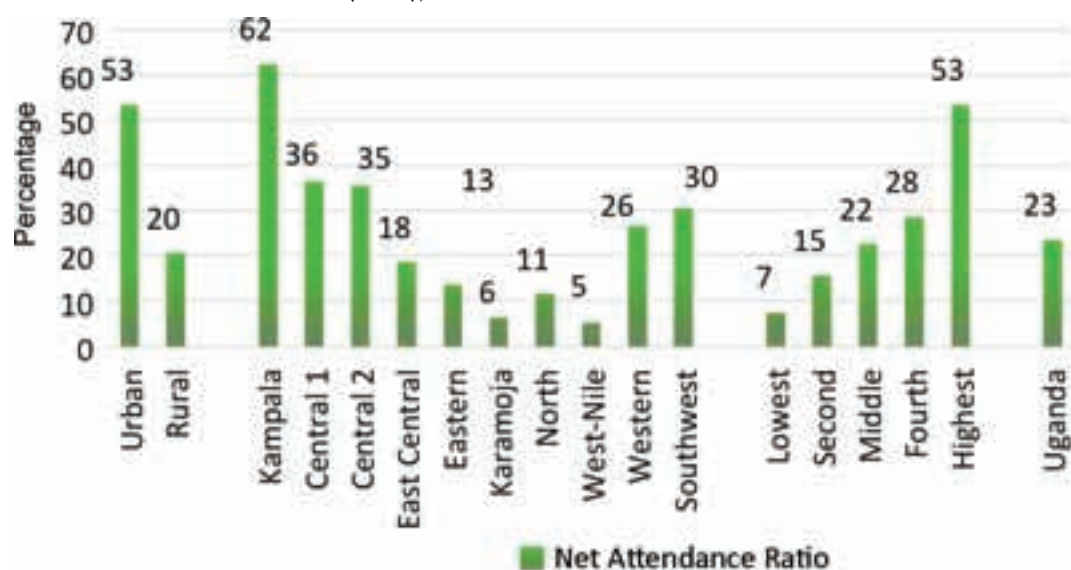
THE RIGHT TO EDUCATION

EARLY CHILDHOOD DEVELOPMENT (ECD)

Only one in every five children aged three to five years is attending a pre-primary school.

- There is no significant disparity by gender for the net attendance ratio (NAR) at pre-primary and primary school level.
- A three to five-year-old child living in a household in the highest wealth quintile is 7.5 times more likely to attend a pre-primary centre or school than a child in the lowest wealth quintile.

NET ATTENDANCE RATIOS (NAR); PRE-PRIMARY

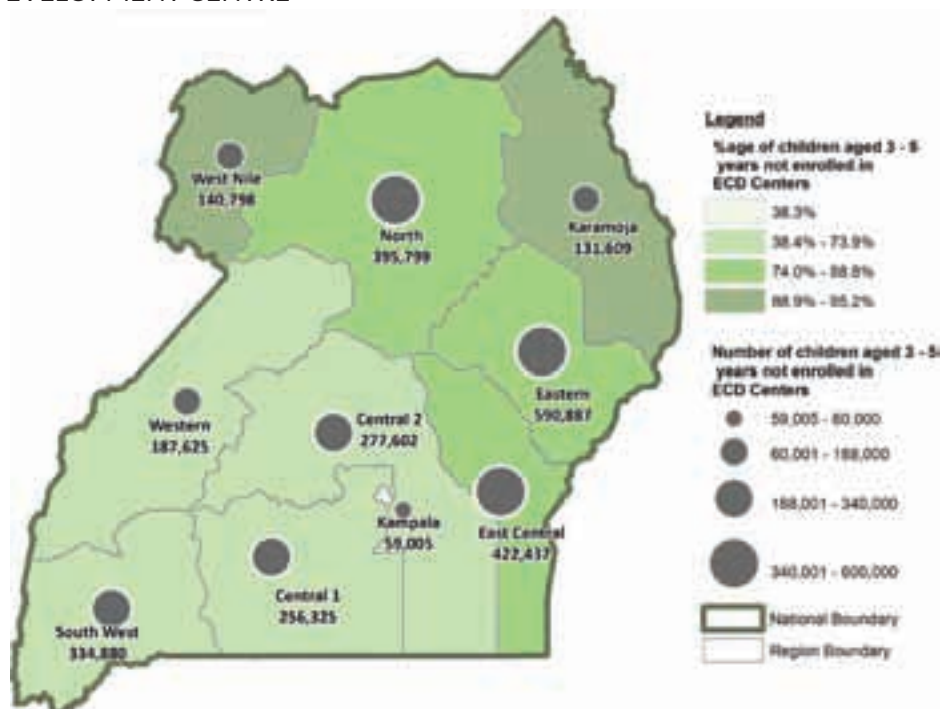


Source: UBOS and ICF International, 2012

3 million three to five-year-olds are not attending a pre-primary centre or school.

- Kampala has the least number of three to five-year-old children not attending an early learning centre (about 59,000) and the highest attendance rate.
- The rest of the regions have hundreds of thousands of three to five-year-olds not attending an early learning centre, with Eastern, East Central, North and Western having the highest numbers.

CHILDREN AGED 3–5 YEARS NOT ENROLLED IN AN EARLY CHILDHOOD DEVELOPMENT CENTRE



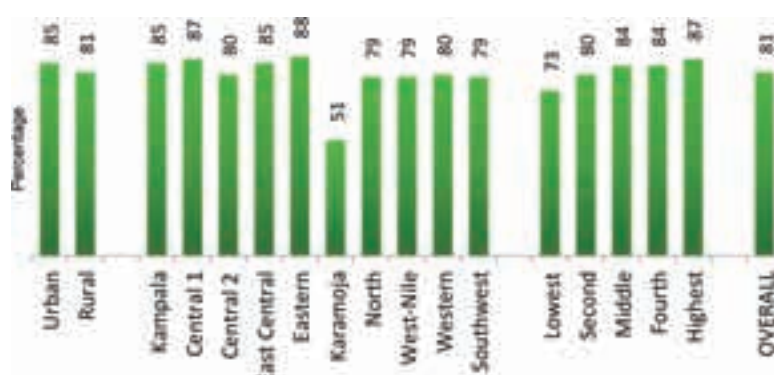
Source: Percentage of children aged 3-5 years not enrolled in an ECD centre: UBOS and ICF International, 2012; Numbers of children aged 3-5 years not enrolled in an ECD centre estimates: UNICEF calculations

PRIMARY EDUCATION

At least four out of every five children of primary school age (6–12 years) are attending primary school at national level (81%), and in most regions, rural/urban locations and wealth quintiles.

- In Karamoja, only one in every two children of primary school age (6–12 years) is attending school.
- The disparity in the NAR between female and male children is negligible.
- Children living in households in the lowest wealth quintile are less likely to be attending school (7 in every 10) than those in the highest quintile (9 in every 10).

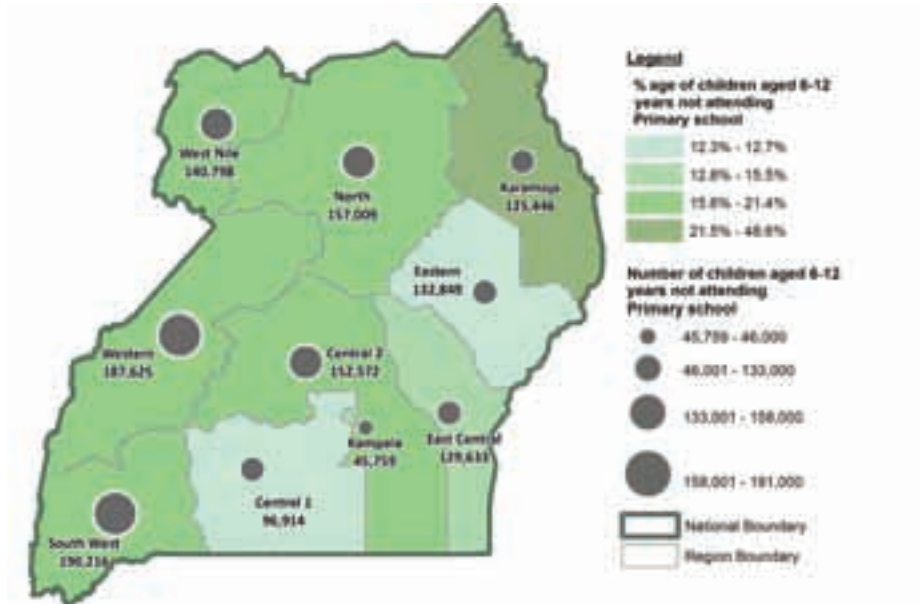
PRIMARY NET ATTENDANCE RATIOS (NAR)



Source: UBOS and ICF International, 2012

1.4 million children aged 6–12 years are not in school.

CHILDREN AGED 6–12 NOT ATTENDING PRIMARY SCHOOL

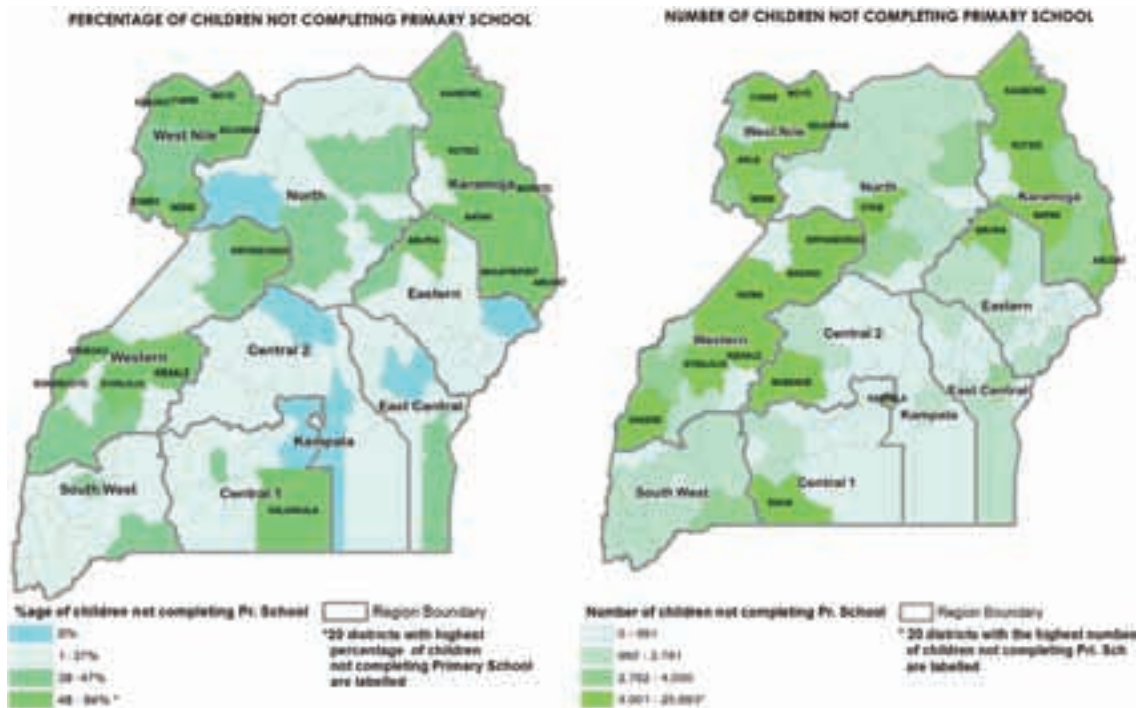


Source: Percentage of children aged 6–12 years not attending school: UBOS and ICF International, 2012; Estimated number of children aged 6–12 years not attending school: UNICEF calculations

Only seven out of 10 children are completing primary school.

- 370,000 children are not completing primary school.
- The majority of those who are not completing primary school are in Karamoja, West Nile and Western regions.

CHILDREN NOT COMPLETING PRIMARY SCHOOL



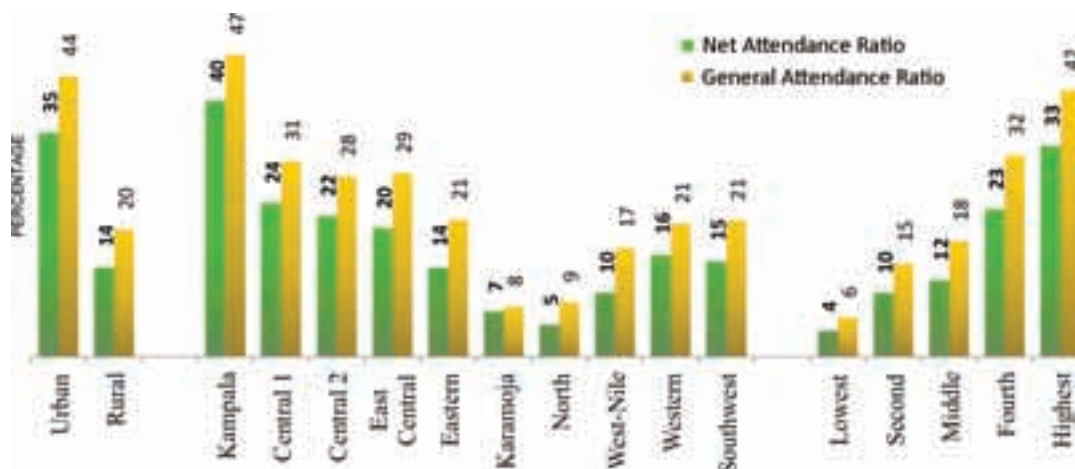
Source: Percentage of children not completing primary school, MoESTS, 2014d; Numbers of children not completing primary school, UNICEF calculations

SECONDARY EDUCATION

Only four in every 25 children (15.8%) of secondary school age are attending secondary school.

- This represents a sharp drop from the four in every five (20 in every 25) of primary-aged children attending school.
- A child in urban areas is more than twice as likely to attend secondary school as one in rural areas.
- A child from a household in the highest quintile is more than 10 times as likely to attend secondary school as a child in the lowest quintile.
- No single group has at least one in every two of its secondary school age children in school.
- In Karamoja and North regions, and in the lowest wealth quintile, fewer than one in every 10 children are attending secondary school.

NET ATTENDANCE RATIOS (NAR) AND GROSS ATTENDANCE RATIOS (GAR) FOR THE DE FACTO HOUSEHOLD POPULATION, BY SECONDARY LEVEL, ACCORDING TO REGION, RESIDENCE AND WEALTH QUINTILES



Source: UBOS and ICF International, 2012

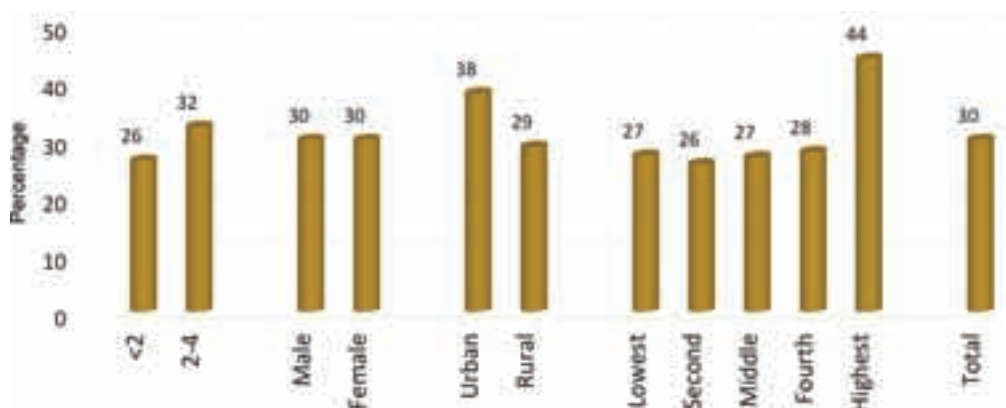
THE RIGHT TO PROTECTION

BIRTH REGISTRATION

Three in every 10 children aged under five had been registered at the time of the 2011 UDHS. Following the introduction of the Mobile Vital Registration System (MRVS), the rate has doubled and was estimated at six in every 10 children in December 2014.

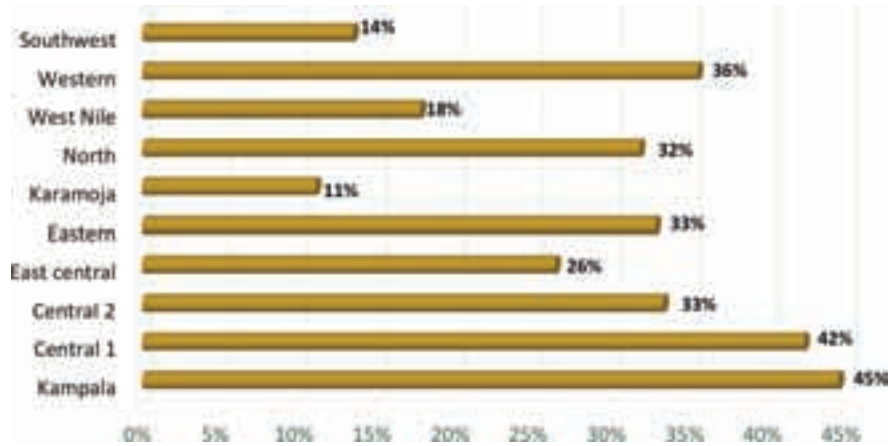
- Children from households based in urban areas and the highest wealth quintile are more likely to be registered.
- In Karamoja, West Nile and South-West regions, fewer than one in every five under-fives are registered.
- Other regions have much higher rates, with Kampala and Central 1 having the highest.

DE JURE CHILDREN UNDER AGE FIVE WHOSE BIRTHS ARE REGISTERED WITH THE CIVIL AUTHORITIES, ACCORDING TO BACKGROUND CHARACTERISTICS



Source UBOS and ICF International, 2012

DE JURE CHILDREN UNDER AGE FIVE WHOSE BIRTHS ARE REGISTERED WITH CIVIL AUTHORITIES BY REGION

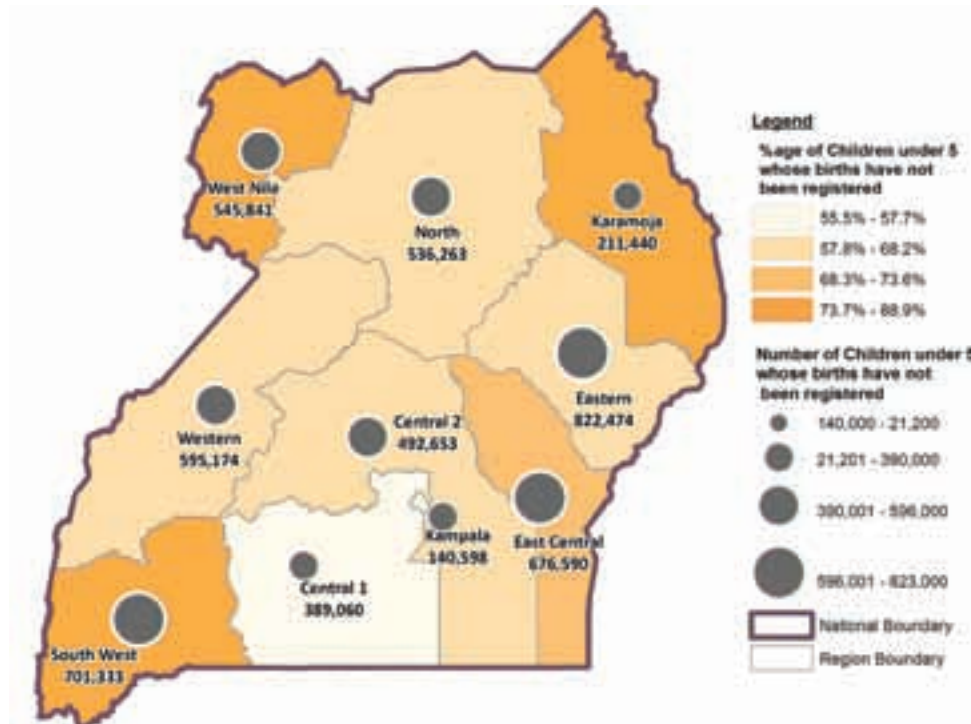


Source: UBOS and ICF International, 2012

In 2011 an estimated 5.1 million children were not registered.

- 30% of unregistered under-fives were in Eastern and South-West regions.
- By the end of 2014, the estimated number of unregistered children had been reduced to 2.9 million (UNICEF calculation based on UBOS, 2014b).

CHILDREN UNDER FIVE WHOSE BIRTHS HAVE NOT BEEN REGISTERED



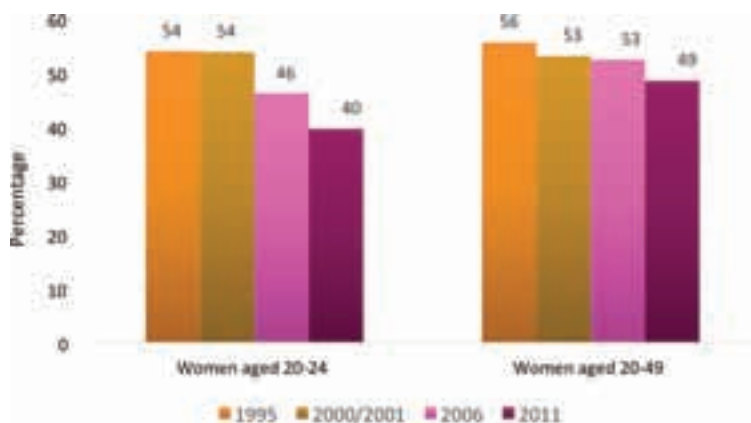
Source: Percentage of under-fives whose births have not been registered: UBOS and ICF International, 2012; Numbers of under-fives whose births have not been registered estimates: UNICEF calculations

EARLY MARRIAGE

Two in every five women aged 20–24 were married or in a union by age 18.

- The teenage marriage rate is still high (40%), although it is declining.

WOMEN AGED 15–49 WHO WERE FIRST MARRIED BY AGE 18



Source: UBOS and Macro International, 1996, 2000-01 and 2007; UBOS and ICF International, 2012

One in every four girls aged 15–19 years has been married, despite the minimum legal age for a woman to get married being 18 years.

- Only three in every 100 boys aged 15–19 has ever been married, and only three in every 50 men aged 20–24 were married by age 18.

AGE AT FIRST MARRIAGE (WOMEN AND MEN AGED 15–49)

Current age	Percentage first married by exact age:					Percentage never married:	Median age at first marriage:
	15	18	20	22	25		
WOMEN							
15-19	3.2	na	na	na	na	77.3	na
20-24	9.9	39.7	61.2	na	na	23.9	18.9
25-29	14.0	48.0	66.8	79.7	90.7	5.6	18.2
30-34	18.1	52.4	71.8	83.0	91.6	2.3	17.8
35-39	16.5	52.9	73.4	84.0	91.4	1.5	17.7
40-44	21.9	55.6	73.1	84.2	93.2	0.8	17.6
45-49	19.3	51.3	70.4	79.5	87.9	2.2	17.9
MEN							
15-19	0.0	na	na	na	na	96.9	a
20-24	0.8	5.5	16.6	na	na	63.4	a
25-29	0.6	8.0	24.0	47.6	67.6	19.9	22.4
30-34	0.3	12.7	27.3	48.7	68.2	6.0	22.2
35-39	0.4	6.9	25.4	46.7	67.3	0.9	22.4
40-44	0.0	5.2	23.5	48.5	74.7	0.6	22.1
45-49	1.0	7.6	26.7	44.0	61.7	0.6	23.0

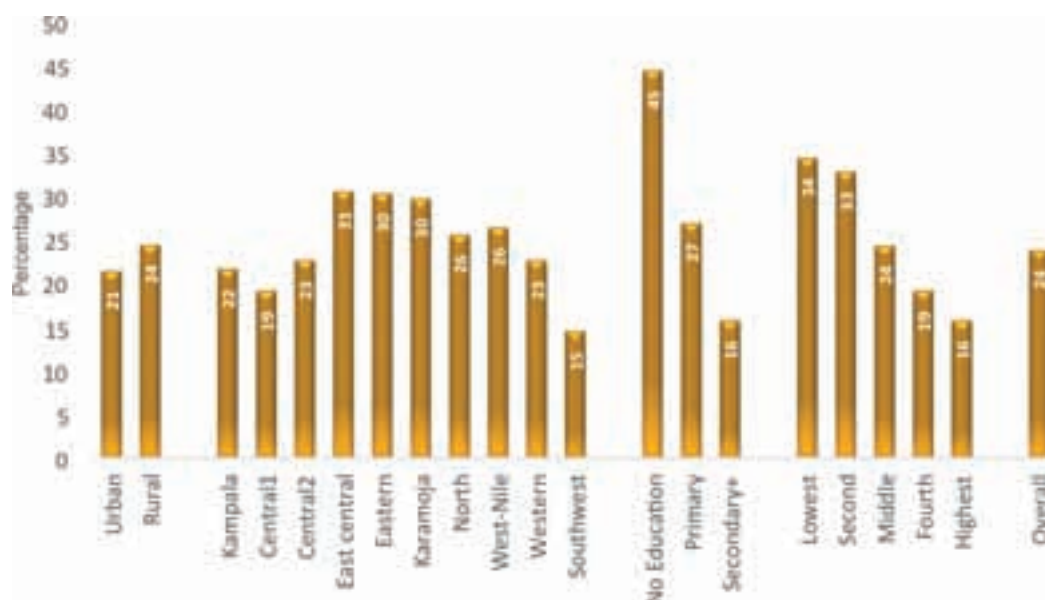
Source: UBOS and ICF International, 2012. Note: Age at first marriage = age at which the respondent began living with her/his first spouse/partner; na = Not applicable due to censoring; a = Omitted because less than 50% began living with their spouse or partner for the first time before reaching the beginning of the age group

TEENAGE PREGNANCY

One in every four girls aged 15–19 years has begun childbearing (is pregnant with their first child or has had a live birth).

- Teenagers with no education are three times more likely to start childbearing as are those with secondary education.
- Teenagers from households in the lowest wealth quintile are twice as likely to start childbearing as are those from households in the highest quintile.
- Teenagers in East Central, Eastern and Karamoja regions are twice as likely to begin childbearing as teenagers in South West region.

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

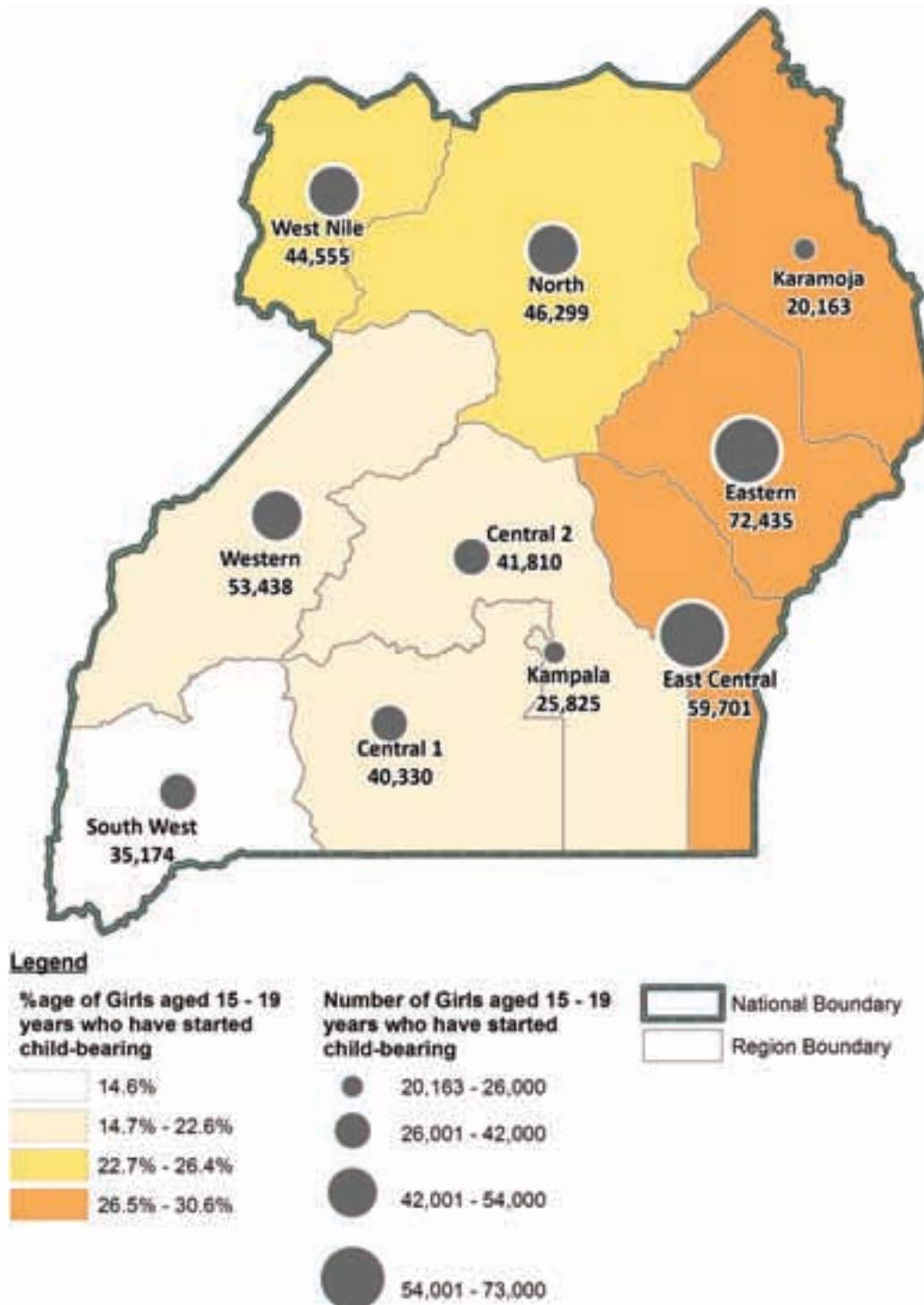


Source: UBOS and ICF International, 2012

440,000 girls aged 15–19 years have begun childbearing.

- 186,000 (42%) of girls aged 15–19 years who have begun childbearing are in East Central, Eastern and South-West regions, each of which has more than 50,000 15–19-year-olds.

GIRLS AGED 15–19 YEARS WHO HAVE STARTED CHILDBEARING



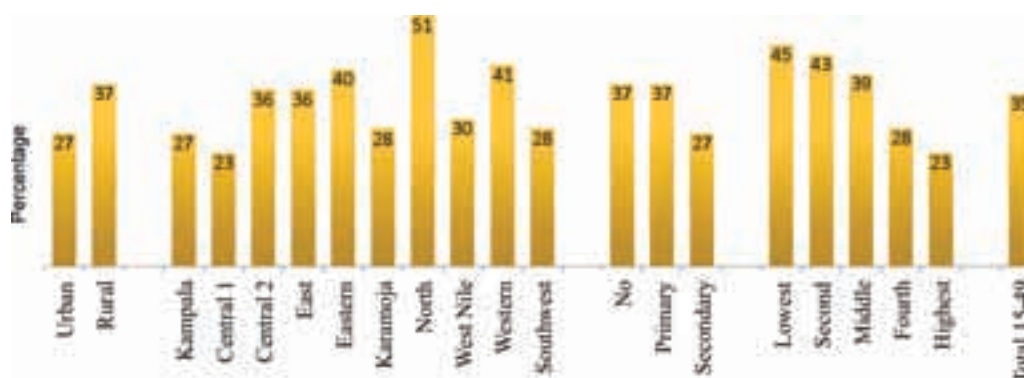
Source: Girls aged 15–19 who have started childbearing prevalence rates: UBOS and ICF International, 2012; Numbers of girls aged 15–19 who have started childbearing prevalence estimates: UNICEF calculations

VIOLENCE AGAINST WOMEN

In 2011, 35% of ever-married women had experienced physical or sexual violence by a husband or partner within the past 12 months.

- Women living in rural areas or who have no education are more likely to have experienced physical or sexual violence than their counterparts.
- Women whose households are in the lowest wealth quintile are twice as likely to experience physical or sexual violence from their husband or partner as women from the highest quintile.
- Women living in the North (51%) and Western regions (41%) were most likely to have recently experienced physical or sexual violence.
- Women with secondary or higher education (27%) were least likely to have experienced physical or sexual violence in the past 12 months.

PERCENTAGE OF EVER-MARRIED WOMEN AND MEN WHO HAVE EXPERIENCED PHYSICAL OR SEXUAL VIOLENCE BY ANY HUSBAND/WIFE/PARTNER IN THE PAST 12 MONTHS



Source: UBOS and ICF International, 2012

Significant proportions of teenage girls (15–19 years) have experienced violence.

- 58% of 15–19-year-old young women have experienced physical or sexual violence.

Violence is also perpetrated against pregnant women, which puts the unborn child's wellbeing at risk.

- 9% of 15–19-year-olds who have ever been pregnant have experienced physical violence during pregnancy.
- Eastern (25%) and West Nile (23%) have the greatest proportion of women who have experienced physical violence while pregnant.
- Women with no education are twice as likely to experience physical violence during pregnancy (21%) as are women with a secondary school education or more.
- Women in the lowest wealth quintile experience physical violence more frequently during pregnancy (5 in every 20) than women in the highest quintile (2 in every 20).

2015

SITUATION ANALYSIS
of CHILDREN *in* UGANDA



THE REPUBLIC OF UGANDA

