The Republic of Uganda

THE STATE OF UGANDA POPULATION REPORT 2008

Theme: "The Role of Culture, Gender and Human Rights in Social Transformation and Sustainable Development"

Funded by UNFPA Uganda

UGANDA: KEY DEMOGRAPHIC, SOCIAL AND DEVELOPMENT INDICATORS 2007

SUMMARY OF INDICATORS		
1.	Total Population (million)	29.6
2.	Total Male Population (million)	14.2
3.	Total Female Population (million)	15.2
4.	Total Urban Population (million)	3.9
5.	Population Growth Rate (%)	3.2
6.	Urban Population Growth Rate (%)	5.7
7.	Maternal Mortality Ratio per 100,000 live births	435
8.	Infant Mortality Rate per 1,000 live births	76
9.	Under five Mortality Rate per 1,000 live births	137
10.	Total Fertility Rate	6.7
11.	Contraceptive Prevalence Rate (%)	24
12.	Supervised Deliveries (%)	42
13.	Full Immunization (%)	46
14.	Unmet Need for Family Planning (%)	41
15.	Stunted Children (%)	38
16.	HIV Prevalence Rate (%)	6.4
17.	Literacy Rate (%)	69
18.	Life Expectancy (years)	50.4
19.	Population in Poverty (%))	31
20.	Human Development Index	0.581
21.	GDP per capita in 2007 (US $)	370
22.	Real GDP Growth Rate 2007/08 (%)	8.9
23.	Private investment Growth in 2007/08 (%)	15
24.	Public investment Growth in 2007/08 (%)	23

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FORWORD

The Government of Uganda is committed to improving the quality of life of her population through, among others achievement of Socio-economic Development and the Millennium Development Goals (MDGs). During the past 20 years remarkable socio-economic progress was made and this progress is reflected in many sectors especially in macro-economic stability, economic growth and rehabilitation of social services and infrastructure. It is therefore important to monitor closely the progress and pace of our efforts in implementation of the development programmes, while identifying achievements as well as challenges that need to be addressed.

Every year the Population Secretariat, in its State of Uganda Population Report, publishes key population concerns that need to be attended to in Uganda's quest to improve the quality of life of its people. The report elaborates key challenges as well as opportunities at various levels. It further highlights the required policy actions that need to be taken in order to catalyze and maximize on the already achieved gains.

The State of Uganda Population Report 2008, therefore, is a significant document and presents an opportunity to all policy makers and development partners to pay attention to issues that require serious national response. The report analyses fertility and HIV/AIDS patterns, access to reproductive health, conflict and post conflict situation, socio-cultural practices in relation to gender, culture and human rights in the context of social, health and human development in Uganda. It further reviews Uganda's ratified convention on gender, culture and human rights.

On behalf of Government, I wish to congratulate the Population Secretariat, Development Partners and stakeholders that contributed to the development of this important report. I am hopeful that this report is another reminder and will go along way in informing all our people on the current population and development issues that require their attention.

Hon. Fred Jachan, Omach M.P.
Minister of State Finance, Planning and Economic Development (General Duties/Planning)

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Thank you all for your tremendous contribution and we look forward to continued collaboration with all our stakeholders.

Charles Zirarema
Acting Director, Population Secretariat

LIST OF ABBREVIATIONS

ABC	-	Abstinence, Being faithful and Consisted Condom Use
ACFODE	-	Action for Development
ACORD	-	Agency for Cooperation, Research and Development
AIDS	-	Acquired Immuned Deficiency Syndrome
ART	-	Anti Retroviral Therapy
ARV	-	Anti retroviral
ASFR	-	Age Specific Fertility Rate
BBC	-	British Broadcasting Corporation
BOD	-	Biochemical Oxygen Demand
CAT	-	Convention Against, Torture and Civil inhuman or degrading Treatment or Punishment.
CBOs	-	Community Based Organizations
CDI	-	Community Driven Initiative
CDRN	-	Community Development Resource Network
CEDAW	-	Convention on the Elimination of all forms of Discrimination Against Women
CFPU	-	Children and Family Protection Unit
COC	-	Convention on the Children
CPR	-	Contraceptive Prevalence Rate
CRPD	-	Convention on the Rights of Persons with Disabilities
CSOs	-	Civil Society Organizations
CSWs	-	Commercial Sex Workers
DANIDA	-	Danish International Development Agency
DDPs	-	District Development Plans
DFID	-	Department for International Development
DWD	-	Directorate of Water Development
EFA	-	Education for All
FCC	-	Family and Children Court
GC	-	General Comments
GDP	-	Gross Domestic Product
GER	-	Gross Enrolment Rate
GoU	-	Government of Uganda
GTZ	-	German Development Cooperation
GUSCO	-	Gulu Save the Children Organization
HIV	-	Human Immuno Virus
HSV2	-	Herpes Virus Sub-type 2
ICCPR	-	International Convention on Civil and Political Rights
ICESCR	-	International Convention on Social Economic and Cultural Rights
ICPD	-	International Conference on Population and Development
IDA	-	International Development Agency
IDPs	-	Internally Displaced Persons
ILO	-	International Labour Organization
ITN	-	Insecticide Treated Nets
JICA	-	Japanese International Credit Agency
LRA	-	Lords Resistance Army
MARPs	-	Most at Risk Population Groups
MDG	-	Millennium Development Goal
MGLSD	-	Ministry of Gender, Labour and Development
MLWE	-	Ministry of Lands, Water and Environment
MWE	-	Ministry of Water and Environment
MMR	-	Maternal Mortality Rate
MoES	-	Ministry of Education and Sports
MoH	-	Ministry of Health
MoU	-	Memorandum of Understanding

MPs	-	Members of Parliament
MRG	-	Minority Rights Group
MTCT	-	Mother-to-Child Transmission
MUISAE	-	Makerere University Institute of Statistics and Applied Economics
MUK	-	Makerere University
NAADS	-	National Agricultural Advisory Services
NACAES	-	National Committee for AIDS in Emergency Settings
NCC	-	National Council for Children
NEMA	-	National Environment Management Authority
NGOs	-	Non-Governmental Organisations
NHSBS	-	National HIV Sero and Behavioural Survey
NSGE	-	National Strategy for Girls Education
NUSAF	-	Northern Uganda Social Action Fund
NWSC	-	National Water and Sewerage Cooperation
OVC	-	Orphan and Vulnerable Children
PAF	-	Poverty Alleviation Fund
PEAP	-	Poverty Eradication Action Plan
PLWHA	-	People Living with HIV/AIDS
PMA	-	Plan for Modernization of Agriculture
PMTCT	-	Prevention of Mother-to-Child Transmission
PRDP	-	Peace, Recovery and Development Plan
PSWO	-	Probation and Social Welfare Officer
PWDs	-	Persons with Disabilities.
RGCs	-	Rural Growth Centers
RH	-	Reproductive Health
S/Cs	-	Sub-counties
SCD	-	Street Children Desk
SGBV	-	Sexual and Gender Based Violence
SIDA	-	Swedish International Development Agency
SSA	-	Sub-Saharan Africa
STDs	-	Sexual Transmitted Diseases
STI	-	Sexual Transmitted Infection
TFR	-	Total Fertility Rate
UAC	-	Uganda AIDS Commission
UBoS	-	Uganda Bureau of Statistics
UDHS	-	Uganda Demographic Health Survey
UN	-	United Nations
UNSC	-	United Nations Security Council
UNAIDS	-	United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
UNFPA	-	United Nations Population Fund
UNHCR	-	United Nations High Commissioner for Refugees
UNHS	-	Uganda National Household Survey
UNICEF	-	United Nations Children Fund
UNIFEM	-	United Nations Fund for Women
UPACP	-	Uganda Prisons AIDS Control Programme
UPDF	-	Uganda Peoples Defence Forces
UPE	-	Universal Primary Education
UPFC	-	Uganda Parliamentary Forum for Children
UPHC	-	Uganda Population and Housing Census
UPS	-	Uganda Prisons Services
USD	-	United States Dollar
UWONET		Uganda Women Network
VCT	-	Voluntary Counselling and Testing

VGS - Vulnerable Group Support
WAWI - Women at Work International
WCRWC - Women Commission for Refuge Women and Children
WCS - Water and Sanitation Committee
WWD - Women with Disabilities
WFCL - Worst Forms of Child Labour
WFP - World Food Programme
WFR - Wanted Fertility Rate
WSI - Water Stress Index
WWD - Women with Disabilities

CHAPTER 1

FERTILITY TRENDS AND PATTERNS: THE ROLE OF CULTURE, GENDER AND HUMAN RIGHTS

POPSEC File Photo

1.0 Introduction

This Chapter presents the situation analysis of fertility trends and patterns in the context of the role of culture, gender and human rights issues in Uganda. The Cairo International Conference on Population and Development (ICPD) 1994 Plan of Action urges national governments to strengthen national capacities for integration of, among other issues, population factors, including fertility, in development planning. Indeed integration and reflection of population issues in policy, planning and implementation of development programs at national, district and lower local government levels of planning is a key prerequisite to ensuring sustainable development. Fertility is addressed in this chapter as one of the factors in the dynamics of population change that act to shape various development perspectives.

1.1 Policy Framework

While Uganda's annual population growth has continued to increase over the past two decades and is expected to do so in the future, its rate is likely to prevent a steady improvement in the quality of life of individual families. A coherent and comprehensive population policy framework that is responsive to societal demands is essential and urgently needed.

In order to address the population and development challenges, Government of Uganda has produced a number of policies including: The National Population Policy, 1995, 2008, Poverty Eradication Action Plan, PEAP (2004), the National Health Policy (1999), the National Gender Policy (2007), Health Sector Strategic Plan II (2005/06 – 2009/10), all which provide the overall framework for improvement of the standard of living of the people of Uganda including the delivery of healthcare services in the country. These policy documents are comprehensive and deal with the technical, managerial and logistical aspects that contribute to the effective eradication of poverty, healthcare service improvement and generally meeting the MDG targets of the country by 2015.

1.2 Fertility Trends and Patterns

Results of the Demographic and Health Surveys (UDHS) of 1989, 1995 and 2000/2001 and for censuses of 1969, 1991 and 2002 reveal a high and stagnant Total Fertility Rate (7.1), despite a rather low Wanted Fertility Rate (WFR) of 5.3 for both urban and rural areas (Figure 1.1). Why should there be a discrepancy between wanted and actual fertility rates? The Total Fertility Rate and Wanted Fertility Rate are higher for northern (7.9 & 6.4 respectively) and Eastern (7.4 & 5.3 respectively) regions, than the other regions of the country. Many reasons, including low median age at first marriage (18 years), median age at first intercourse (17 years), median age at first birth (18.6 years), survival status of previous births, recent sexual activity, high teenage pregnancy rate (31%), and short birth intervals (29 months), explain these high fertility rates both total and wanted. Results of a baseline survey for Government of Uganda/United Nations Population Fund (GoU/UNFPA) 5th Country Population Programme showed a link between early marriage and teenage pregnancies, with other factors that underlie the fertility observations. We therefore need to understand the factors for the revealed fertility levels in order to design programs, including messages that can respond to district and region specific challenges of the high and stagnating TFR, despite lower desired WFR. One of the key explanations for the high total fertility rates experienced by the country is the average longer duration of exposure to child bearing.

Age specific fertility rates and total fertility rates are presented in both Table 1 and Figures 1.1 and 1.2. These data show the high fertility experience by the country and more so, the early peak in fertility.

Table 1: Age specific fertility rates for Uganda for the period 1969-2006

Age group	1969 Census	1991 Census	1995 UDHS	2000-2001 UDHS	2002 Census	2006 UDHS
15-19	198	152	204	178	204	152
20-24	341	329	319	332	344	309
25-29	322	324	309	298	314	305
30-34	253	275	244	259	256	258
35-39	189	207	177	187	179	190
40-44	87	95	89	76	86	94
45-49	35	32	29	40	22	26
TFR	**7.1**	**7.1**	**6.9**	**6.9**	**7.0**	**6.7**

Results in Table 1 shows the age specific fertility rates (ASFR) for years 1969 to 2006 indicating the pattern of fertility levels across years and age groups. ASFR used in the table is measured as the number of children women in a specific age group produce in every 1000 women who are in the reproductive age(15-49) while the Total Fertility Rate (TFR) is the average total number of children one woman would produce in her reproductive life time .

There is substantial fertility rate in the age group 15-19, which then peaks in the age interval 20-24. Once fertility has peaked, it is sustained even at ages above 35 years. The High fertility rate revealed among the age groups 20-24 and 25- 29 indicate the most productive age groups in Uganda who are most productive. The other possible reason is that most of the Ugandan women in those age groups are either not in school or have dropped out of school and due to the patriarchal culture in Uganda that views women as instruments of production, these women end up giving birth as a major role.

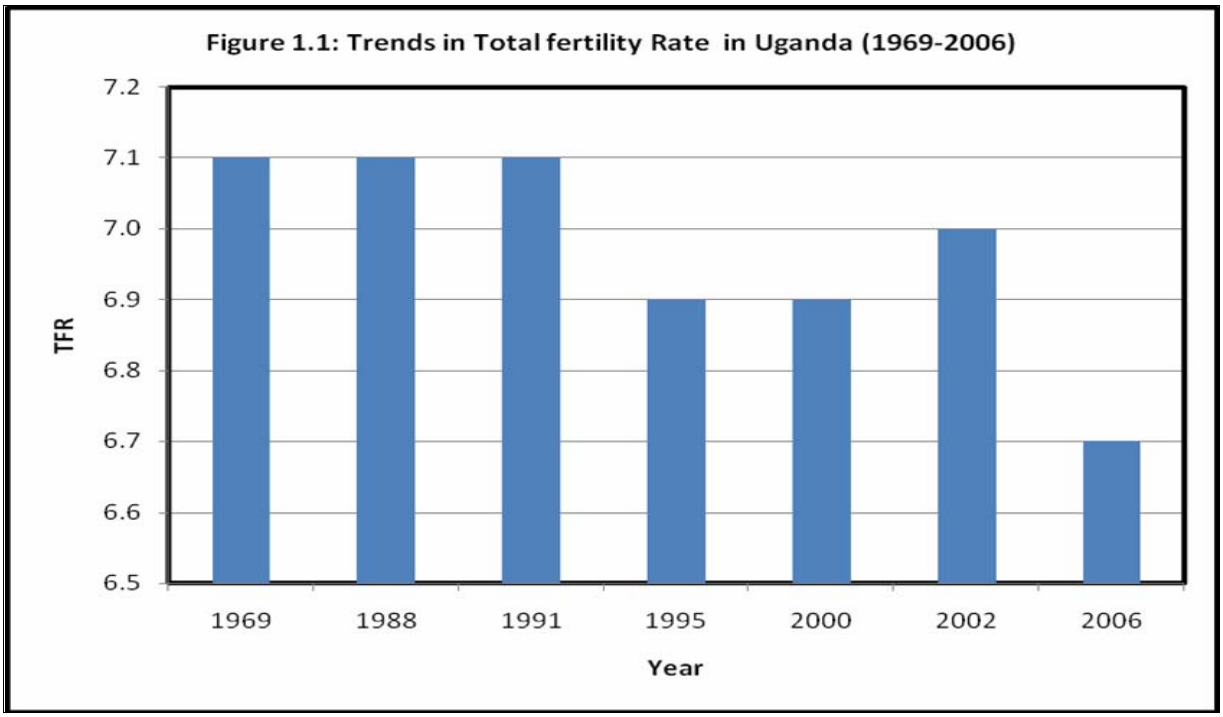


Figure 1.2: Age specific fertility rates for Uganda, 1969-2006

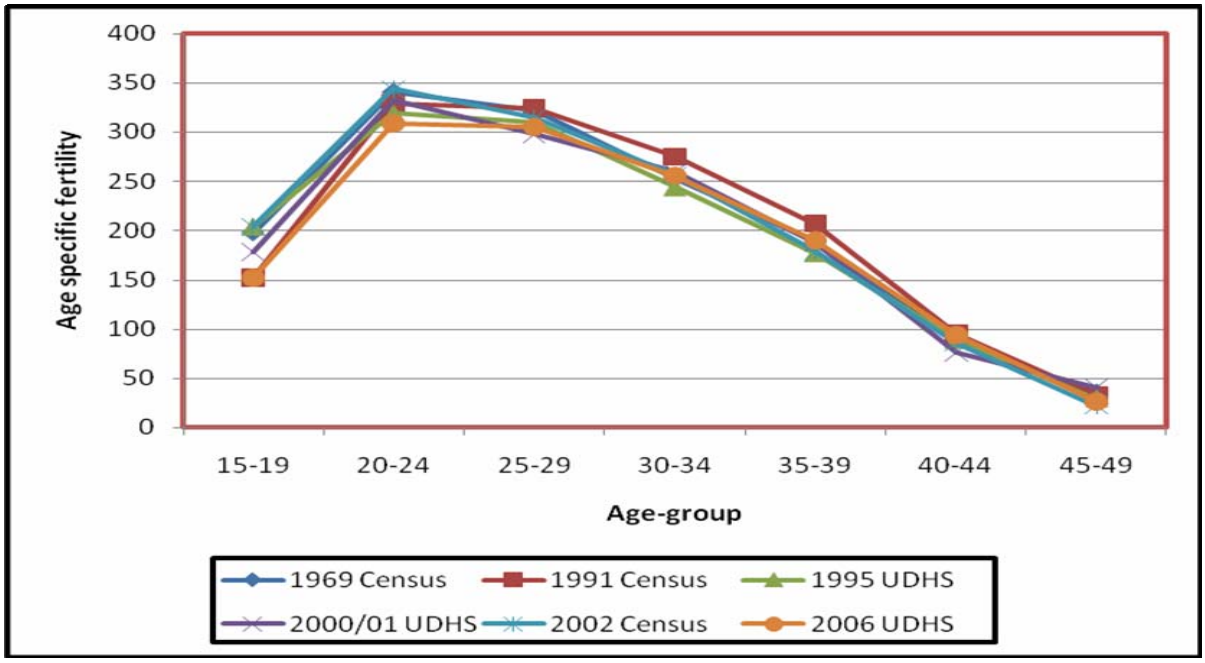
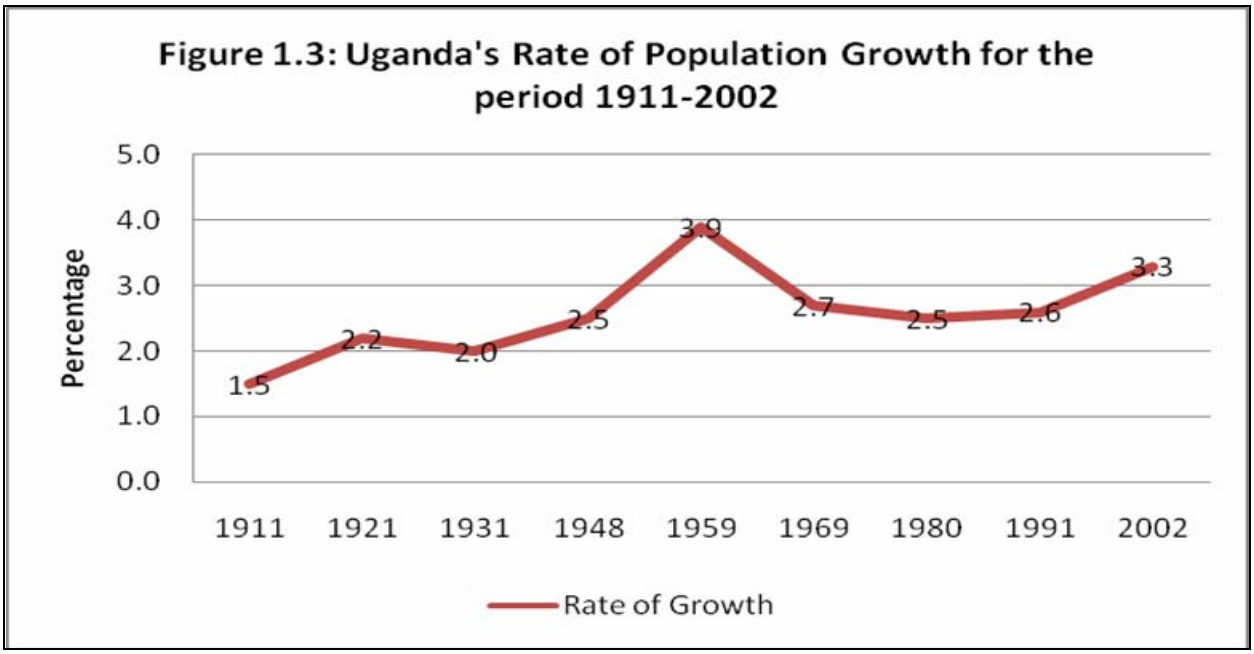


Figure 1.2 presents a comparison of the total fertility rates in Uganda for the period 1969 to 2006. The figure shows that Uganda's fertility has remained high and fairly constant over the past four decades. As a result of the high and sustained fertility, the country's population growth rate has remained steadily high over the years as shown in Figure 1.3.



1.3 The Role of Culture, Gender and Human Rights

Attaining the goals of sustainable and equitable development requires that individuals are able to exercise control over their sexual and reproductive lives. This includes the rights to reproductive health as a component of overall health, throughout the life cycle, for both men and women. Right to reproductive health is manifested by rights to:

- Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice.
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.

High fertility is highly valued in most African societies and Uganda is not an exception. One of the main purposes of marriage is to have children (NCC, 1994, Ntozi, 2001). Women (and men) who are not able to bear children are ridiculed. In some cases, childbearing outside marriage, polygamy or arrangements where a woman can get a child from another man (if there are problems with the spouse) is preferred to not bearing children. Individuals are urged to bear children irrespective of their physical, economic or social conditions. The increase in demand for children among PLWHA is a major challenge for health care and support organizations. Children are still viewed as a way of perpetuating lineage, form of status, recognition and a form of social security in old age (NCC, 1994, KIT, 2007). Important gender issues that affect reproductive health include sex preference which limits opportunities for girls, the status of women and men in society with deeply rooted socio-cultural attitudes and practices that lower the status of women; the asymmetrical gender division of roles and responsibilities, and women's limited time to access the points of service provision due to the multiple roles. Gender being culturally defined, women too, many of who have limited rights awareness agrees with the system (NCC, 1994, Ejolu and Rehmer, 2006). Traditionally, a woman's role is strongly linked with fertility and motherhood and her status, largely measured by her capacity to reproduce, hence the pressure to have more children (NCC, 1994, MGLSD, 2007c).

Apparently, the perceived benefits of large families are rarely linked with costs in terms of maternal morbidity, mortality and other costs involved in uncontrolled fertility. The socio-economic status of both women and men has a major bearing on fertility. Poverty for instance interacts with gender relations to the disadvantage of women. Women of high socio-economic status fare better than poor ones (Hardon, Kabeer, 1994, Neema et al, 2004) and they are therefore in a better position to take care of their children well and also seek health care as compared to poor women.

One of the major reasons for the high fertility is the strong, pro-marriage tradition. The 1991, 1995, 2000/01 and 2006 UDHS reports suggest that the mean age at first marriage was below 18 years. Indeed early marriage implies early age at first birth and a longer duration and this involves risks in child bearing as a result of longer exposure to sex since they start it early. The 1969 and 1991 censuses showed that the proportions ever married were 94% and 97% respectively, by the age of 45 years. Associated with early marriage traditions are the high values placed on children in many Ugandan societies. Producing many children especially sons is a great source of happiness and physical security and an indicator of high status and power in society (Ntozi 1995).

Most families in Uganda still highly value producing several sons, who would continue the lineage of the family. Hence, the search for sons makes many couples, including the highly educated ones end up with larger families than initially desired. Even highly educated men marry second wives or use mistresses in order to produce several sons (Ntozi 1993). The 1995 UDHS found a strong desire to have children and a preference for large families in Uganda. Married men (48%) were found to be in favor of many children than married women (18%) after producing 6 living children (Department of Statistics and Micro International 1996).

The other reason for sustained high fertility which has some active connotations is limited use of modem contraceptives. Bongaarts (1978) and Bongaarts and Potter (1983) demonstrate that modem contraception can drastically reduce fertility levels in a short time. In the case of Uganda current use of modem contraceptives has remained too low to make an impact on fertility since the inception of Family Planning in 1995. In 1988/89 demographic and health survey, the current use by currently married women (CPR) was 4.9% and it rose to only 8.9% in 1995 and 18% in 200/01. This is despite high level of awareness of modern methods, from 77.9% in 1988/89 to 91.6% in 1995 and 98.7% in 2000/01. It is important to note that the majority of currently married women in the 1995 UDHS (37%) explained the wide difference between their knowledge and use of methods in terms of wanting children. This shows that the desire for children is very strong and with 6 living children; over a quarter of these women did not want to limit their childbearing. Other reasons given for non-use of contraceptives were temporarily unable or completely unable to conceive (by 12.4%), knowing no method (8.3%), had reached menopause (7.2%), partner opposed (6.6%), respondent opposed (5.6%), knew no source of methods (5.6%), side effects (4.5%) and prohibited by religion (3. 1 %).

Frequent sexual activity exposes women to high risk of pregnancy. In the absence of effective contraception, the risk of pregnancy is highly influenced by the frequency of sexual intercourse among Ugandan women. Four weeks before the 1995 UDHS, a high 60% of women in reproductive age group were sexually active. The likelihood of women being sexually active was highest in ages 25-29 (70.2%), 30-34 (69.2%), 35-39 (66.9%) and 20-24 (65.5%) as well as among the uneducated (64.5%) and rural women (61.3%). However, sexual activity is high even among the adolescents (40.9%), urban women (52.9%) and the most educated (48.3%). In the 1985 survey of women in South-western Uganda, the mean number of times women had sexual intercourse per week was 3.5 partly because of cultural obligations to do so (Ntozi 1995).

In the absence of sexual abstinence, short breastfeeding contributes a lot to high fertility. Short periods of breastfeeding among Ugandan women were found to lead to fairly short postpartum amenorrhea (resumption of menstrual periods) with a median of 12.6 months (Department of Statistics and Micro International 1996). This period varies from I I to 16 months between young women (below 30 years) and older women (30 years and above), 7 to 13 months (urban-rural) and 6 to 15 months (uneducated - highly educated). Combining postpartum amenorrhea with abstinence leads to a median

length of postpartum insusceptibility, which was reported in the UDHS of 1995 to be 13.4 months, which is fairly short, ranging from 9 to 16 months between the uneducated and highly educated.

High infant and child mortality levels may have contributed to sustained high fertility in the country. The killer diseases of children notably malaria and diarrhea have continued to be highly prevalent in the country (Department of Statistics and Micro International 1996). For instance, of the 770 infants aged 6-11 months, a high 38% had suffered from diarrhea in mere two weeks before the 2000/01 UDHS (UBOS 200 1). The censuses of 1969 and 1991 indicated that infant mortality rose from 118 to 122 deaths per 1000 live births and under-five mortality increased from 198 to 203. Although the 1995 UDHS showed dramatic improvement in infant and under-five mortality to 81 and 147 respectively, the UDHS of 2000/01 reported some lost ground back to 88 and 152 respectively. It is likely that couples reacted to the worsening mortality situation by producing more children so that some can survive.

The above reasons for the limited use of modern contraceptives in Uganda are influenced by a number of cultures in view of the tripple roles of women that leaves women as instruments of reproduction, child bearing and rearing and the culture that encourages male dominancy in Uganda. Family planning services are viewed largely as services of women and not men; this has largely limited men involvement in seeking reproductive health care services.

It is also important to note that despite the women's need to seek healthcare more than men, they have limited access to the means. Rights over resources to seek health care are controlled by men and women's roles are continually being largely house centered with daily house chores that limit women from exercising their full potential and abilities despite the steps being taken by the government to empower women.

1.4 Conclusion

It is evident that culture, gender and human rights perspective have an influence on fertility, where as significant strides have been made by the government and other international bodies to empower women, through education of the girl child, Universal Primary Education, supporting family planning programs, the gender and cultural perspective as understood and practiced in the Ugandan context have still constrained the achievement of fertility goal. Total Fertility Rate has remained unacceptably high at 6.7 and the contraceptive use has remained low at 24 percent as well as the high unmet need of family planning at 41%. Child preference as a source of prestige for families, sex preference for inheritance purposes and family name perpetuation, replacement for the dead children and a source of security for the parents in their old age with the gender and cultural dimensions inherent in them have all combined to keep TFR high. Therefore every strategy to influence fertility in Uganda needs more beyond providing family planning supplies perse but also understand this variable in socio-cultural context of those involved in order to create a difference.

1.5 Policy Recommendations

- Family planning services programmes need to be of gender and culturally sensitive in their implementation.
- Services especially to the women need to put into consideration the socio-cultural context in which they operate in terms of the women's roles
- Fertility transformation and targets and the means to achieve them should put in mind the men and their reproductive health needs, no isolation of men and women in implementation
- Women empowerment needs to continue to meet the bridge the gender divide that exist in the Ugandan society.

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CHAPTER 2

PATTERNS AND TRENDS OF HIV/AIDS IN UGANDA: THE ROLE OF CULTURE, GENDER AND HUMAN RIGHTS

2.0 Introduction

Over a quarter of a century since the first cases were identified, the HIV/AIDS epidemic is still raging in Uganda and different parts of the world. Owing to its impact on the economically productive adults, the epidemic is an intricate part of social and economic development efforts at individual, household, community and national levels. In Uganda, HIV is predominantly transmitted through heterosexual contact, a factor that closely links the epidemic to social, cultural and religious beliefs, norms and practices of the various population groupings, with both positive and negative outcomes.

The epidemic seriously impacts on the quality of life of the infected and affected. It is considered a major development crisis that potentially undermines economic, social and political structures and threatens to reverse social economic development gains at national and global levels[1]. The epidemic is acknowledged among key aspects responsible for in addressing extreme poverty in all its different dimensions. Despite notable achievements in the national response to combating HIV/AIDS in Uganda, the MDG target of halting and reversing the spread of HIV/AIDS is still far from reality. The epidemic also directly and indirectly impacts on achievement of other MDGs especially the socio-economic and health related ones.

2.1 Overview of the Response

Uganda has, since 1986, sustained a structured response addressing the epidemic as a multi-sectoral challenge that demands for concerted efforts at individual and institutional levels. The multi-sectoral policy strategy, adopted in 1992, calls on everyone to address the epidemic within their mandates and capacities. This policy has informed the development of national, sector and thematic HIV/AIDS-related policies, and successive planning frameworks and programmes by different stakeholders at various levels. The epidemic was declared a development crisis in 2000 and mainstreamed in the Poverty Eradication Action Plan. The Uganda HIV/AIDS Partnership coordination structure provides a platform for stakeholder involvement in the management of the response at different levels as they contribute to national development.

The country has registered modest achievements in the response. This is demonstrated through the significant decline in HIV prevalence rates in the 1990s and the increase in the number of the infected accessing antiretroviral therapy (ART), estimated at 42% of those in need, that has contributed to reduction in AIDS-related deaths. Achievements have been attributed to political and leadership commitment and involvement right from the head of the country; openness about the epidemic that dispelled myths and enhanced awareness and knowledge about HIV/AIDS, multi-sectoral approaches for a comprehensive response; and community-owned responses.

Currently, there is priority focus on prevention, acknowledging challenges to sustaining access to life-long treatments for the increasing numbers of the infected. The draft National Overarching HIV/AIDS Policy and National Strategic Plan 2007/8-2011/12 emphasize focus on HIV prevention and addressing factors that increase vulnerability to HIV infection. The Country Road Map to accelerated HIV Prevention 2007/08-2011/12 prescribes a comprehensive prevention package of public health, social, cultural, economic and technological interventions applied within contexts of those at high risk and vulnerable to HIV infection. Treatment, care and social support for the infected and affected are also priorities that will be exploited to boost prevention interventions.

The country response is however faced with a host of challenges that undermine achievement of targets. Such include resource and infrastructure constraints; a rapidly growing population that impacts

[1] *Smith, S, Cohen D, 2000; Jefferis, K, [et al], 2007*

on the equity and quality of services; and limited uptake of available services due to cultural, social, economic and structural reasons. Particularly, the role of social and cultural norms and practices to prevention of further transmission of HIV and promoting access to available services requires special recognition. It is also apparent that the multi-sectoral approach has not been deeply entrenched into development programming and consequently HIV/AIDS is still largely addressed from public health perspectives.

2.2.0 Situation, Trends and patterns of the HIV/AIDS epidemic

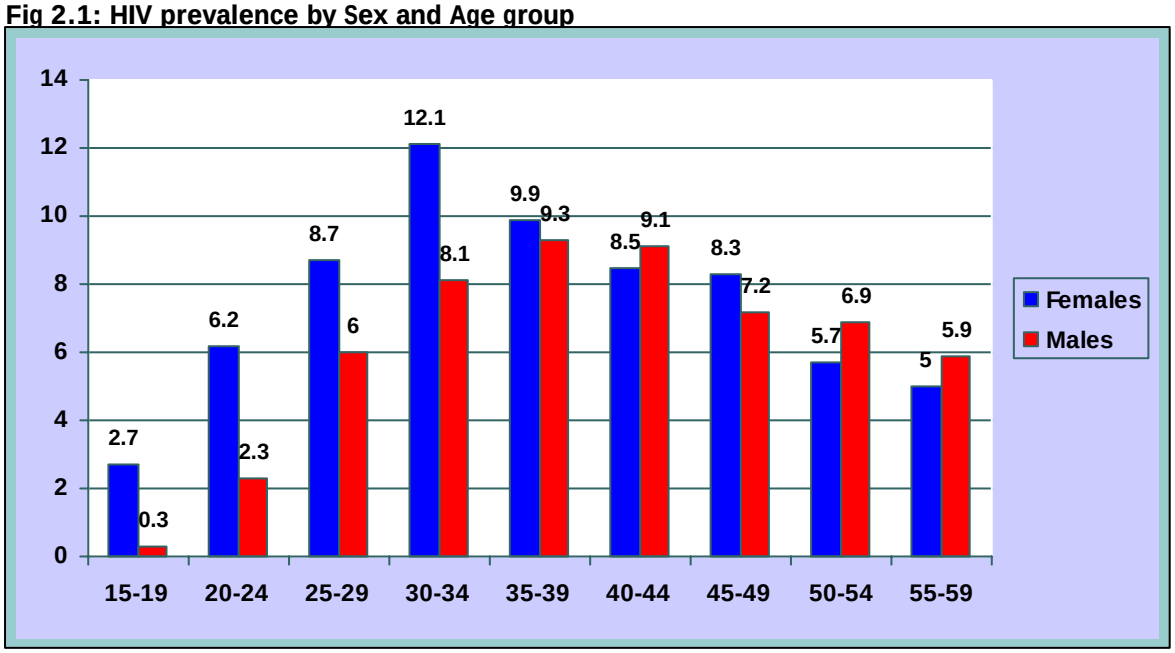
2.2.1 Global status of HIV/AIDS

Globally, the epidemic is still spreading albeit at a slower pace, with the epicentre in Sub Saharan Africa where Uganda lies. UNAIDS, the United Nations joint co-sponsored programme on AIDS, estimated a total of 2.7 million global new infections in 2007 alone and about 1.7 million of them in Sub Saharan Africa (SSA)[2]. By the end of 2007, about 33 million people globally were estimated to be living with HIV with about 67% of these being in SSA. About 72% of the global AIDS-related deaths in 2007 were in SSA, a region where the epidemic is the single largest cause of deaths. On a daily basis, UNAIDS estimates over 6,500 new HIV infections and 5,700 AIDS-related deaths around the world. For every infected individual enrolled on Anti-retroviral Therapy (ART), about five get infected, illustrating the need to intensify prevention interventions while expanding access to treatment.

2.2.2 Status of the Epidemic in Uganda

Uganda, the global HIV/AIDS prevention success story of the 1990s, is facing challenges of sustaining achievements in reducing the rate at which new HIV infections are occurring in different population groups. The cross-sectional population based National HIV Sero and Behavioural Survey (NHSBS) of 2004/05 by the Ministry of Health estimated the national HIV prevalence rate, or percentage of persons infected with HIV, at about 6.4% of the adult population 15-49 years of age. The survey revealed that the country is experiencing several epidemics in one, with variances by gender, geographical area, social and economic characteristics. The epidemic has a feminine face, with more women infected than men in both rural and urban areas (see figure 1.2).

Fig 2.1: HIV prevalence by Sex and Age group

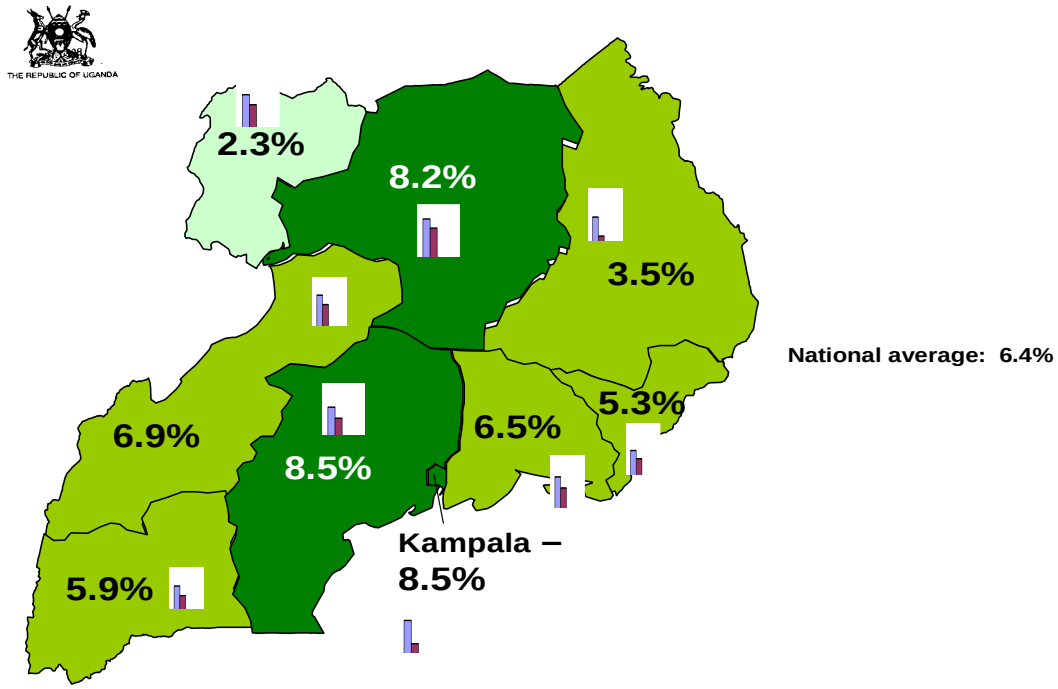


Source: Ministry of Heath, NHSBS report 2006

[2] *UNAIDS, 2008*

The NHSBS of 2004/05 estimated HIV prevalence among women at 7.5% relative to 5% among men. This pattern is more significant in urban areas and also among young women where for example the prevalence rate among the 15-19 year olds was about 9 times higher among young women than young men. HIV prevalence was higher among urban residents at 10.2% compared to 5.7% among rural residents. HIV prevalence was lowest at 2.3% in the West Nile region and highest in Kampala and the Central and mid-north regions above 8%, a trend that appears to be linked to socio-cultural factors and prevalence of sexually transmitted infections. (see figure 2.2)

Fig 2.2: HIV Prevalence by region



Source: Ministry of Heath, NHSBS report 2006

HIV prevalence is also high among specific population groups including those currently married, widowed, separated, and women in the highest wealth quintile. While the HIV prevalence rate at national level has generally stabilized, some sentinel sites such as Mbarara, Arua, Masindi have reported increases and others such as Nsambya Hospital and Kagadi have reported decreases[3].

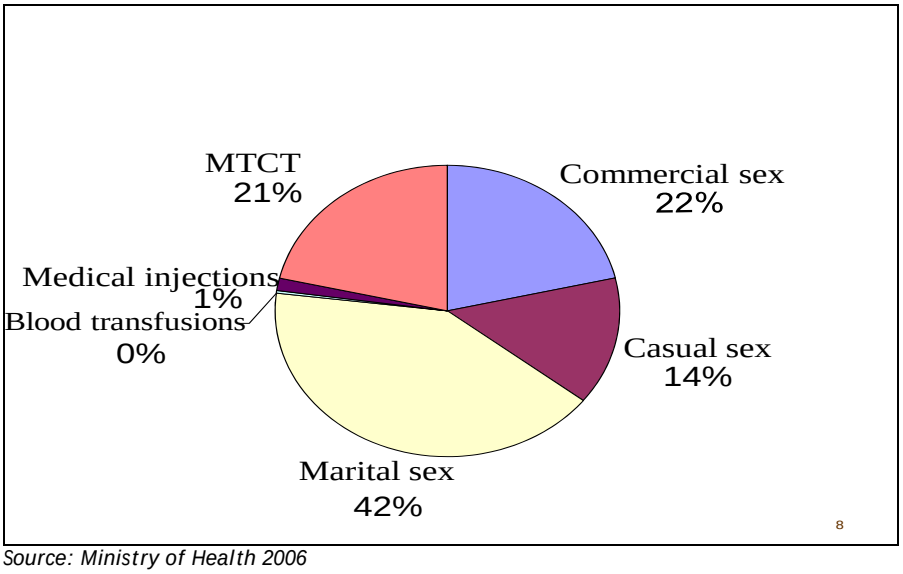
An estimated 135,000 new HIV infections and 76,000 HIV/AIDS related deaths occurred in the year 2005 alone[4]. The epidemic is the leading cause of deaths among adults and the 4th cause of deaths among children. Sexual transmission of HIV accounts for about 76% while mother to child transmission (MTCT) contributes 21-25% of all the new HIV infections. Further analysis of new sexually transmitted HIV infections revealed that most of these are occurring in marriage or long-term sexual relationships as compared to casual, and commercial sexual contacts[5] (see fig 2.3).

[3] *Wabwire-Mangen, F [et al], 2006*
[4] *UAC, UNAIDS, 2008 Report 2*
[5] *UAC, 2007(1)*

2.2.3 Evolution of the Epidemic

The HIV/AIDS epidemic in Uganda has this far evolved through three broad distinct phases[6]. The period from early 1980s to around 1992 constituted the first phase of rapid spread of the epidemic with the prevalence rate peaking at an estimated national average of 18%. The second phase between 1992 and 2000/02 was characterized by significant declines in HIV prevalence and incidence (the rate at which new infections are occurring) in both urban and rural areas (see figure 2.4). Since 2002, prevalence rates have stabilized albeit at high levels of 6-7%. The Modes of Transmission study 2008 has revealed evidence for an upward trend in both HIV prevalence and incidence in the country.

Fig.2.3: Distribution of new HIV infections by source

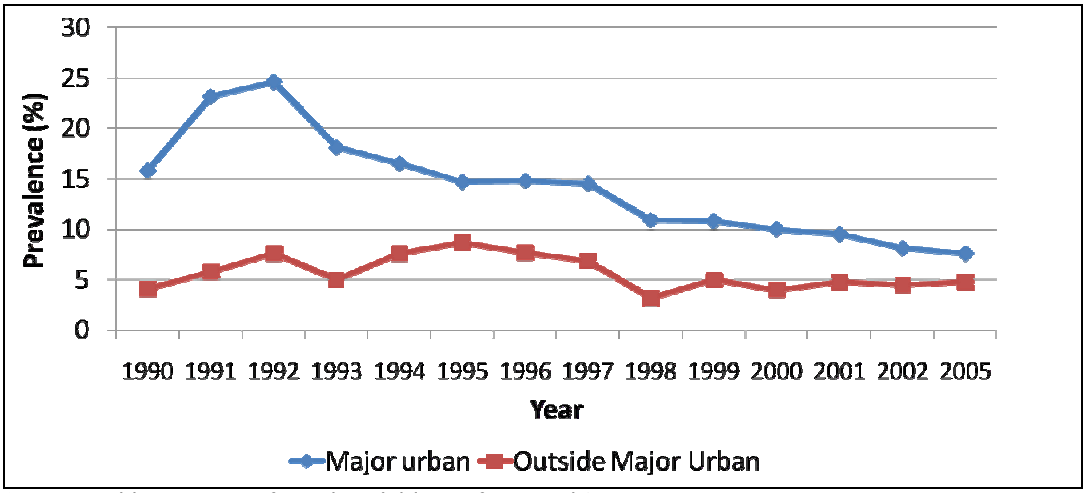


Source: Ministry of Health 2006

The epidemic has evolved from initial concentrations in high risk groups, such as commercial sex workers and long-distance truck drivers into a mature generalized epidemic. According to the global classification of the epidemic, this implies that HIV prevalence in the general population can be sustained independent of such high risk groups. In this context, therefore, every individual in any community anywhere in the country is at risk of acquiring HIV, though some population groups are at a higher risk. Such groups are currently referred to as most at risk population groups (MARPs) and are mostly exposed through high risk sexual behaviours and sexual networks. These include among others: fisher folk; mobile populations such as long distance truck drivers; uniformed forces; commercial sex workers; and negative partners in HIV discordant relationships. On the other hand, some population groups are more vulnerable to HIV infection largely due to the social, cultural and economic circumstances that predispose them to high risk sex. These include among others women; people in long term sexual relationships; people in situations of conflict and displacement; the disabled; young people and especially orphans and vulnerable children.

[6] *Wabwire, F [et al], 2006*

Fig 2.4: Median HIV prevalence of ANC attendees from major towns and outside major towns from 1990 to 2005



Source: Rapid assessment of trends and drivers of HIV… Vol 2

The shift of the epicentre from young un-married people 19-25 years to older, married or formerly married individuals signifies another important factor in the evolution of the epidemic in this country. Most new infections are occurring among people aged 25 years and older. Considering that over 60% of the adult population are married or in cohabiting relationships, most adult new infections are taking place in these long-term sexual relationships.

The risk to HIV infection attributed to behavioural and biological factors varies with the different stages of the evolving epidemic, with societal and cultural implications. In Uganda, stabilization of HIV incidence and prevalence trends coincided with increased risky sexual behaviours and decline in preventive sexual behaviours in various population groups. It is documented that the high HIV/AIDS awareness levels at over 90% is not matched with adoption of preventive behaviours[7]. This underlies the importance of factors that predispose individuals to HIV infection beyond ignorance and lack of knowledge.

2.3.3 Risk Factors and Drivers of the Epidemic

UNAIDS defines a risk factor as an aspect of personal behaviour or life-style or an exposure which on the basis of epidemiological evidence is known to be associated with HIV transmission or acquisition. A driver refers to the environmental, structural and social contextual factors that are not easily measured which increase individuals' vulnerability to HIV infection[8]. Locally studies and surveys have established proximate, behavioural and contextual key factors influencing the epidemic in different population groups[9].

Behavioural risk factors increase the probability that an individual engages in unprotected sexual contact with an infected partner. Such behaviours include multiple and concurrent sexual partnerships, extramarital sex, commercial sex, sex with a partner of unknown status even in marriage, unprotected sex with an infected individual, sex between men, and initiating sex at an early age. All of these are referred to as high risk sex[10]. The NHSBS revealed deteriorating indicators in most of these practices including inconsistent condom use during such high risk sex. For example among men, extramarital sex increased from 13% to 18% while casual sex (sex with a non-marital, non-cohabiting partner) rose from

[7] *MoH, ORC Macro, 2006*
[8] *UAC, UNAIDS Task report 1, 2008*
[9] *UAC, 2007 (1)*
[10] *Uganda HIV/AIDS Partnership Committee, 2007*

29% to 37% between 2000 and 2005, yet condom use among men during high risk sex decreased from 62% to 58%. While most new infections are occurring in marriage, the NHSBS revealed that over 60% of married individuals who acquired new infection had a negative spouse, implying that the infection was acquired from a source outside marriage. The result is an increase in numbers of discordant couples (one partner is infected the other is not) where HIV transmission rates to the uninfected partner are 10-12 times higher than in the general population.

Contextual factors driving the epidemic act directly and indirectly to influence individual's behaviours to engage in high risk sex. These include structural factors that erode socio-cultural cohesiveness such as poverty, armed conflict and displacement that might lead to survival sex especially among women, and also engaging in risk sexual activities as a coping mechanism. Low status of women and girls, human rights abuse, stigma and discrimination, and inequity in access to HIV/AIDS services also play key roles. On the other hand, wealth could be a factor in the dynamics of the epidemic especially in as far as it increases mobility and affordability of new multiple sexual partners. Irrational spending of spare income among some transient population groups such as fisher folk and subcultures of risk taking and hyper masculinity increase risk behaviours[11]. Risky sexual behaviour is also linked to alcohol consumption which is closely related to the socio-cultural life in most communities across the country. There are also reported increasing trends of drug use in the country

Proximate factors increase chances of HIV transmission with contact. These include presence of a sexually transmitted infection that causes genital ulcers especially Herpes Virus Sub-type 2 (HSV2) and mother to child transmission. HSV2 is linked to a four-fold increase in risk of HIV transmission yet its prevalence is high in the country at about 62% among adults aged 15-40 years[12]. Despite universal coverage of the Prevention of Mother to Child Transmission Programme (PMTCT), mother-to child transmission of HIV still accounts for many new infections[13]. Influencing factors include poor service uptake; high fertility rate in a context of limited access to HIV testing services before and during pregnancy; poor disclosure of test results among couples; and failure of mothers to deliver in health facilities. The NHSBS also revealed that less than 40% of men and women knew that HIV can be transmitted through breastfeeding and that antiretroviral drugs can reduce transmission to babies.

2.4 The role of Culture, Gender and Human Rights in the Dynamics of the Epidemic

Culture represents an identity of a specified grouping of people resulting from established beliefs, norms, traditions, values and aspirations that govern the way individuals relate amongst themselves and within marriage, families and communities[14]. These influence behaviours and practices including sexual behaviours and practices that are at the heart of the HIV epidemic in Sub-Saharan Africa. Culture defines social belonging, prescribes male and female gender norms, roles and expectations, and is central to a people's well being. As such culture is central to social and economic advancement, including preventing the spread of HIV and mitigating its impact.

Culture constantly evolves with and in turn impacts on social and economic transformations, though cultural conservativeness is also common. Uganda's population is highly and spiritual beliefs form an intricate part of the different cultures. Culture promotes cohesiveness that ideally provides social safety nets and community surveillance systems which should enhance formation and adoption of positive behaviours. Uganda's wealth of cultural diversity has however had both positive and negative influences on the evolution of the epidemic, as demonstrated in the established drivers of the epidemic, and on the national response[15].

2.4.1 Culture and Drivers of the Epidemic

Most behavioural and contextual factors fuelling HIV transmission in Uganda's mature HIV epidemic are rooted in social, cultural and gender norms and practices. These largely hinge on male and female

[11] *Bukuluki P, Kyaddondo D, 2006*
[12] *MoH, ORC Macro, 2006*
[13] *UAC, UNAIDS Task Report 3, 2008*
[14] *http://www.crossculturalfoundation.or.ug/, 20/8/2008*
[15] *Bukuluki, P; Kyaddondo, D, 2006*

gender norms and expectations and on marriage and the family as key cultural and social values and institutions that underlie socialization. On the other hand, they inform socio-economic inequities that disproportionately predispose females to HIV infection.

Many cultures in Uganda condemn sex before marriage for women, but despite strong religious values, often men's pre-marital, extra-marital and multiple sexual relationships are condoned and even perceived as a symbol of prowess for both young and adult males[16]. The NHSBS revealed that over 86% of men currently in union have ever had sex with someone other than the current partners.

Similarly, sex and sexuality issues are rarely discussed in families and between couples before and during marriage. Most cultures expect couples to engage in unprotected sex whatever the circumstances. Yet the NHSBS estimated that 8.1% of couples in Uganda including about 57% of married HIV infected individuals are in discordant relationships. Considering that only about 23% of adults have ever tested and received their results and fewer still have shared results with partners, most culturally and religiously sanctioned sex can therefore be categorized as high risk sex. The NHSBS did establish that 85% of HIV transmission risk behaviour is with spouses

Most cultures attach a lot of importance to reproduction with emphasis on male progeny. The value of children and society expectations partly influence men's multiple sexual partnerships and the HIV infected to engage in unprotected sex often with partners of unknown sero-status. This does not only contribute to the country's high population growth rate but is a key aspect in the high rates of HIV transmission among people of reproductive age and from infected mothers to babies. On the other hand, societal expectation that continuous child bearing is a social and familial obligation puts women at risk from unprotected sex and maternal ill-health while child care curtails their involvement in other socio-economic undertakings.

Studies have revealed limited adult support to adolescents and young people especially in issues of communication about sex and sexuality including safer sexual practices in the context of acquiring HIV/STI infections[17]. This is an outcome of deeply entrenched cultural norms, yet the cultural system of the extended family where aunties and uncles are ideally expected to play such roles is increasingly affected by factors like urbanization and education that create physical and virtual distances between the older and younger generations.

Furthermore, there is a growing trend of normalization of HIV that can easily become a norm. Normalization has been defined as considering HIV/AIDS as no longer an immediate threat of death or serious illness but a chronic condition that is not going away soon[18]. Many perceive HIV/AIDS as any other manageable condition especially with the increasing access to antiretroviral therapy (ART). This results in limited individual HIV risk perception and internalization and the apparent behavioural dis-inhibition and complacency especially among young people and those who are not aware of their sero-status.

Male circumcision is both a religious and traditional practice in the country but for a smaller proportion of the population and as such has not had significant impact on the dynamics of the epidemic. Where male circumcision is practiced as initiation into adulthood for example among the Bagisu, some traditional practices such as knife sharing and expectation to engage in sexual intercourse before complete wound healing result in limited benefits of the practice in the context of HIV transmission.

Other cultural practices that initially contributed to HIV transmission but might have been modified, abandoned or less prevalent include traditional sexual healing, and sharing skin cutting or piercing instruments during traditional healing sessions and tattooing.

[16] *Ibid*
[17] *UNICEF, 2004*
[18] *Bukuluki, P; Kyaddondo, D, 2006*

2.4.2. The Woman's Cultural, Social and Economic Status and HIV/AIDS

Despite the gains from women emancipation policies, the low cultural, social and economic status of women in most cultures remains the key driver behind the female face of the epidemic in the country[19]. Women are less educated compared to men, they are less formally employed and in most cultures, are not expected to own property or even make and act on decisions on their own health and economic earnings. Such cultural values and gender orientations deprive women of their independence and realization of their full human rights especially in marriage. The Uganda Demography Survey (UDHS) 2006 for example indicated that only 22% of married women independently decide on their own health.

Women are expected to be subservient to men, cannot negotiate for protected sex in or outside marriage and cannot question the infidelity of their sexual partners. On the contrary, studies have shown that women take such male sexual behaviours as acceptable and some blame themselves for the errant behaviours of their partners[20].

The allure of material gain from dowry to parents and guardians often results in early and sometimes forced marriages of young girls, usually to older men. This exacerbates power relations in marriage rendering young wives more vulnerable. Some cultures still condone wife sharing, a practice that women fail to protest. Widow inheritance, that traditionally provided a safety net for women, is still practiced in some parts of the country without benefit of HIV testing and mutual disclosure of results. Where the practice has gradually phased out, property grabbing from the bereaved instead becomes the norm robbing women and children of their livelihoods.

Sexual exploitation of young people especially girls is also a growing trend through cross-generation and transactional sex[21]. Increasingly, society condones the sugar daddy and sugar mummy practice while young people fail to appreciate the level of sexual exploitation as they also target economic exploitation. Some parents and guardians are also implicated in encouraging such relationships.

Domestic and sexual gender based violence are prevalent and condoned in most cultures to the extent that women accept it as a way of life, find it justifiable or even a welcome exhibition of emotion from spouses[22]. The UDHS 2006 revealed that 70% of women 15-49 years have been physically and sexually abused, 39% have been sexually abused and 44% of these by the current partner, and the first sex for 24% was forced. Studies have shown that women who suffer such violence face disproportionately higher risk of HIV infection. Besides the marriage institution, sexual violence is happening in different spheres of life including education institutions, workplace, conflict and displacement situations and other social aspects of life. The high levels of defilement partly explain HIV incidence and prevalence among children and adolescents born free of infection, yet defilers in most societies are protected from the arm of the law by the parents/guardians of defiled children.

The economic and decision making dependence on men constrains women's access to vital information and services to protect themselves and their families against HIV infection. On the other hand, in cultures that uphold male masculinity, male social and economic dis-empowerment may result in extra marital sex as a coping mechanism for males to boost their self value, putting women more at risk. Inevitably, the centrality of marriage in families and society as a crucial building block in social advancement is threatened with HIV/AIDS.

Gender norms and expectations of male masculinity and female social and economic subservience are an integral part of the socialization processes, reinforcing potentially unsafe behaviours especially in the context of HIV/AIDS among children and young people. Young girls are socialized to look upon their husbands as the supreme decision makers and providers while boys perceive themselves to be superior

[19] *UNESCO, 2002, Bukuluki & Kyaddondo, 2006*
[20] *Bukuluki, P; Kyaddondo, D, 2006; Straight Talk, 2007*
[21] *UNICEF, 2004*
[22] *Bukuluki, P; Kyaddondo, D, 2006, Horizons Program, Straight Talk Foundation, 2007*

over women. This is likely the root of the differentials in vulnerability and impacts of HIV/AIDS on men and women.

Worse still, there are threats of adapting new cultures that might not necessarily be more protective as Uganda increasingly becomes part of the global village through information and communication technology (ICT) advances. Increasing easy access to especially visual media through television and internet might potentially result in establishment of role models and upholding of new social values such as freedom of sexual expression that may be radically different, thereby negating relevance of local social and cultural support mechanisms. The danger of loosing cultural identities thus might present more daunting challenges than non-protective indigenous cultures.

From the human rights perspective, besides the low social economic status of women, the persistent and mostly inexplicit stigma and discrimination against the infected and affected still impacts on preventive behaviour at individual and community levels. The fear of stigma is among factors that inhibit many from accessing HIV testing and disclosing results to sexual partners. Some population groups such as the disabled and the orphaned and vulnerable children, experience layered stigma that puts them at higher risk of infection due to limited social, economic and psychosocial support.

2.4.3 The role of Socio-Cultural factors in the Evolution of the HIV/AIDS response

Social, cultural and religious norms, values and institutions have positively and negatively influenced programming for HIV/AIDS and response outcomes in the country. On the other hand, the dynamics of the epidemic and the response have also led to socio-cultural transformation to adapt to the threat of HIV/AIDS.

Declining HIV prevalence trends in the 1990s were significant among young people especially urban women 15-24 years of age, largely attributed to the adoption of positive behaviours, at population level, related to abstinence, being faithful and consistent condom use (ABC). There was documented increase in age at first sex for both boys and girls, reduction in multiple sexual partners, and increasing correct and consistent condom use during casual sex or sex outside marriage[23]. The country's acclaimed ABC approach to HIV prevention was largely informed and reinforces positive cultural and religious norms and values and is testimony to their impact on the response in communities. The same norms however render ABC unfeasible especially to women who have no control over their bodies heightening the need for combination of prevention approaches. The realization resulted in the ABC+ concept during recent national strategic planning processes.

Similarly, in the past two decades most cultural and socio-economic developments have been linked to HIV/AIDS. As such, religious and cultural resources, institutions and structures have been developed and utilized, within respective mandates and also ideologies, to mobilize the populace and to deliver HIV prevention, treatment and care information and services in different contexts. The role of cultural gate keepers and religious leaders has particularly been significant, both as enablers and bottlenecks in innovations and delivery of proven interventions in the response. Many people depend on opinions and guidance from these leaders to shape behaviours and relationships which has significant impact especially in prevention programming. For example, sex education for young people and condom use are among those proven interventions that have met challenges from cultural and religious ideologies impacting on the scale of their application[24].

Cultural and spiritual values and approaches have been the backbone of the care and support components of the national response through for example the institution of extended family; traditional herbal healing; and nutritional support[25]. The cultural attachments to care for the sick, the bereaved and the affected has provided invaluable support to the country's limited social and health infrastructure through home-based care, psychosocial, moral and material support to the infected and

[23] *UAC, 2005*
[24] *Asingwire, N [et al] 2006*
[25] *Cross-Cultural Foundation of Uganda, (2008)*

affected. Support to the orphaned children and established community support mechanisms around deaths and funerals have been significant though threatened by the ever increasing HIV/AIDS burden and rapid urbanization. On the other hand, persistent stigma towards the infected and affected at family and community levels partly linked to the social perception of HIV/AIDS as a disease of the immoral, still constrains uptake of services at individual and family levels. For example, uptake of HIV testing services and disclosure of results to spouses are significantly impacted for both men and women for fear of rejection, abandonment, violence and marital instability due to positive test results[26]

On the other hand, studies have documented cultural changes and adaptations that have taken place in different parts of the country due to the epidemic. Many harmful traditional practices including knife sharing during traditional male circumcision, traditional or spiritual healing, wife sharing and widow inheritance have been either minimized or modified to promote safety while protecting traditions. Some cultural and social changes have been negative further aggravating the epidemic situation. For example increase in mortality rates resulted in an increase in orphaned children and a disintegrating extended family system that otherwise provided a social safety net.

At national level, structural adjustments have resulted in policies that have directly and indirectly supported the response through elevation of the socio-economic status of Ugandans especially girls and women and upholding of their human rights. Policies and programmes for poverty eradication, women empowerment and Universal Primary Education are among the examples. The heightened focus on women however potentially exacerbates the trend of limited male involvement in health issues for themselves, their spouses and families, thereby reinforcing rather than positively modifying the harmful gender norms.

While appreciating the role of culture in the response, it is also important to note that trends in development and the dynamics the epidemic and the global response pose challenges to cultural approaches to the HIV/AIDS response. For example the global research community continues to invest heavily into prevention technologies such as medical male circumcision, microbicides and pre-exposure prophylaxis among others. Application of any proven technology requires context-specific socio-cultural dialogue and potentially cultural modifications to exploit benefits to populace.

2.5 Impact of Gender, Culture and Human Rights on Universal access

Uganda is striving to achieve global and national targets for development generally and particularly for universal access to HIV prevention, treatment, care and support services for all those in need by 2012[27]. Universal access literally translates into 100% coverage of services for those who need them. In Uganda's context, however, acknowledging the various challenges to service delivery and uptake, the concept has been translated into different targets for different services. While exploring the positive points, culture, gender and human rights aspects feature among key challenges to universal access, especially from the perspective of intervention relevancy and service uptake.

The biggest role that culture plays in HIV prevention is its influence on individual risk perception and internalization and adoption of sustainable positive behaviours[28]. Limited focus on the role of culture in enhancing or inhibiting individual behaviours in a context of false hopes for a cure in ART, potentially negate prevention efforts. Uganda has been engaged in a debate on the merits and demerits of the components of the ABC approach, but often this debate is divorced from the factors that hinder adoption of any of the components[29]. While culture and religion scorn pre-marital sex, pre-marital pregnancy and extra marital sex, the highlighted contextual drivers of the epidemic often leave girls and women unable to consistently practice any of the ABC components. Early forced marriages and men's extra-marital sexual relations render abstinence and being faithful a mockery, while their low status in relationships makes it difficult for them to initiate and/or negotiate condom use.

[26] *Bukuluki P, Kyaddondo, D, 2006*
[27] *UAC, (2007)*
[28] *UNESCO, 2002*
[29] *UAC, 2005*

Studies have revealed poor trends in health seeking behaviours particularly among males largely due gender norms and expectations[30]. This in turn impacts on their economic and moral support to women and children to access services. Particularly, focus on the role of males in sexual transmission of HIV and their involvement in the response at this will greatly shape approaches to an epidemic among adults that requires attention to couples beyond focus on individuals.

The impact of HIV/AIDS on cultural resources and institutions also creates more challenges for the national response. The increasing orphan burden due to high adult mortality rates has devastated the extended family system resulting in child and granny headed households and an influx of street children that heighten their vulnerability to HIV infection. Similarly, the growing urbanization trends are impacting on rural traditional cultures that inherently provide social safety nets.

The deep seated traditional and religious morals remain prejudiced against some practices such as sex work that are fuelling the spread of HIV. Yet such cultures rarely hold clients of sex workers responsible for their part in the practice and to their regular sexual partners. Sex work is increasing in the country, probably an indicator of a matching demand side. The recent modes of transmission study identified clients of sex workers and the partners they leave at home among the most vulnerable population groups. The illegal nature and social stigma attached to sex trade, men who have sex with men and drug users, make access to preventive and health services impossible and also constrains research efforts to establish extent of existence and their impact on the dynamics of the epidemic at population levels. To a great extent, therefore, moral values hinder some population groups from attaining their human rights which in turn is potentially detrimental to the health of the wider population.

2.6 Culture and Service Delivery

Cultural resources and approaches have been applied positively in HIV prevention and care of the infected and affected in different localities. Exploiting the large following in the population, cultural and religious settings have played a key role in taking HIV/AIDS information and services to the different parts of the country, albeit the ideological differences. There are also challenges to response emanating from societal, cultural and religious factors that impact on intervention appropriateness and service uptake.

Cultural attitudes and perspectives to HIV/AIDS as a disease have largely been prejudiced. The resulting stigma and discrimination against the infected and affected is not only a human rights issue but a documented driver of the epidemic largely in its role in inhibiting service uptake[31]. The PMTCT programme in Uganda presents the height of the impact of cultural and societal barriers to service uptake. Despite national coverage of the service, the UDHS 2006 estimated that only 18% of pregnant women who had babies two years before the survey tested and received their results. Factors of stigma and discrimination, low participation of men in family health issues, low social and economic status of women, domestic violence, cultural beliefs and practices around child birth and infant feeding, come together to constrain a proven public health intervention. Besides infrastructure challenges, similar cultural and societal factors impact on uptake of and adherence to ART and also uptake of HIV counselling and testing which is a pivotal intervention for prevention, treatment and care services in the context of universal access

Cultural sexual norms and practices especially around the culturally fragile population groups such as people in marriage relationships and MARPS impact on adoption and utilization of the ABC model. Abstinence is futile for young people when they get infected through sexual violence and in formal marriage relationships due to lack of life skills, information withholding, poor couple communication and lack of HIV testing and mutual disclosure of test results. Challenges for addressing an epidemic among adults will largely hinge on cultural and societal factors that influence behaviours around faithfulness and multiple sexual partnerships. Constraints to mutual fidelity and negative attitude

[30] *Bukuluki, P; Kyaddondo, D, 2006*
[31] *Ibid*

towards condom use in marriage increasingly negate preventive efforts for spouses and might potentially lead to another explosion of the epidemic.

Cultural and religious beliefs and practices are indirectly impacting on achievement of universal access targets through their influence on the population growth rate in the country. Prevention responses demand for context specific and interpersonal interventions, for example in the HIV counselling settings, that get more complex with increased numbers in need. Consequently, this impacts on equity, scope and quality of interventions and limited sustainability especially from the resources adequacy perspectives

2.7 Conclusions and Policy Recommendations

HIV/AIDS is still raging in country with devastating impacts on individuals, families, communities and the nation generally. The epidemic is a multifaceted development challenge, with fundamentally structural determinants that requires in-depth understanding of its dynamics in relation to the development discourse to mount effective multisectoral responses at various levels. Adopting and sustaining positive behaviours at individual levels is largely a factor of the cultural, social, economic and political environments around the individuals and population groups. Significant progress will therefore not be possible without focus on the role of poverty and related economic inequities and social, cultural and gender aspects in the evolution of the epidemic.

A socio-cultural approach to the delivery of the HIV/AIDS response is necessary to enhance relevance and effectiveness of interventions. A more supportive human environment that relies on peoples' capacity and innovation to understand and respond within their own cultural references and resources as needed. Inevitably there is need for re-thinking and repackaging the response and particularly to focus prevention beyond individual behaviours to address structural challenges and enhance positive social change. Similarly, pursuing development goals cannot be divorced from the construct of the HIV/AIDS response and vice versa. Anticipated positive changes at individual and community level can only be achieved within broader macro level development-oriented changes.

From a gender and socio-cultural perspective therefore, the following actions at policy and programmatic levels are recommended;

- National policy development and development programming should strategically address socio-cultural and economic environments as a foundation for an effective national HIV/AIDS response and development generally.
- Expand and support multisectoral approaches through mainstreaming HIV/AIDS in development programming and contextualized integrated social, economic and health service delivery approaches.
- Programming should focus beyond individual behaviours to enhance social change, systematically exploring the strong influence of societal and cultural factors on HIV/AIDS as a contemporary challenge
- Human rights and gender sensitive approaches are specifically required to enhance focus on the most at risk and vulnerable population groups. Such programming should prioritize male partnerships for shared perspectives on equitable arrangements
- There is need for legal reform to advance positive cultural and socio-economic development. Expedited enactment of the Domestic Relations Bill is crucial as the country implements the new National HIV/AIDS Strategic Plan
- Cultivate and nurture strategic partnerships to explore utilization of and reshaping of societal and cultural norms and resources to contribute to HIV prevention.
- Planning for human resources needs for the HIV/AIDS response and development generally should focus on community resources and leadership for a comprehensive and context specific people-centred approaches
- While learning from global perspectives, policies and programmes should be hinged on locally generated evidence to enhance relevance and appropriateness. Continuous research on the dynamics of the epidemic and the response is required to enhance intervention targeting.

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CHAPTER 3

POPULATIONS IN CONFLICT AND POST CONFLICT SITUATIONS: IMPACT ON GENDER AND DEVELOPMENT

Children in Pabbo IDP Camp, Amuru District

3.0 Introduction

This chapter focuses on armed conflict in Uganda during the last two decades and the impact it has had on gender relations and the development process. Several areas in Uganda have experienced armed conflict of varied magnitude including: the infamous Luwero Triangle[32] in the 1980s; several districts in western Uganda[33] in the 1990s; the north eastern districts[34] during the 1990s; brief stint in West Nile in the late 1980s[35], and the more than 20-year armed conflict in northern Uganda[36] since 1986. The negative impact of war in the above mentioned areas notwithstanding, the discussion in this chapter focuses on the conflict in northern Uganda, not least because it has been the longest armed conflict with possibly the worst impact on gender and development. The chapter is about people caught up in situations of armed conflict and post conflict and the impact of these phenomena on gender and development. It should be stressed that whereas men and women, boys and girls have experienced the effects of the 22-year old war in northern Uganda, the experiences have been gendered; they have been felt and responded to differently by men and women. Similarly, even as the populations are

[32] *Districts covering the Triangle included Luwero, Mpigi, Mukono, Nakaseke, Kiboga, Mubende, Mityana, Nakasongola and Kampala. The conflict was between the national Resistance Army/Movement (NRA/M) and the Uganda government.*
[33] *The districts included Bunidbugyo, Kasese, Kamwenge, Kabarole, Kibaale, Hoima, Kyenjojo, etc. The armed conflict was staged by the Allied Democratic Forces (ADF) against the Uganda government*
[34] *Budaka, Pallisa, Soroti, Katakwi.*
[35] *In Aringa County (Aringa district)*
[36] *The districts affected by the conflict include Apac, Amuru, Gulu, Kitgum, Lira and Pader.*

returning to their original homes (or to new ones) they have had gender-specific needs that must be addressed.

Gender is a social construct variable, which stipulates the societal roles for men and women, how they are perceived and valued and their culturally prescribed entitlements. The argument the chapter seeks to make is that the socio-cultural gender pattern in Uganda yields to gender inequality and retards development. Addressing gender in the development process is therefore crucial for gender equality and equitable development. The chapter further recognizes that women in Uganda, like anywhere in sub Sahara Africa occupy a subordinate status relative to their counterparts the men. The low status compounded by patriarchy, in which men are the sole decision makers makes access to resources problematic. This chapter attempts to analyze the impact of the armed conflict on the populations (with the major focus on women) and the repercussion on gender and development and proposes some recommendations.

3.1 The Legal and Policy Framework for Populations in Conflict and Post Conflict

Like with any individual in a non conflict setting, the fundamental rights of populations in conflict situations are inherent and not granted by the State. Their rights and freedoms are enshrined in the Constitution of the Republic of Uganda. The ongoing civil strife in northern Uganda has been of concern to Uganda government to the extent that a new pillar, 'Security, Conflict Resolution and Disaster Management' has been included in the Poverty Eradication Action Plan (PEAP) (2004/5-2007/8) to address the effects of disasters, crises and emergencies on the vulnerable populations. The PEAP notes that nationally over 5% of the population has been displaced and the effects on poverty spread beyond the distress suffered by the displaced. It further recognizes that the widening inequality since 1997 and the increase in poverty since 2000 are partly the result of persistent insecurity in parts of the Northern and Eastern Uganda. Other policies which recognize the vulnerability of people in conflict areas include, among others; the National Policy for Internally Displaced Persons (2004), the Orphan and Vulnerable Children Policy and the National Population Policy for Transformation and Sustainable Development (2008), Persons with Disability Policy (2006), The Uganda Gender Policy (2007), the Disaster Preparedness and Management Policy Framework (draft) (1999).

There are programmes and projects which have been developed to deliberately target the population in conflict areas. They include the Northern Uganda Social Action Fund (NUSAF) and Northern Rehabilitation Programme, World Bank-funded government projects aimed at eradicating poverty and reducing regional inequalities in war affected districts in Uganda. Nevertheless, the implementation of NUSAF has coincided with the return and reintegration phase. It will be crucial that monitoring and evaluation, from a gender perspective be undertaken to establish their gendered impact on poverty eradication.

The recently launched Peace Recovery and Development Plan (PRDP) (GoU, 2007) for Northern Uganda is a three year plan aimed at empowering and rebuilding northern Uganda. It seeks to contribute to community recovery, improve the conditions and quality of life of the displaced persons and reintegration of displaced population[37]. While the stated objectives for the PRDP are oriented to poverty eradication, a closer gender analysis shows that in most cases gender was ignored in the formulation of the plan.[38] For instance, women have had minimal or no involvement in the peace talks at the national level. Government of Uganda has facilitated some women and male Members of Parliament (MPs) hailing from northern Uganda enabling them to attend peace talks as observers in Juba. This was after some concerns about the lack of women involvement in the peace talks from several corners. This was amidst the UNSC Resolution 1325 (to which Uganda is a party) that states categorically the crucial importance of the participation of women in peace processes.

[37] *Minister David Wakinona see The New Vision Friday, July 18, 2008*
[38] *" Gender perspective on the PRDP in North and North Eastern Uganda" Paper presented to Deniva workshop, 27 February 2008 at Lira Hotel by Deborah Mulumba*

In addition, several UN agencies have supplemented government effort in the protection and provision care and support to people maintenance role during the emergency and post emergency phases and now in post conflict areas. They have also contributed towards the peace process. They include, inter alia, UNDP, UNFPA, WFP, UNHCR and UNIFEM. It should be noted that UNFPA and UNIFEM in particular have focused on the reproductive health and other rights of women in crisis situations and have supported the UNSC Resolution 1325, which addresses the impact of war on women, women's contribution to conflict resolution and sustainable peace.

Others constitute international and national organizations, such as Save the Children, OXFAM, Action Aid, ACCORD, Samaritan Purse, Action against Hunger, World Vision and Reproductive Health Uganda. The organizations, apart from funding government directly as in the case of the UN agencies, have implemented projects aimed at basic survival needs, capacity building, skills training, reproductive health, human rights, peace reconciliation, reintegration of abducted children and income generation. There are also local non-governmental organizations (NGOs) and community based organizations (CBOs), such as Gulu Save the Children Organization (GUSCO) and Concerned Parents that have played an instrumental role in providing psycho-social counseling to formerly abducted children. The faith based organizations mainly the Christian Churches and the Muslims have provided spiritual guidance (and at times advocacy), thus maintaining a certain level of sanity of the populace.

3.2 The Effects of War in General

One of the major consequences of the armed conflict in Northern Uganda (and elsewhere) has been displacement of people. When people are forced to flee, they not only lose their land, which is about the only viable means of livelihood, but also lose social networks. Their dependency on the ecosystem is hampered with as well. While the encampment of people was a government strategy to curb the insurgency and minimize the rebel activity, life in camps was characterized by congestion, disease, gender based violence, and dependency on relief. Nevertheless, there are many people from the war affected districts in the north who opted to seek refuge in other parts of Uganda, such as Bweyale in Masindi, Kampala, the surrounding and more secure districts, the urban areas and even beyond borders.

For the most part of the last twenty-two years (1986-2008), districts in Northern and North Eastern Uganda have had to grapple with the effects of gender based violence which has caused untold suffering including serious effects on the sexual and reproductive health of the population, such as sexually transmitted infections and HIV/AIDS (UNFPA, 2006). The consequences of the violence with its ramifications have had a retarding effect with regards to human development.

Armed conflict causes disruption, not only in people's life style, but also in the social services delivery system. Similarly, in Northern Uganda, the social services delivery system including, health, education, etc, has suffered the inadequacy of human resource and dilapidated infrastructure. Besides Clinical Officers have held the mantle of health service provision in war affected northern Uganda[39], it has been difficult to recruit and retain doctors, nurses, midwives and other Para medics in the health sector in northern Uganda. The health service in Gulu operates at 50 per cent of qualified staffing levels. As a result, it is not possible to keep many health units open on a continuous basis.

Women, girls and children in northern Uganda have been susceptible and vulnerable to violent attacks because they have lacked institutional safe guards. For instance, women body parts were mutilated as punishment by LRA[40]. Reports abound in Uganda where women were gang raped in Luwero Triangle war (Isis/WICCE, 1999). A recent study (MoH, 2007) established that in addition to rampant violence against women and girls, girls sold sex for money due to extreme poverty.

Conflicts typically cause significant demographic changes such as loss of men killed in combat, migration from rural to urban areas, large cohorts of orphaned and vulnerable youth and elderly survivors, and loss of talent to other nations. Each demographic change has gender ramifications,

[39] *Personal communication with Dr Peter, DDHS for Lira*
[40] *See the New Vision, 15 October 2006*

including increased female –male ratios in communities and economies, increased numbers of female headed households, more women familiar with agricultural production (for example in Eritrea, Namibia and Rwanda). In the case of northern Uganda, an ongoing study[41] has established the existence of unaccompanied children in Pader district with absolutely no care. In addition, although many households were headed by males, women ended up doing every thing to ensure the survival of households.

Without alluding to the people who opted for non camp setting, statistics show that there have been approximately 1.5 million IDPs (see Table 2) in camps in northern Uganda. However, the statistics are not gender disaggregated; it is therefore difficult to know the number of male and female IDPS in camps. Other writers have argued that there are more female headed households in conflict settings because most of the men have fled to urban areas, been killed or conscripted by the warring factions. However, there is evidence that during the past several years, the majority of households in northern Uganda are headed by men. It is likely that the above statistics did not include the IDPs in camps. Moreover, it is also not clear from Table 3 whether child-headed households were included. A recent study[42], established that child headed households as well as unaccompanied children exist in the several war ravaged districts.

Table 2: IDP Camps indicating population sizes in Northern Uganda

Districts	Total number of IDP camps	Total persons	Total households
Lira	42	351,020	70,455[43]
Pader	31	349,538	n.a
Kitgum	21	331,167	n.a
Apac	18	107,130	n.a
Gulu	52	460,226	118,338
	164	1,599,081	

Source: World Food Program Food distribution lists (September 2005-May 2006)

Table 3: Percentage of Household Headship by Residence, Sex and Region 2002

Residence	1997		1999/00		2002/03	
	Male	Female	Male	Female	Male	Female
Total	**72.7**	**27.3**	**72.9**	**26.4**	**73.9**	**26.1**
Rural	73.3	26.7	73.6	31.1	76.0	24.0
Urban	72.7	30.7	68.9	27.1	64.1	35.9
Central	70.9	29.1	70.7	29.3	70.8	29.1
Eastern	75.5	24.5	75.8	24.2	77.3	22.7
Northern	76.9	23.1	65.4	34.6	68.6	31.4
Western	66.5	33.5	78.4	21.6	78.3	21.7

Source: Uganda National Household Survey, 2002/3

[41] *Ongoing study on micro analysis of violent conflict funded by the European Union through IDS.*
[42] *EU funded study on analysis of violent conflict*
[43] *Source: WFP Lira and Gulu Office food lists*

3.3 Social, Health and Economic Indicators

The disruption in health service delivery in northern Uganda has resulted into poor social and health indices. Reports of the flight of qualified health providers abound. According to the Human Development Index (2004) acute malnutrition rate was in the range of 7% to 21%. While malnutrition is most noticeable in children, it was also observed in adults. Weeks (2001) reported that half the children were stunted and one third wasted. For Pader district, total fertility rate (TFR) at 7.4 and the growth rate of 4.6% (Uganda's national being 3.4%) (UBOS, 2007) are the highest in the country.

While nationally the maternal mortality rate (MMR) has reduced from 505 per 100,000 live births (UDHS, 2000/1) to 435 deaths (UDHS, 2006/7), it is believed that MMR is higher in conflict affected districts. While the infant mortality is 88 per 1000 live births (UDHS, 2007), it is widely acknowledged that the rate could be higher for northern Uganda (although there are no statistics to back this assertion).

According to UNFPA (2007) the literacy rate in the district of Gulu is 64.6 per cent. (Female literacy rate is 38.2 while male was 61.6 per cent). This revelation indicates a gender gap in access to education opportunities (see table 4). Life expectancy (2007) was 43.7 years (females 42.2 years, males 45.2 years) (Source: Population Survey, 2005), 48 per cent of the population is under 15 years showing a very dependent population. In Karamoja, 67 per cent of girls are illiterate, while 35 per cent of boys have had formal education. The drop out rate has remained high especially for girls. In primary schools, 54 per cent of boys and 69 per cent of girls drop out of schools against the national statistics of 17 for boys and 35 for girls. This means that only 46 per cent of boys and 31 per cent of girls in war affected districts in northern Uganda complete primary school.

Table 4: Selected Social Indicators for Gulu District 2005

Indicators	Females	Males
Life expectancy	45.2%	42.2%
Literacy rate	38.20%	61.60%
Illiteracy rate	35%	17 %
Drop out rate (primary)	69%	54 %

Source: 1. UNFPA, 2007
2. Population Survey 2005, UBOS (published in the New Vision June 11 2008)

3.4 Health Status

One of the guiding principles of the National Health Policy and the Health Sector Strategic Plan (HSSP) II is to strengthen attention to gender concerns in the health sector and establish effective affirmative action for the attainment of health equity to the vulnerable groups including women, children under five, the poorest quartile of the population, IDPs, orphans and persons with disablity (PWD) (MOH, 2005:11).

Ill health amongst the communities in conflict and post conflict situations poses a challenge to seeking health care. It is compounded by the high poverty levels in the North (60 percent, PEAP, 2004/05), which are higher than elsewhere in the country. This makes it difficult for the communities, particularly women to seek health care. In a recently concluded study, patients[44] complained of lack of availability of medicines at government health units. A study by UNFPA in 2006 established the existence of drug stock out in several health units in war affected districts of northern Uganda.

3.5 Women and Poverty

During the 1990s income poverty fell dramatically from 56% in 1992 to 44% in 1997/08 and even faster to 34% in 2000 (PEAP, 2004). However, since 2000, the trends have been less encouraging with an increase in income poverty from 34% to 38% (UBOS, 2003) and to the current 31% (The Republic of

[44] *As majority of patients constituted children, their mothers had the duty to look for the medicine.*

Uganda, 2008). A gender analysis of the National Household Study (2003) revealed that poverty affects more women than men in the rural areas, especially in the war-ravaged north. Nevertheless, households headed by widows were consistently poorer than others, and households headed by married women (probably mostly married to polygamous or absent husbands) are poorer than other households.

Another factor which is contributing to persistent poverty is high fertility which results from among others preference for large families and negative attitudes to contraception control. Although the national TFR is 6.7 (UDHS, 2006) (itself already high), districts particularly in war ravaged areas have TFR higher than 7.4 (UBOS, 2002; Donor News, 2003). The high TFR contributes to a high population density, a situation likely to lead to land tenure insecurity for many women even in areas, such as the north where land is communally owned. Given the fact that almost 70% of Ugandans are rural based, the issue of land ownership is paramount. Reports abound on rampant abuse of women land rights. In the case where the rights of women, children and people with disability are transgressed (such as has been the case in war affected northern Uganda), many rural based women are likely not to have this information about what to do to seek redress and thus unable to exercise their rights due to their low literacy levels (female-52%; male-77%) (UBoS, 2005).

3.6 Girls' Education

The government of Uganda has in line with Millennium Development Goal 2 has declared its commitment to providing Education for All [EFA] and address the constraints that hinder female participation in schooling (The Republic of Uganda, 1998 and 2005; Children's Statute (1996) and Children Act 2003; and The National Youth Policy, 2001). Subsequently a number of policies and programmes (both equity and gender specific) have been initiated to expand and improve the education of girls. The policies include UPE which has come along with school fees waivers, provision of bursaries, and abolition of school uniform, flexible timetabling (in pastoral communities). Other initiatives include affirmative action, setting minimum age at marriage, sanitation programme, recruitment of female teachers, special needs education, support to private education provision, establishment of the gender unit/committee and development of the National Strategy for Girls Education [NSGE] (MGLSD, 2004; MOES, 2005, The Republic of Uganda, 2005).

The introduction of Universal Primary Education (UPE) in 1997 saw a drastic increase in the Gross Enrolment Ratio (GER) for both boys and girls from 3.4 million to 7.4 million with a slight decline[45] in 2004, leading to narrowing of the absolute gender gap[46] from 24.8% 1997 to 6.16 in 2004 (MOES, Statistical abstracts, 1997, 2004). Although access to schooling at secondary education level is still limited for both boys and girls (Gross Intake ratio: 35.9% male and 27.4% female), it has expanded over the years.

It is worth noting that the northern region has the highest percentages of males and females with no education (17 % and 35 % respectively) (UDHS, 2006: 23). Slightly more than one in four females (28%) in the IDP camps have no education while about one in ten males (9 per cent) have no education. In the Karamoja sub-region, two of three females (67%) and more than half the males (53%) have no education. An analysis of several schools in almost all districts in northern Uganda shows marked gender differentials in favour of boys between P5-P7 (MoES, 2004 Abstract).

The statistics for most of the districts in northern and north-western Uganda[47] show marked gender disparities in school attendance (MoES, 2004). While more boys than girls repeat P.6, P.7, S4[48] and S6[49], girls' repetition rates are higher in lower classes (MoES, 1997- 2002). The Constraining factors include the protracted armed conflict in northern Uganda, pregnancy, early marriage, poor sanitation facilities, poor management of sexual maturation especially menstruation and cost of education

[45] *Decline attributed to decline the population of children outside the 6-12 years bracket (underage and overage (MOES, 2005)*
[46] *Absolute gender gap = male enrolment rate – female enrolment rate. It indicates how many more girls need to be educated in order to achieve equality (parity) between the sexes.*
[47] *Gulu, Apac, Kitgum, Lira, Masindi, Moyo, Nebbi and Yumbe*
[48] *The fourth year of secondary education (senior four)*
[49] *The sixth year of secondary education (senior six)*

(MFPED, 2004; MGLSD, 2004; Mulumba, 2005). Other factors include gender stereotyping in education curriculum and teaching materials, lack of systematic policies to address specific gender concerns in education (an education gender policy), poor monitoring and evaluation of gender related outcomes, lack of gender responsive budgeting and weak gender focal points (EASSI, 2006).

3.7 Sexual and other forms of Violence against Women

Sexual violence is not a function of the general breakdown of law and order, but there is evidence from many conflicts that systematic rape and sexual abuse have been used as part of a strategy to demoralize the community under threat (Greenberg, 2001b). Moreover the vulnerability and hopelessness of women and girls in these situations exposes them to sexual encounters (Bouta and Frerks, 2002:34) which may not necessarily be violent but in which they get infected with STDs and HIV/AIDS. According to UNIFEM/UNDP report (2005; 2006), the war in northern Uganda has been responsible for most of the poverty and moral degeneration[50]. Sex has become a commodity and in many areas the only people with money are the soldiers. Rape, particularly by government soldiers (but also by rebels) is common and has gone largely unpunished.

Isis/WICCE (1989; 2004) undertook studies to document the effects of the conflict on women in Luwero Triangle and Gulu district. The findings reveal that there has been severe repercussion of the war on women and girls. Sexual and gender based violence escalated; many women and girls were raped, forcedly impregnated and many were infected with sexually transmitted infections (STIs). In addition, because of the insecurity that reigned, pregnant women could not access maternity centres and ended up delivering unassisted something that caused perineal tears and fistula. Many such women had to undergo vaginal and fistulae repairs after the war. Although fistulae are not war specific, it can be argued that they can be worsened by the poor health services during war. Fistula can also result from sexual assault. This condition has both health and psycho-social implications. Women with this condition may usually have no access to care to repair the fistula. They are stigmatized by society and often abandoned by their spouses. According to the UDHS it (2006:134), the proportions of women in central 1, north and western regions and in IDP camps who report fistula are higher than the national average.

The scare of violence and assault to be violated led to night commuting, a situation involving girls and boys leaving their rural homes and moving to verandahs in towns for 'safety'. A report by a New York – based Women's Commission for Refugee Women and Children (WCRWC) revealed that the ''night commuter girls and women had reported that those sexually abusing and harassing them were mainly youth and government soldiers. Young night commuters also faced an increased risk of HIV/AIDS and unwanted pregnancy as a result of sexual violence or unprotected sex''[51].

A study by UNDP and UNIFEM (2006-06) on sexual and gender based violence (SGBV) intervention among the internally displaced persons in the camps within the conflict affected districts of Acholi and Lango sub-regions of Northern Uganda established that that SGBV occurred on a daily basis. In addition, there was a culture of impunity regarding certain forms of SGBV which were culturally accepted and not understood to constitute any violation of the rights of women and girls. There are no comprehensive measures to prevent SGBV from occurring, nor to support and protect groups vulnerable to SGBV.

It is further noted that during conflict, besides armed groups, women and girls experience violence at the hands of many others. Women are physically and economically forced or left with little choice to become sex workers or to exchange sex for food, shelter, safe passage or other needs; their bodies become part of a barter system, a form of exchange that buys the necessities of life (Bouta and Frerks, 2002). Recent study on SGBV (MoH, 2007) in northern Uganda revealed that girls were willing to risk their bodies than die of hunger.

[50] *For further analysis see also The MoH Report on Sexual and Gender Based Violence in northern Uganda (2007)*
[51] *The New Vision, January 29, 2004*

Another form of violence has been the injury resulting from gunshots and land mines. There were several injuries sustained during the LRA insurgency with gender implications. For instance, men and women are victims of land mines and gunshots. However, the specific gender roles in society require that women who are responsible for the reproductive and productive roles for the survival of their households be assisted to acquire artificial limbs. It is necessary that reintegration occurs in landmine free zone and that efforts are undertaken to provide artificial prosthesis for the disabled

3.8 HIV/AIDS

The health impact of sexual violence can be disastrous, with HIV/AIDS among the physical consequences. Most of the studies on sexual violence and conflict have however not specifically focused on women's particular vulnerability to HIV/AIDS in the context of conflict, and, as a result, HIV rates among sexual violence victims are not known. What is clear though is the fact that the HIV prevalence rate in war affected areas at 12 per cent is higher than the national prevalence rate at 6.4%[52], which calls for specific measures in the post conflict phase to address the prevention of HIV/AIDS. Transmission is influenced by a complex set of social factors, including *inter alia* gender inequalities, and levels of commercial or 'survival' sex. Although many countries with high infection rates have not been to war, there is evidence that conflict situations exacerbate the epidemic (UN, 2000).

Factors that contribute to the spread of HIV/AIDS in conflict situations, with particular gender dimensions, focus include sexual and gender- based violence; breakdown in social and community structures; lack of physical and legal protection; lack of health infrastructure; lack of education and skills training; poverty, forced sex of the para-military, combatants.

In war affected districts of northern Uganda, armed conflict rendered regular HIV surveillance impossible as many parts were virtually cut off from public health services. Data about sero prevalence rates in the Acholi sub region is available at St Mary's Hosptial Lacor, in the outskirts of Gulu Town. However, as peace has gradually continued to return to northern Uganda, the government health units and NGOs, such as Marie Stopes have also continued to implement HIV- related programmes. A recent study, (UNFPA, 2006) established an over concentration of HIV NGOs to the detriment of other reproductive health conditions.

3.9 Orphans and Vulnerable Children

The contributing factors to orphan hood are many; however, two are being singled out in this paper, namely, war and HIV/AIDS. Since the early 1980s, Uganda has had to grapple with the HIV/AIDS scourge in which tens of thousands of people have died. It is worth noting that the majority who have died have been those in their child bearing age leaving their children as orphans to be catered for by their ageing grand parents. In addition, while many Ugandans have enjoyed relative peace during the last twenty years, for the people in war affected areas in Uganda, peace has been elusive due to the more than twenty-two year old protracted conflict in northern and north-eastern Uganda. As the social services delivery and social support systems get disrupted in the conflict zones compounded with increased morbidity and mortality, it is the most vulnerable categories of the population, the women and their children including the orphans who bear the brunt of the conflict and are most exploited with regards to sexual abuse and the exacerbation of HIV/AIDS and sexually transmitted infections (STI).

Although the phenomenon of orphans is not new in Uganda, their increasing numbers raise specific concern and the problem this poses in a developing country, such as Uganda with limited resources and a weakening social support structure caused by the HIV/AIDS pandemic. While it is a fact that the childbearing age group (15-49) has been hit most by the HIV/AIDS (GoU/UIC, 2004), leading to deaths or incapacitation, girls in their early teens in conflict affected areas have been infected with HIV/AIDS resulting mainly from early indulgence in sex and/or sexual and gender based violence (rape) in which they have been infected (UNICEF, 2005).

[52] *Although there are disturbing reports that the rates are rising.*

3.10 Children and Armed Conflict

Children like adults have suffered the brunt of the war in northern Uganda. Pickup *et al* (2001) point to the large number of children that are increasingly being recruited into armies as combatants in countries such as Angola, Ethiopia, Liberia, Mozambique, Sierra Leone, Sudan and Uganda. At least 300,000 children under the age of eighteen are taking part in hostilities around the world. Girls are recruited although in smaller numbers than boys – and used as cooks or concubines. Machel (2001) documented how children have greatly been affected by war. Her study revealed that hundreds of thousands of children under 18 were made part of government armies, rebel forces and paramilitary and militia groups. Girls who become child soldiers were frequently subjected to rape and other forms of abuse. Children have been kidnapped by the LRA; they have been used for sexual services, as combatants, messengers, porters and cooks. It is estimated that approximately 20,000 children have been kidnapped by the LRA: in fact the UN Secretary General has called upon the LRA to surrender the women and children[53]. In addition several non governmental organizations, such as World Vision, GUSCO and Concerned Parents are involved in the reintegration of formerly abducted children. It is quite likely that during such activities the children especially girl children get exposed to unwanted pregnancies, sexually transmitted infections and HIV/AIDS. In addition to the physical and sexual related injury, children were exposed to high degree of psychosocial wounding (GoU and UNICEF, 1998), which calls for psychosocial interventions.

Children have been the victims not only of sexual violence but also of serious physical injuries. The violations of the children's rights in northern Uganda have been depicted widely in the local and foreign media. The BBC has disseminated such information occasionally (Will Cross of the BBC). For instance, the LRA rebels have been accused of murdering civilians, mutilating survivors, and abducting children who later become soldiers and sex slaves[54].

3.11 People with Disability

As with any population, people with disabilities do exist in conflict affected districts and internally displaced persons (IDP) camps. The major challenges of the people with disability (PWD) (UNFPA, 2006[55]) consist some of the following:

- Violence against girls with disability: a recent study, UNFPA (2006) established that the girls suffer from STIs and do not get access to counselling and treatment because they are always at home. They are easily taken advantage of because of their status. Taking care of them is hard and most parents ignore them when they are sick.
- Stigma: the girls complained about the stigma that is attached to being disabled during which they are called all sorts of names. Boys with disability complained that it was difficult for them to become parents because women ignore and reject them. In some IDP camps, parents were reported not to take their disabled girls to health centres when they are sick because they considered them useless; many parents were reported not to take their disabled girls to school.
- Poverty: survival is difficult for the disabled, as they cannot engage in income generating activities.
- Lack of user friendly services: in Opiri in Amolater, the school has user-friendly services for the deaf who are taught in sign language; despite this there are many disabilities, such as blindness, paralysis, Spina Bifida, etc., that do not receive attention. In Pader for instance, discussions revealed that the girls with disabilities face poor hygiene because they do not have user friendly services e.g. toilets. In Gulu the girls with disability were found not to have access to facilities like walking sticks and wheel chairs. This hindered their mobility especially to the toilets and bathroom areas.

[53] *The BBC 27 June 2008 'Africa News'*
[54] *Daily Monitor, 24 July 2006*
[55] *UNFPA, 2006*

- Problems with accessing services: when PWDs get sick, they cannot easily go to health units because of lack of transport, which is a big constraint. In addition, due to the limited number of health workers in the camps, it is not possible for health care service to be taken to people with disability. Instead the health care workers expect the PWD to access the health units for treatment, something they cannot do with ease.
- Lack of professional personnel: the needs of PWD were difficult to manage due to the lack of trained personnel. For instance there is only one person in the entire Apac district who was qualified to deal with the health of disabled persons, but that this person did not have any transport means to take service to persons with disability.
- Poor hygiene facilities for girls: there are no friendly facilities in the IDP camps and schools. The girls with disabilities complained of unhygienic toilet facilities; which were also difficult to use as they were meant for 'normal' boys and girls. The causes of disability were several and included land mines, gunshots, accidents in gardens, car accidents, snake bites, domestic violence, and injections administered poorly at health units, and diseases such as polio. Suggested solutions to needs of PWD included provision of mobility equipment, constructing toilet for them, providing them treatment and exempting them from heavy work at school and at home. There is clearly a need for specific interventions which address the reproductive health needs as well the survival needs for the youth with disability.

3.12 Return and Reintegration

The foregoing is a discussion of armed conflict and its effect on the populations, gender and development. In a nutshell, the IDP camps in northern Uganda characterized by insecurity, restricted livelihoods, food insecurity, breakdown of family and social structures, limited health services including HIV information, limited condom use and VCT services provide a high risk environment which make people more vulnerable. It should be noted that since 2006, with the initiation of the peace talks in Juba, the Government of Uganda has encouraged the IDPs to return to their homes. The process has been more successful in Lira and those districts where the conflict was not so intense. Moreover, those who still feel that their homes could be insecure have been moved to transit camps near their places of origin. Meanwhile the heavily mined areas are being cleared of mines. In addition, relief aid for the communities to resettle and integrate has been distributed. However, it is felt that in order for proper resettlement and reintegration, the following recommendations should be implemented.

3.13 Policy Recommendations

- In as much as there is an IDP Policy, there is need for a post conflict, reconstruction and reintegration policy; much of what is in the PRDP appears not to consider gender.
- There is need for a gendered assessment of needs for proper planning of interventions;
- There is need for gender disaggregated data, where it is missing, in order to have a gendered programmes planning and implementation.
- Ensure that there is a properly worked out mechanism for provision of VCT and ARVs in the new areas of settlement;
- More schools should be constructed (and old ones refurbished) in areas of resettlement and sensitize the community on education especially the girls education.
- The vulnerable groups including formerly abducted boys, orphans and vulnerable children, child mothers, persons with disability (PWD), the aged, single mothers should be specifically targeted for service delivery including education, health and microfinance (where applicable).
- The returning men and women should be helped under clan system (and other means) to acquire land for livelihood.
- The formal and informal institutional mechanisms that deal with violence should be empowered to deal with the various forms of violence in a gendered fashion.

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54. **CHAPTER 4**

ACCESS TO REPRODUCTIVE HEALTH INFORMATION AND SERVICES: TIME FOR A RIGHTS BASED APPROACH

Mothers attending Ante Natal Clinic in Pader District

4.0 Background

4.1 Human Rights and the Right to Health

Since the United Nation's inception in the 1940's, it has established internationally recognized standards for a range of human rights, including the right to health. Converting such treaties into real commitment in areas such as reproductive rights has taken a lot of effort from continued pressure from groups like women's advocates.[i] Several important meetings in the 1990's enabled the creation of a new consensus on reproductive rights and ensure that they are an important focus for health programs and policies around the world. These landmark meetings included:

- The 1993 World Conference on Human Rights in Vienna.
- The 1994 International Conference on Population and Development in Cairo
- The 1995 Fourth World Conference on Women in Beijing

The importance of reproductive rights in terms of meeting international development goals, including the eight Millennium Development Goals, is widely acknowledged by the international community. Reproductive Rights are recognized as valuable ends in themselves, and essential to the enjoyment of other fundamental rights.

4.2 Why a Rights-Based Approach?

A rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and

protecting human rights. Essentially, a rights-based approach integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development.[ii]

Rights-based approaches focus on raising levels of accountability by identifying claim-holders (and their entitlements) and corresponding duty-holders (and their obligations). In this regard, they look both at the positive obligations of duty-holders (to protect, promote and provide) and at their negative obligations (to abstain from violations). They take into account the duties of the full range of relevant actors, including individuals, States, local organizations and authorities, private companies, aid donors and international institutions.[ii]

While every human being is entitled to the highest attainable standard of health, it is not imperative that poor governments must put in place expensive health services for which they lack resources. However, by adopting a rights-based approach to health, governments undertake to put in place policies and action plans that will lead to available and accessible health care for all in the shortest possible time. This includes access to health related information on preventive and health promoting behaviours as well as how to access health services.

4.3 Reproductive Rights

The right to maternal and reproductive health is a fundamental component of the right to health. There are three fundamental principles that are key for reproductive health in the context of human rights:[iii]

1. Individuals have the right to control their sexual and reproductive lives and make reproductive decisions without interference or coercion. This principle underpins provision of family planning services as well as efforts to prevent child or coerced marriages, sexual violence, HIV/AIDS and other sexual transmitted diseases as well as to treat reproductive tract infections that cause infertility.
2. The right to non-discrimination and respect for different sexes requires governments to ensure equal access to health care for everyone and to address the unique health needs of women, men and adolescents. The right to non-discrimination implies that reproductive health services should be accessible to all groups, including adolescents, unmarried women, indigenous people and migrants, including refugees. It also implies that services should be available to meet the distinct needs of women and men.
3. Governments are obliged to make comprehensive reproductive health services available and remove barriers to care, in order to fulfil people's rights to life and health. This principle is crucial in reducing maternal mortality, preventing HIV and ending pre-natal sex selection. When they allocate budgets and implement policies, States should address the rights to reproductive health of the most vulnerable women, men and youth.

Most-at-risk populations

The human rights imperative of a rights-based approach means that particular attention is given to discrimination, equality, equity and vulnerable groups. These groups may include women, minorities,

indigenous peoples and prisoners, as well as other groups that are deemed most vulnerable in a given context.

4.4 Reproductive Health Situation of Uganda

Uganda experiences challenges similar to many countries in Africa and the developing world, who struggle to provide basic services to their populations in the face of meagre resources. Therefore, while Uganda is a member of the international community that is obligated to guarantee the rights of its citizens to health, there are still many constraints that she faces in meeting these obligations for the general population, let alone the most-at-risk populations. To illustrate the extent of the challenges in this area, Table 5 below shows the gaps in providing maternal health services. This chapter will deal with the factors that affect access to reproductive health information and services for at-risk populations in Uganda and what can be done to address the gaps.

Table 5: Trends of Selected Maternal Health indicators in Uganda 1995 - 2006

Indicator	1995	2001	2006
Maternal mortality ratio (per 100,000 live births)	527	505	435
Antenatal clinic from skilled attendant (%)	91	92	93
Antenatal clinic 4 times (%)	-	42	47
Births with skilled assistance (%)	38	39	43
Birth in health facility (%)	-	37	41
Post-natal care (%)	-	8	26
Contraceptive prevalence rate (%)	15.4	18.6	24.4

Source: Annual health sector performance report 2006-2007

4.5 Access to RH Services by the Most-at-Risk Populations in Uganda

4.5.1 Persons with Disabilities (PWDs)

In addition to the impacts of physical, mental, intellectual or sensory impairments, persons with disabilities often face stigma, discrimination, violence and poverty. In addition, their sexuality is often ignored and their reproductive rights denied.[iv] Many PWDs do not enjoy the experience of marriage and family life because of stigma and discrimination, as well as lack of access to information and services on sexual and reproductive health.

The Convention on the Rights of Persons with Disabilities declares that States Parties need to ensure that persons with disabilities can decide freely and responsibly on the number and spacing of their children while retaining their fertility on an equal basis with others (Article 23). The rights of disabled people are stipulated in the Ugandan Constitution of 1995 as follows, "Persons with disabilities have a right to respect and human dignity and the state and society shall take appropriate measures to ensure that they realize their full mental and physical potential." The Persons with Disabilities (PWDs) constitutes about 10% of the total population of Uganda.

The reproductive health problems faced by women with disabilities (WWDs) include sexual exploitation, unwanted pregnancy and complications during childbirth. WWDs are vulnerable to sexual violence because many in society believe that WWDs are asexual and thus are free from HIV/AIDS. The statistic that 22% of the WWDs in a 2003 study were raped in their first sexual encounter (Mulindwa, 2003) is a grim one. The same study points out the low usage of preventive measures against sexually transmitted diseases including HIV/AIDS.

PWDs are often left out of reproductive health sensitization and awareness programmes because the providers consider them asexual. Other times, they are unable to access media and service points due to blindness, deafness or long distances that a person with disability in the limbs cannot undertake.[v]

Although Uganda has a disability policy and planning framework, the above scenario points to a dire need for the incorporation of RH services into this policy. Adopting a rights-based approach will ensure that national programmes and planning processes integrate RH access and services for PWDs in equal measure the population without disabilities.

4.5.2 People in Detention

Even when people enter prisons, they retain the majority of their human rights including the right to highest attainable standard of health and security of person.[vi] However, overcrowding in prisons, combined with poor nutrition and inadequate supplies, leads to a situation where HIV infections can spread easily and quickly, especially amongst those engaging, or forced to engage, in male homosexual activities.

The Uganda Prisons Service (UPS) oversees 194 prisons and detention centres. Several measures have been taken to ensure the rights to health of prisoners in Uganda are protected. Uganda Prisons AIDS Control Programme (UPACP) was established in 1993 to reduce the spread of HIV/AIDS and address its effects on the prison community. Many prison inmates that qualify for ARV treatment receive it in Uganda's prisons. In addition, as part of an ongoing Prisons Reform process, there are plans to implement the rights of prisoners by offering them conjugal rights, even though this may take a while to implement due to lack of facilities. This decision, which guarantees prisoners' sexual rights, has been influenced by a new Prisons Act as well as preparations for the set up of a Special Division of High Court to try war criminals in northern Uganda.

Though resource constrained, the UPS continues to work with local and international partners that hold the institution accountable for ensuring the human rights of inmates and improving conditions as much as possible within its limited resources.

4.5.3 Commercial Sex Workers (CSWs)

All over the world, many organizations that are working with commercial sex workers (CSWs) have learned that it is ineffective to provide reproductive health and HIV prevention services to them if they do not consider sex workers' work environments. Stigmatisation fuels discrimination of CSWs and other human rights violations in the form of violence and denial of rights. As in Uganda sex work is illegal and CSWs can be targeted for criminal arrest, it is often forgotten that they also have the human right to life, liberty and security of person. They have the right of equal access to public services like reproductive health services.

Surveillance data on HIV/AIDS from several parts of Uganda suggests that young women under 25 years account for more than 30% of female HIV infections. Many of the commercial sex workers fall in this age group. In April 2008, it was reported that the commercial sex industry is booming along the border between Uganda and Sudan following a recent increase in jobs and commercial trucking.[vii] Rural-urban migration and civil conflict have also led women to engage in prostitution and increased their vulnerability.[viii]

CSWs have often been stigmatized and blamed for "causing" HIV/AIDS and other STDs. They have frequently been identified as "reservoirs of infection" or as "vectors of transmission" to their male partners (clients) and their offspring. This view has denied CSW interventions and services which address these circumstances.

As commercial sex work is a criminal offence in Uganda, it has been left to activists and NGOs to advocate for the rights of CSWs to access RH services. Women at Work International (WAWI) is one such Ugandan NGO founded and supported by a group of leading and celebrated female musicians. The main project objectives are to increase correct and consistent condom use among CSWs with both clients and intimate partners, increase the number of CSWs who access voluntary counselling and testing (VCT) and diagnosis and treatment of STDs, and to increase the number of CSWs who leave the streets for other income generating activities. In 2007, 447 CSWs accessed VCT services and 120 CSWs were recruited by WAWI to be involved in the sale of condoms. Peer educators recorded sales of 72,000 condoms to fellow CSWs and their clients. There is no single, universally agreed rights-based approach to reproductive health access for CSWs, but there are some elements that can be part of such an approach.

4.5.4 Armed Forces

All over the world, the military population is predominantly male, usually young and highly mobile. As a result, they face challenges that can make life stressful. The over-emphasis that the military has traditionally attributed to masculinity, virility, promiscuity, and violence, is often combined with ignorance of sexual and reproductive health issues. All these factors contribute to risky sexual behaviours such as irresponsible sexual practices and in some cases violence against women. It is therefore vital that the armed frces is one of the groups that are specially targeted in the planning of interventions that ensure access to RH information and services.

The Ugandan People's Defence Forces (UPDF) has participated in several programs of RH that are mainly focused on prevention of HIV and STDs. For example, the UPDF mobilized military and civilian communities in the districts of Nakasongola and Masaka during December 2006. Activities included holding educational sessions on HIV prevention, showing related films and staging stop-and-go drama shows for soldiers and neighbouring communities in the army barracks of Kasaagirwa and Air force in Masaka and Nakasongola districts.[ix] The UPDF has also undergone extensive training on HIV/AIDS prevention, clinical care and management, as well as VCT. Soldiers diagnosed with HIV are not excluded from promotion or training and are given treatment and care by the army.[x] While the government has done a commendable job in the provision of RH and HIV/AIDS services in the Army, there are still lots of opportunities to harness the role of this institution as a tool for improving RH outcomes across the wider population, as well as within the institution itself.

4.5.5 Young People

Adolescence is a stage of life often characterised by experimentation and frequent risk taking. Young people in Uganda are vulnerable to sexual and reproductive health problems which include: lack of awareness and lack of correct information about the risks of unwanted pregnancies and STIs, peer and other social pressures, lack of skills needed to resist such pressures and to practice safe behaviour, lack of youth-friendly sexual health and counselling services, poverty, traditional cultural norms that give

young women a low social position, and little power to resist persuasion or coercion into unwanted sex.[xi]

In Uganda, a rights-based approach has been adopted with regards to ensuring that young people have access to RH services and information. The Government has put in place policies aimed at improving the sexual and reproductive health of adolescents. These policies include the National Youth Policy (in draft form); the National Policy on Young People and HIV/AIDS; Adolescent Reproductive Health, the Sexual Reproductive Health Minimum Package, the Affirmative Action Policy, a minimum age of sexual consent policy setting the minimum age for sexual consent at 18, a universal primary education policy, and laws prohibiting harmful customary practices such as early marriage. These policies were geared towards the improvement of adolescents' health and life status and are targeted at addressing adolescent challenges like early pregnancies, STIs and HIV/AIDS.

While there have been positive steps in ensuring the rights of young people to access RH information and services, some gaps still exist:

- Adolescent sexual and reproductive health services and information are still inadequate and not "youth-friendly,"
- Information, education and communication materials on reproductive health for adolescents in the form of videos, posters, leaflets, magazines like *Straight Talk*, and radio programs are available but have not been adequate in terms of quantity, quality and types/choices presented.
- Misinformation, inaccuracies and myths about adolescent sexual and reproductive health still exist and may inhibit positive behaviour change especially with regards to HIV/AIDS.
- Special high risk groups, such as adolescents in refugee camps and internally displaced people's camps, HIV-positive adolescents and street adolescents remain vulnerable and lack services that cater to their needs. Both boys and girls reportedly have multiple partners and there is low acceptance of condoms and contraceptives.

4.5.6 Internally Displaced Persons (IDPs) and Women living in conflict areas

People are displaced from their homes for many reasons, and a number of preventable deaths and illnesses related to reproductive health affect populations in crisis.[xii] In times of upheaval, pregnancy-related deaths and sexual violence soar. Reproductive health services - including prenatal care, assisted delivery, and emergency obstetric care - often become unavailable. Many women lose access to family planning services, exposing them to unwanted pregnancy in perilous conditions.[xiii]

In Uganda's conflict-affected northern region, abuse of alcohol, high unemployment, restricted freedom of movement and a breakdown of traditional social structures and values all contribute to high rates of violence in and around displaced persons camps.

Table 6: IDP Population Distribution in the districts of Northern Uganda

District	Population	Camps	IDPs	Night commuters	% Displaced
Apac	683, 993	16	94,988	NA	14%
Gulu	475,260	42	505,443	18,187	93%
Kitgum	286, 122	18	267, 078	15,711	93%
Lira*	757, 763	43	279,091	NA	37%
Pader	293, 679	30	395,107	NA	93%
Katakwi	-	52	88,623	NA	
Adjumani[1]	-	NA	41,005	NA	27%

*Source: OCHA Gulu, Kitgum, Lira; IOM, *MSF puts the % displaced at 83%*

In February 2007, a team comprising the Women's Commission for Refugee Women and Children and the United Nations Population Fund (UNFPA) conducted a reproductive health assessment among conflict-affected populations in Kitgum and Pader districts of northern Uganda. The high levels of sexual violence that has affected the women and girls caught up in this conflict points to an obvious need for reproductive health services. The team found that while some basic services were in place, many were greatly lacking. The proportion of health units filled by appropriate health staff is very low, and the facilities that do exist are under-staffed. Supplies of essential reproductive health care commodities are erratic, and there is a widespread lack of awareness and information among adults and youth about the importance of reproductive health care and how to access and advocate for services.[xiv]

To ensure access to services for this vulnerable population, the Uganda government is implementing a rights-based approach by putting in place policies and interventions that address their plight. This includes an Emergency Health Plan covering health, nutrition and HIV/AIDS worth over $11million that addresses the health needs of IDP camps as part of the Government efforts to scale up interventions.

In addition, the government of Uganda recently established the National Committee for AIDS in Emergency Settings (NACAES). The objective of the committee is to work with district leaders and other stakeholders to develop a single strategic plan for HIV/AIDS in the North. These interventions should consider several improvements that need to be made on the ground.

4.6 People living with HIV/AIDS (PLWHAs)

PLWHAs are struggling with a substantial number of sexual and reproductive health (SRH) issues, such as repeated requests to disclose their HIV status, HIV discordancy, safe sex strategies to prevent sexually transmitted infections (STI), re-infection, or infecting partners, family planning, pregnancy and gender-based violence.[xv] In addition, stigmatizing and discriminatory attitudes and behaviours of health providers, employers, family members and friends often results in misinformation and in violations of the rights of PLAs.

For a developing country like Uganda, there is competition for budgetary resources with other needs, especially antiretroviral therapy (ART), and the provision of comprehensive SRH care for PLWHAs, can often take low priority. This situation results in a situation where RH services are often restricted to a single focus on pregnancy prevention, omitting the concept of dual protection or counselling on safe parenthood or STI prevention. Providers often recommend condoms only, without thinking about broader contraceptive needs. Providers are also largely unaware of important implications of potential drug interaction between ARVs and hormonal contraceptives which can influence contraceptive decision-making of PLWHAs. A rights-based approach can provide a framework for empowering PLWHAs to seek comprehensive RH services, by enacting policies that improve practices in service delivery.

4.7 Conclusion

Despite limited resources, the Uganda Government has endeavoured to ensure access to reproductive health information and services to its population but still faces challenges in making special consideration for the at-risk populations mentioned in this chapter. Even when policies and legal instruments exist to support the internationally agreed obligations and rights, translating them into action on the ground is not an easy feat to achieve. Many underlying factors that limit the enjoyment of the right to health by the people of Uganda are to do with gender inequality, poverty, insecurity and the HIV/AIDS epidemic. The challenges faced by the health sector include inadequate funding, mismanagement of funds and inadequate human resource.

Even with the above mentioned constraints, the Government of Uganda can use the available human and financial resources to lay a strong foundation for the achievement of its targets in meeting these international obligations. This can be done by putting in place sound policies and effective plans that will create an environment that enables these most-at-risk populations to enjoy their rights to reproductive services. Adopting a rights-based framework will go a long way in ensuring that gains made so far are not lost and will provide a mechanism for tracking progress and building upon achievements. In addition, catering to the special needs of the most-at-risk groups has a cascading positive effect on the reproductive health and general health outcomes of the general population.

4.8 Policy Recommendations:

- Representatives of PWDs need to engage more effectively with decision making processes in order to shape good quality responses, including those related to reproductive health.
- Consider the needs of PWDs in sexual and reproductive health policies and strategies, programmes.
- Make information on the sexual and reproductive health of persons with disabilities available to sexual and reproductive health service providers. Include persons with disabilities in the training of service providers.
- Make sexual and reproductive health information and services appropriately accessible to persons with disabilities and their families.

- Train persons with disabilities to become peer educators on sexual and reproductive health for other persons with disabilities.
- Increase resources to Uganda Prisons Services in order reduce overcrowding in prisons. Scale up already existing interventions to improve prisoners' access to adequate reproductive health care, and HIV prevention.
- Ensure adequate RH information and guidance to prisoners prior to their release and provide follow-up care and links to community services.
- Conduct peer-based education on condom use and reduction of violence (i.e. conflict prevention tools) among prisoners and prison staff during incarceration and prior to release.
- Many sex workers cannot fully benefit from the educational programs about HIV/AIDS since they are either illiterate or semi-literate. Therefore, STD and HIV/AIDS interventions among sex workers should include adult and functional literacy.
- Use of peer educators is cost-effective as many of these are often volunteers and are within the reach of the target population. Government can support NGOs like WAWI, which use peer educators.
- Sex workers must have access to comprehensive health care services with an emphasis on quality sexually transmitted infection (STI) treatment. It should also include other sexual and reproductive health services, and access to prevention of mother-to-child transmission (PMTCT) services. Availability of HIV counselling and testing and AIDS care, including antiretroviral therapy is also essential.
- The image of the army as the ultimate masculine institution should be used to promote positive role modelling of positive reproductive health practices, and male involvement in reproductive health.
- The army should continue to work with different organizations specializing in particular aspects of reproductive health to train all levels of personnel and set up teaching teams.
- Negative attitudes towards condom use should be addressed and condoms made freely available and accessible to service men.
- Greater attention should be given to education campaigns about family planning and emergency contraception, particularly among internally displaced men.
- In order to prevent and respond to widespread gender-based violence in the area, leaders should ensure that women and girls have safe access to water, food, fuel, sanitation and income generation opportunities.
- Health care workers must be trained to provide comprehensive clinical care to survivors of rape and sexual abuse, including post-exposure prophylaxis to prevent HIV infection.
- Adolescents need information even before they become sexually active in order to be adequately prepared to make choices protecting their health.
- There is need to scale-up existing services as the demand for adolescent sexual and reproductive health services has continued to remain high for young people.
- There is need for more youth centres that provide important health education and services in a youth-friendly environment.
- Ensure that facilities that provide HIV care and treatments provide RH services as well. ART programs are ideal sites for linking HIV and SRH services including contraception, gynaecological care and screening for gender-based violence.
- Health care providers should be equipped with appropriate counselling skills with regards to the RH needs of PLAs.

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CHAPTER 5

TAKING STOCK OF UGANDA'S RATIFIED CONVENTIONS ON GENDER, CULTURE AND HUMAN RIGHTS FOR POPULATION AND DEVELOPMENT

5.0 Introduction

United Nations Conventions are treaties or agreements which member states commit themselves to be bound first by signing and later by a binding process called ratification. Monitoring implementation of the conventions is done by committees appointed by member states referred to as States Parties.

Human rights[56] derive from the dignity and worth inherent in the human person. That women and men enjoy the same rights and dignity has been reaffirmed by states including Uganda.

Each individual in the population whether a child, female, male, young, old, rich, poor, educated, non educated, able-bodied or disabled, of whatever religion or ethnicity is entitled to some level of dignity. Development plans and policies, therefore, need to take into consideration the composition of the country's population if they are to serve human diginity.

Gender is the relationship between women and men together with the attributes and behaviors"appropriate" to women or men. So culture shapes gender identities and gender relations and shapes the way daily life is lived in the family, wider community and workplace.

Gender defines roles of men and women in communities. In most societies there are clear patterns of "women's work" and "men's work," both in the household and in the wider community and cultural explanations of why this should be so. The patterns and the explanations differ among societies and change over time.

While the specific nature of gender relations varies among societies, the general pattern is that women have less personal autonomy, fewer resources at their disposal, and limited influence over the decision-making processes that shape their societies and their own lives. This pattern of disparity based on gender is both a human rights and a development issue.

Culture is part of the fabric of every society, that shapes the way things are done and peoples' understanding of why things should be what they are. A more comprehensive definition of Culture is that which was adopted at the World Conference on Cultural Policies (Mexico, 1982) and used in day today discussions on culture and development. Culture is the whole complex of distinctive spiritual, material, intellectual and emotional features that characterize a society or a social group. It includes the modes of life, the fundamental rights of the human being, value systems, traditions and beliefs.

There is a strong link between gender, culture and human rights. Culture defines the roles of men and women (gender) and it spills into the entitlements of men and women (the rights of men and women). This is reflected in the characteristics of Uganda's population where by men are more privileged than women in terms of having more access to education, better access and control over resources, in spite of the population of women being more than that of men and women contributing more to production than men.

[56] *Human rights are natural entitlements to a human being by virtual of being human. (They are not given). Human Rights include the Right to life, the right to personal liberty, the right to respect for human dignity and protection from inhuman treatment, the right to protection from slavery, servitude and forced labour, the right to own property, the right to privacy, the right to a fair hearing among others.*

5.1 Major *C*onventions on Culture, Gender and Human Rights that Uganda has ratified:

There are a number of conventions on culture, gender and human rights that Uganda has ratified as a sign of commitment to International Human Rights. Uganda as also taken steps to implement the provisions of the ratified Conventions although it has performed better on some compared to others. Some of the ratified Conventions include the following:

The *Convention on the Rights of the Child (CRC)* ratified by Uganda in 1990. The CRC was made to build upon the Universal Declaration of Human Rights, where it was proclaimed that childhood is entitled to special care and assistance. Another observation was that the child, by reason of his or her physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth. The Convention emphasizes the best interest of the child in all policies and programs meant to benefit children.

The Convention against Torture, and other cruel, Inhuman or Degrading Treatment or Punishment (CAT) ratified by Uganda in 1987. This Convention prohibits the use of severe intentional pain on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing a person with the consent of a public official. This Convention puts obligations upon states parties to put in place measures to prevent acts of torture in their countries.

The *Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)* ratified by Uganda in 1985. It builds upon the principal of the inadmissibility of discrimination and equality in dignity and rights and that everyone is entitled to all the rights and freedoms without distinction of any kind including distinction based on sex. It was made in recognition that in spite of various instruments, discrimination against women continued to exist. It calls for inclusion of the principle of equality of men and women in the national constitutions, adoption of appropriate sanctions prohibiting discrimination of women, abolition of existing laws, regulations, customs and practices that discriminate against women.

The *International Convention on Civil and Political Rights (ICCPR)* 1976 ratified by Uganda in 1995. The principle is to promote the right to self determination (which includes freely determine the political status and freely pursue one's economic, social and cultural development). Other rights guaranteed under this Convention include; the equal right of women and men to the enjoyment of all civil and political rights, the right to life, prohibiting of slavery, prohibiting of forced labour, the right to equality before courts of law, the right to presumption of innocence until proven guilty, the right to privacy, the right to freedom of thought, conscience and religion and the right to freedom of.

The *International Covenant on Economic, Social and Cultural Rights (ICESCR)* 1976 ratified by Uganda in 1987. Rights guaranteed under this Convention include the right to self determination, the equal right of men and women to the enjoyment of all economic, social and cultural rights, the right to work, the right to form and join trade unions, protection of children and young persons from economic and social exploitation, the right to education and the right to take part in ones' cultural life.

Uganda also ratified the United Nations Convention against Corruption (UNCAC) in 2005, which is the first anti-corruption convention that is truly global. The UNCAC takes a comprehensive approach to the corruption problem, as a basis for effectively preventing and combating corruption. This Convention obliges the States parties to implement a wide and detailed range of anti-corruption measures affecting their laws, institutions and practices. These measures aim to promote the prevention, detection and sanctioning of corruption, as well as the international cooperation between states on these matters.[57]

Uganda actively participated in the proceedings of *International Conference on Population and Development (ICPD) in 1994.* ICPD was the first international agreement to explore the crucial link

[57] *The Preamble of the UNCAC 2005*

between gender equality, population and reproductive health. The Conference endorsed a Programme of Action, which emphasizes the integral linkages between population and development and focuses on meeting the needs of individual women and men, rather than on achieving demographic targets. Key issues emphasized in this conference include: empowering women and providing them with more choices through expanded access to education and health services, skill development and employment, and through their full involvement in policy- and decision-making processes at all levels, making family planning universally available by 2015 as part of a broadened approach to reproductive health and rights among others.

The latest Convention that has a bearing on gender, culture and human rights that Uganda has ratified, is the *Convention on the Rights of Persons with Disabilities* ratified on 25th September 2008. This Convention is made in recognition that issues and needs of persons with disabilities had not yet been mainstreamed into strategies for sustainable development. The Convention is made in recognition of protection of the rights of PWDs including those who need more intensive support to overcome barriers to participation in mainstream development. It recognizes that women and girls with disabilities are often at greater risk of both within and outside the home violence, injury or abuse, neglect, or negligent treatment, maltreatment or exploitation. It also focuses on children with disabilities.

5.2 Existing Policies and how they are linked to the Ratified Conventions

Conventions provide standards to be upheld by states parties (member countries), but these standards need to be domesticated to suit the circumstances of the individual countries through laws, policies and action plans. There a number of policies that have been made to domesticate the ratified conventions as will be seen below.

The *Universal Primary Education Policy (UPE),* 1997. Government put in place this policy to fight poverty, reduce discrimination against women, promote equality between men and women, ensure that women and men enjoy the right to economic, social and cultural rights, promote access and control of resources to women, promote the rights of the child, among others. UPE policy provides affirmative action to girls and children with disabilities. The UPE policy also addresses Millennium Development Goal number two; Achieve Universal Primary Education

The *Poverty Eradication Action Plan (PEAP*) was first launched in 1997 as Uganda's over arching planning framework and has since been reviewed after every 5 years. PEAP provide a pillar for National Development Plans which address issues raised in the CEDAW on mainstreaming gender issues in development, girl child education which as emphasized in the UPE Policy and of issues of promotion of reproductive health.

The *Plan for Modernization of Agriculture (PMA*) has also been aimed at fighting poverty. The NAADS component of PMA has emphasized some aspects of gender to ensure that women, who are a critical mass in the production sector, benefit from the Programme. PMA also addresses issues to do with the right to food and issues of nutrition among others.

The *National Gender Policy of 1997:* This policy recognizes gender relations as a development concept. It identifies the social roles and relations of women and men of all ages and how these impact on development. It stipulates that sustainable development necessitates maximum and equal participation of all social groupings in economic, political and social cultural development. This policy is a vivid attempt to implement CEDAW.

Gender Mainstreaming Policy (1985): Earlier on before the National Gender Policy of 1997, Government started with a gender mainstreaming guidelines which were aimed at ensuring that issues of gender cut across all sectors as a means of ensuring that men and women benefit from development.

Other policies with relevance on gender, culture and human rights put in place by government include: *Orphans and Vulnerable Children (OVC) Policy*, Policy on Internally Displaced Persons, Policy on HIV/AIDS and Policy on ART.

5.3 Implementation of some of the Ratified Conventions by Government

As highlighted above, one of the Conventions that Uganda has ratified that is very relevant to Population and Development is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) which Uganda ratified in 1985.

CEDAW's relevance is in its ability to identify the injustice against women who comprise 51% of Uganda's population (Census 2002). After ratifying the Convention on Elimination of all forms of Discrimination against Women (CEDAW) in 1985, Uganda also pledged to implement the Beijing Platform for Action.[58]

To this end, government created a ministry responsible for women called "Ministry of Women in Development" in 1986, to advance the issues of the marginalized. It began as the Ministry of Women in Development but was later changed to the Ministry of Gender and Community Development and now the Ministry of Gender Labour and Social Development (MGLSD). The Ministry coordinates implementation of the National Gender Policy and National Action Plan for the Advancement of Women which identifies the social roles and relations of women and men of all ages and how these impact on development.

The National Action Plan identifies areas of concern for addressing, which include poverty, income generation and economic empowerment; reproductive health and rights; legal framework and decision making; and the girl child education. Another area; violence against women and girls is soon to be added.

The Constitution of the Republic of Uganda was enacted and promulgated in 1995. The Constitution provides for the equality of both men and women and outlaws all practices that impinge on the rights of another person. This domesticates Article 2(a) of CEDAW that provides for the embodiment of the principle of equality of men and women in national constitutions or other appropriate legislation. Uganda Government has realized the need to empower women so as to redress marginalization based on gender, age, disability or any other reason created by history, tradition, or custom for the purpose of redressing imbalances which exist against them. This is clearly provided for under Article 32(1) of the consititution.

At national level, women have participated at the legislative making level (Parliament), as a means of influencing policy and mainstreaming issues of women in development. This operationalises Article 7 of CEDAW that provides for women's participation in the political and public life of their countries.
Uganda has taken positive steps to ensure participation of women representation in the Legislative arm of Government. The current Parliament of Uganda has women Members of Parliament (MPs) in three categories:

(a) County Representatives (14)
(b) Special Interests Representatives

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[58] *The Beijing Platform for Action set out its goals as gender equality, development and peace and constituted an agenda for the empowerment of women. The Beijing Platform for Action identified 12 critical areas of priority to achieve the advancement and empowerment of women. The twelve areas include, Women and poverty; Education and training of women; Women and health, Violence against women, Women and armed conflict; Women and the economy; Women in power and decision Institutional mechanisms for the advancement of women; Human rights of women, Women and the media, Women and the Environment; and The girl child.*

(c) District Women Representatives.[59]

The proportion of women in Parliament is now 30.4% having risen from 18% in 1996. Although Uganda has taken significant steps to increase representation and visibility of women in the public arena, their effectiveness depends on their vigilance to enforce and guard against political manipulation to serve purely political interests of their parties. The biggest challenge is that representation of women in the legislative arm of government alone cannot deal with all imbalances arising from history, culture and traditions; a lot is still needed if this is to be addressed.

Participation of women at the Local Government level is through the Local Government Act 1997 that stipulates that women must occupy 30% of all positions of the Local Council structure while people with disabilities occupy 20% of these positions (a man and woman). These provisions have resulted in a significant increase in the number of women in political decision making at the different levels of the local government (i.e., district councils, sub-county councils, city division councils, municipal councils, municipal division councils and town councils).

However, the active participation of women and people with disabilities to represent their constituencies is still low due to lack of skills in advocacy, lack of enough resources to mobilize them and the continued power and culture structures that promote gender inequalities. Participation of women in local councils rose from 6% in early 1990s to 44% in 2003.

The lack of effective access to and control over important resources by a significant majority of women is also a major challenge to their ability to participate in the decentralized structures. Access to and control of property, credit and cash play a key role in political participation.

5.4 Women and the PEAP

Women issues have been mainstreamed into the Poverty Eradication Action Plan (PEAP) which has been Uganda's overarching Planning framework since 1997.[60]

Issues of women addressed in the PEAP include, girl child education, operationalized by the UPE Policy, promotion of reproductive health (reducing infant Mortality and Maternal Mortality, among others).

PEAP 2004 deals with gender as one of the main cross-cutting issues of development. Among the specific actions planned to address gender inequalities are strengthening women's access to land, addressing gender-based violence through the judicial system, and increasing by 2010 the percentage of safe water and sanitation coverage to 90 percent in both rural and urban areas from 65 percent in urban areas and 55 percent in rural areas. PEAP 2004 calls for the implementation of the National Gender Policy and for the preparation of a Gender Mainstreaming Strategy for Local Governments.

The PEAP also supports initiatives to provide women's greater access to the justice system by tabling a Domestic Relations Bill now in Parliament and the Sexual Offences Bill to Cabinet are some of the initiatives meant to empower women. These Bills are expected to provide an important foundation for addressing issues of improving women's security, especially in relation to access to and control of resources. They will also provide a critical basis for tackling issues related to gender-based violence including sexual violence and spread of HIV/AIDS.

Overall, PEAP has had a positive impact on education. Adult literacy rates have risen from around 50% in 1986 to close to 70% to date; and the gender gap has fallen. National enrolment rates at primary level have increased, while enrolment disparities between rural and urban areas, rich and poor, boys and girls, and between regions have all declined. Since the introduction of UPE in 1997, enrollment has increased from 2.5 million to 7.7 million in 2006 with a 50:50 female/male ratio. Issues that need to be

[59] *Government continues to create new districts. Currently the districts are more than 80 and each district is supposed to be represented by a woman MP.*

[60] *The PEAP is now being transformed into the National Development Plan*

addressed include how to reverse low completion rates, poor quality of education, high teacher absenteeism and other forms of waste.

Government has taken steps to implement actions that promote positive cultural values and practices and addresses practices on marriage, property, inheritance, incorporation of gender equality themes in HIV/AIDS prevention initiatives and the domestic relations bill currently before parliament is yet another endeavor by government to address issues of gender, culture, human rights, population and development. In some cases, culture and religion are misused to deny women fundamental rights and freedoms and to maintain discriminatory laws and practices. The situation is made worse by the fact that most men and women remain unaware of the legal rights of women.

Although there a number of legislations provisions which prohibit discrimination on the basis of sex, a lot still needs to be done to raise awareness of the evils that arise out of the non-observance of women's rights and how it impacts on population and development.

Government has created an enabling environment for NGOs and CSOs involved in the promotion of gender and human rights to play thie roles. Women organizations including ACFODE, FAWE, UWONET have worked closely with the media to make the voices of women heard in addition to being at the forefront of defining gender issues and gender equality strategies.

On the whole, Government, Civil Society Organisations and Development partners have played a vital role in uplifting the profile of gender issues. Although, much has been achieved especially as far as representation of women both at local and national level, a lot still needs to be done if women have to have equal access and control to productive resources. Mainstreaming gender in the PEAP has also played a pivotal role in allocation of resources to gender strategic needs of women.

Nonetheless, there is an important unfinished agenda which will require a greater willingness to tackle some of the more difficult and systemic issues which remain, notably the attitudes and beliefs which continue to prevent many women in many spheres of life from having any effective control over productive resources, including their sexuality and fertility, and that continue to prevent many men from contributing more fully and more effectively to the wellbeing of their households and families.

With all the efforts made in legislation, it is important to note that there is a big gap between the provisions of the law and practice. Laws are either not systematically enforced or there are structural and procedural obstacles, including the lack of gender sensitive enforcement in agencies, making the rights protected inaccessible to the majority of women. Thus, abuses on the rights of women, especially by private individuals remain endemic in spite of the law. This is particularly so in the case of violence against women, inheritance and land rights, and traditional practices harmful to women and girls.

PEAP has been supporting the Northern Uganda Social Action Fund (NUSAF) which is a government initiative of the World Bank, launched in 2003 to run for 5 years. It is aimed at reducing poverty and achieve reconciliation in the 18 districts of Northern sub-regions (West Nile, Acholi, Lango, Teso and Karamoja), which have a combined population of around 6.3 million people.

NUSAF has three components namely Community reconciliation and conflict management; this has supported formerly abducted children and ex-combatants to be re-integrated into society, particularly in Acholi. The second component, the Community Driven Initiatives (CDI) focuses on building small scale infrastructure in health, education, water, sanitation, roads and bridges. The third component Vulnerable Group Support (VGS) that develops income generating activities and provides labour saving technologies, vocational training and psychosocial counseling for vulnerable and disadvantaged groups such as widows, PWDs and those affected by HIV/AIDS, who are often excluded from development projects. These are yet other initiatives by government to address the rights of the marginalized and vulnerable population.

5.5 Convention on the Rights of the Child (CRC) Implementation in Uganda

The Convention on the Rights of the Child (CRC) aims at securing the best interest of the child in whatever is being planned in a country. Judging from Uganda's population statistics where Uganda is predominantly children and youth, the CRC and its attendant protocols is very relevant to population and development. Government of Uganda has expressed commitment to the realization of children's rights by ratifying the Convention on the Rights of the Child (CRC) in 1990. Uganda has also ratified the Optional Protocols on Sale of Children, Child Prostitution and Child Pornography on 19th August October 2002.

Government of Uganda domesticated the CRC in 1996, by enacting a law for children (Children Act (Cap 59), Laws of Uganda). She also ratified the Optional Protocol to the Convention on the CRC in 2002. As a result Administrative Structures and law enforcement mechanisms have been put in place to ease enforcement of Uganda's obligations.

Although government has not fully domesticated the optional protocols to the CRC through a specific law for children, some of the provisions are addressed in the Penal Code, that is the section on sexual offences, specifically prohibiting prostitution and sexual intercourse with a person below the age of 18 years; and to the Media Council Act that mandates the Media Council to monitor exposure of children to pornography. It is expected that Government will soon review the Children Act to consider provisions of the Optional Protocols, so as to comprehensively address the rights of children.

The implementation of this Optional Protocol to the UN Convention on the Rights of the Child in Uganda is a collective effort by the Government, NGOs, donors, and religious organizations. Through the decentralization system of governance, administrative units have been formed at lower levels ranging from Local Council one at the village level to Local Council five at the district level. At all these levels there is a Secretary for Children who is responsible for all issues relating to children. In addition the public service has also provided for two Community Development Assistants at each sub-county to cater for social needs of communities including handling matters of children. At the district level there is Probation and Social Welfare Officer (PSWO). Local Councils therefore have an opportunity to influence planning and budgeting for children at the lower levels up to the district. Attempts have been made to make the district development plans (DDPs) "child-friendly", however, this has not happened throughout the country. A survey carried out by the MoGLSD revealed that only 73% of the districts had integrated childcare and protection activities into the DDPs. Districts still lack the capacity to fully integrate childcare and protection issues into their respective DDPs. The main reasons for this are; inadequate staff (in terms of quality and quantity); inadequate funds; and lack of awareness/appreciation of the issues affecting children by district authorities

Government has also designated Family and Children Courts (FCC) in addition to the Magistrate's Courts in each district. These maintain law and order and provide legal services within reach for communities including children. Currently there is a toll free help line that children faced with abuse can call and solicit for help.

Government works closely with Development partners, NGOs and faith-based organizations to meet the needs of children and these have provided a significant proportion of the resources (financial, material, technical, human and organizational) for the implementation of these treaties. Some of the institutions that have been helpful in the implementation of the Protocol can be identified as below:

Ministry of Gender, Labour and Social Development (MGLSD) through the Department of Children and Youth, Gender and Community Development; the National Council for Children (NCC); Uganda Human Rights Commission which has trained the Police Force and other child advocates on issues that concern child protection and investigating violations of Children's rights;

A *Children and Family Protection Unit (CFPU)* set up in most police stations and these handle cases of child abuse and neglect including those provided by in the Optional Protocol; the Criminal

Investigations Department (CID) with the role to investigate criminal offences such as sexual abuse and exploitation.

In additional, the Children Act Section 13 calls for the establishment of the Family and Children Court (FCC). The court has power to hear criminal cases against a child, except those which carry the maximum death sentence such as murder, defilement and rape; and civil cases related to only applications concerning childcare and protection such as maintenance cases, or parentage cases. Grade II Magistrates in the various districts in Uganda have the jurisdiction to handle cases brought to the FCC. While FCCs are not fully functional in all the districts, plans are underway to institute them in all districts. For cases beyond the FCC, children are tried in ordinary courts and are supposed to be detained in remand homes. Government has not been able to institute functional remand homes in all the districts; however, alternative places have been designated for remand of children in conflict with the law. Functional remand homes exist in Kampala, Kabale, Mbale, Kabarole and Gulu.

Over 70 NGOs working in the field of child rights in Uganda have formed the Uganda Child Rights NGO Network (UCRNN) to uphold rights and responsibilities as set out in the UN Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child and the Uganda's Children Act. This structure and mechanism for NGO co-ordination, needs adequate human and financial resources to effectively perform the requisite co-ordination functions.

Street Children's Desk (SCD): was established having realized that several offences mentioned in the Optional Protocol Article 3 Parag.1 are mostly committed against street children whom the state has a duty to protect according to the Constitution. Uganda has over 10,000 street children in and 85% of these are homeless (Caritas Australia 2001). The Street Children's Desk (SCD) together with the National Street Children Committee in the MGLSD department of Youth and Child Affairs co-ordinate activities of all NGOs working with street children

Uganda has a big problem of Child labour. As such A child Labour Unit and the National Planning Committee on Child Labour, Employment and Industrial Relations has been set up in the Ministry of Gender Labour and Social Development. The Unit and the Committee develop programmes to address the issue of Child labour which includes child prostitution and pornography among the worst forms of Child Labour (WFCL). Pornography is one of the forms of commercial sexual exploitation. Over 64 % of the children involved in prostitution are also engaged in Pornography according to the Ministry of Gender.

Another step in raising the profile of Children issues has been the launching of the *Uganda Parliamentary Forum for Children (UPFC)* on 15th July 2005. The forum has established a number of district policy networks. The UPFC advocates for the protection of children by initiating bills and reviewing legislature in favour of children's rights. Members of Parliament monitor the policies and programmes designed for children.

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CHAPTER 6

THE IMPACT OF CULTURAL BELIEFS AND PRACTICES ON POPULATION AND DEVELOPMENT IN UGANDA

6.0 Introduction

Uganda is comprised of sixty one different ethnic groups. The total population of the minority ethnic groups totals 160,799 (0.7%). These ethnic groups include: the Banyabindi, Banyara, Basongora, Batuku, Batwa, Ik (Teuso), Mening, Mvuba, Nyangia, So (Tepeth), Vonoma, Napore, Jie, Ethur, Napore, Bahehe, Babukusu and Chope (see table 7). Most of these minority ethnic groups are settled in different parts of the country. The focus of this paper will be based on their cultural beliefs and practices as well as the impact of their spatial distribution on development in Uganda.

This article's focus will be based on the Ik (Teuso) of North Eastern and the Batwa of South Western regions of Uganda. The Ik speak Icetot while the Batwa speak the language of the dominant tribes surrounding them. These languages have been a historical development and have been influenced by the neighbouring ethnic groups.

Table 7: Ethinic minorities and their proportion to the Ugandan population

Ethnic Group	Ethnic Population	%age minority	%age of Population
Banyabindi	13,912	8.7	0.06
Banyara	20,612	12.8	0.09
Basongora	10,153	6.3	0.04
Batuku	20,532	12.8	0.09
Batwa	6,705	4.2	0.03
Ik (Teuso)	8,497	5.3	0.04
Lendu	11,155	6.9	0.05
Mening	1,777	1.1	0.01
Mvuba	863	0.5	0.004
Nyangia	332	0.2	0.001
So (Tepeth)	21,527	13.4	0.09
Vonoma	119	0.07	0.001
Napore	330	0.2	0.001
Jie	1,092	0.7	0.005
Ethur	2,342	1.5	0.01
Dodoth	2,545	1.6	0.01
Bahehe	3,358	2.1	0.01
Babukusu	14,961	9.3	0.06
Chope	20,517	12.8	0.09
Total	**160,799**	**100**	**0.692**

Source: UBOS, 2002

The majority of the populations in Uganda live in the rural areas estimated at 88%. Poverty levels currently stand at 31%. Most, if not all, the selected minority ethnic groups live below the poverty line.

6.1 Cultural Practices and Traditions among the Ik and the Batwa

6.1.1 Background

Culture is the sum total of the ways in which a society preserves, identifies, organizes, sustains and expresses itself. Uganda is endowed with a rich and diverse cultural heritage, which includes sixty-five indigenous communities with unique characteristics according to the Government of Uganda[61]. Culture includes intangible and tangible heritage, which is in constant evolution. The tangible heritage includes among others monuments or architecture, art and crafts as well as books. The intangible heritage includes language, oral traditions, performing arts, music, festive events, rituals, knowledge and practices concerning nature.

[61] *Ministry of Gender, Labour and Social Development: The National Culture Policy, 2006*

With over 50 languages recognized in the national constitution, Uganda is a country with a lot of diversity where different communities have respectable norms, cultures, beliefs and practices. This reach of culture diversity poses challenges to development that need solutions.

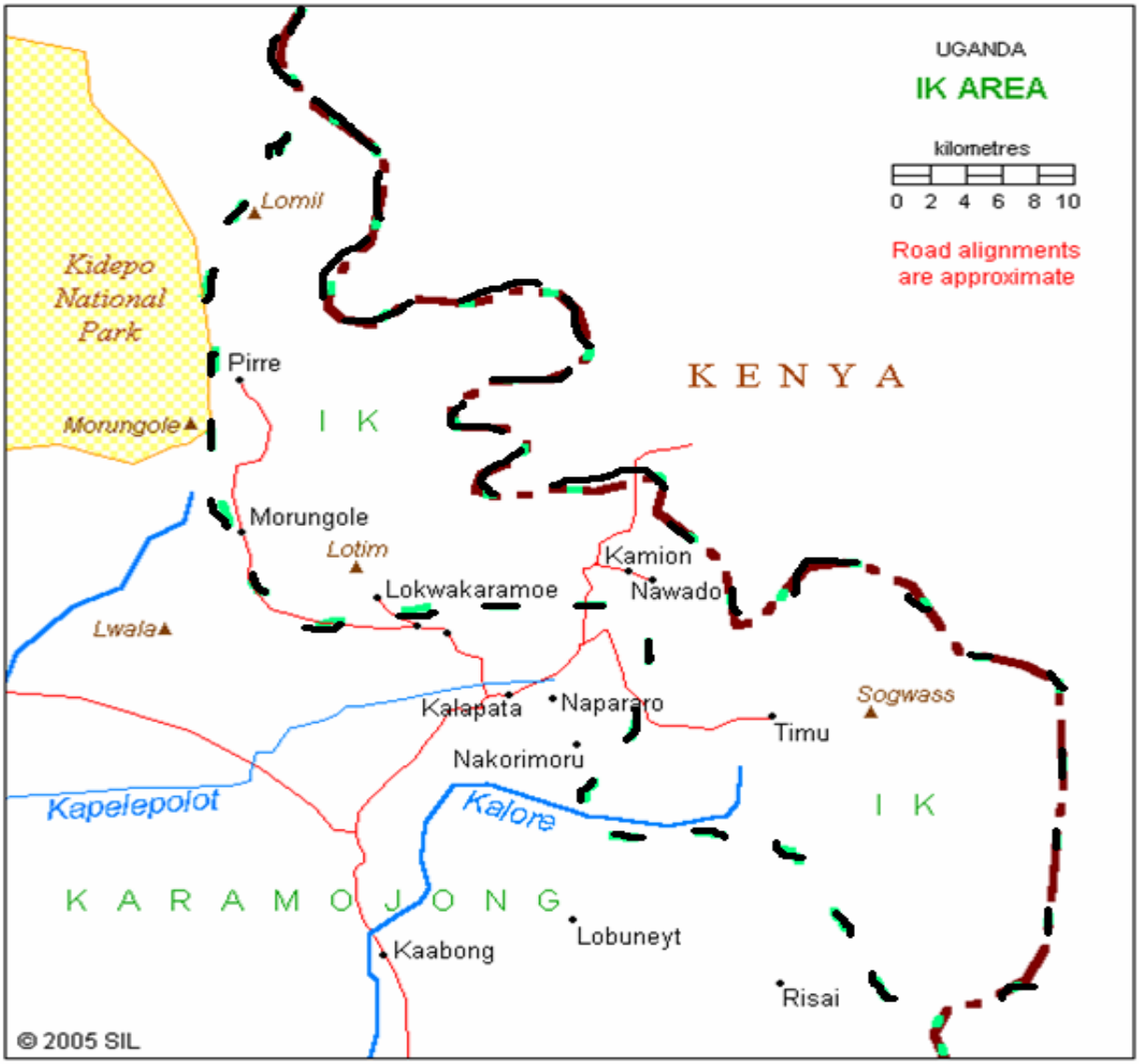
6.1.2 Geographical Location

The Ik live in the northern part of Kaabong District, in Dodoth County, Kalapata and Kathile Sub Counties (see figure 6.1). The Ik villages are scattered on top of a remote mountain escarpment along the Kenyan border between Timu Forest in the South and Kidepo National Park in the North. The Ik are bordered in the north by the Didinga and Toposa of Sudan, in the west and south by the Dodoth (an ethnic subgroup of the Karamojong), and in the east by the Turkana of Kenya.

The Batwa, popularly referred to as pygmies live in Rwanda, Burundi, Uganda and the Democratic Republic of the Congo (DRC) and are estimated to have a population of between 70,000-87,000, according to Minority Rights Group International (2003).The Batwa are said to be closely related to the Bambuti of Mt. Rwenzori.They have been mostly hunter-gatherers, live in the mountainous forests, and some in savannah forests or lake environments. The Batwa do not have traditions of early migration from anywhere. They are believed to have been the earliest inhabitants of East Africa together with the settled life.

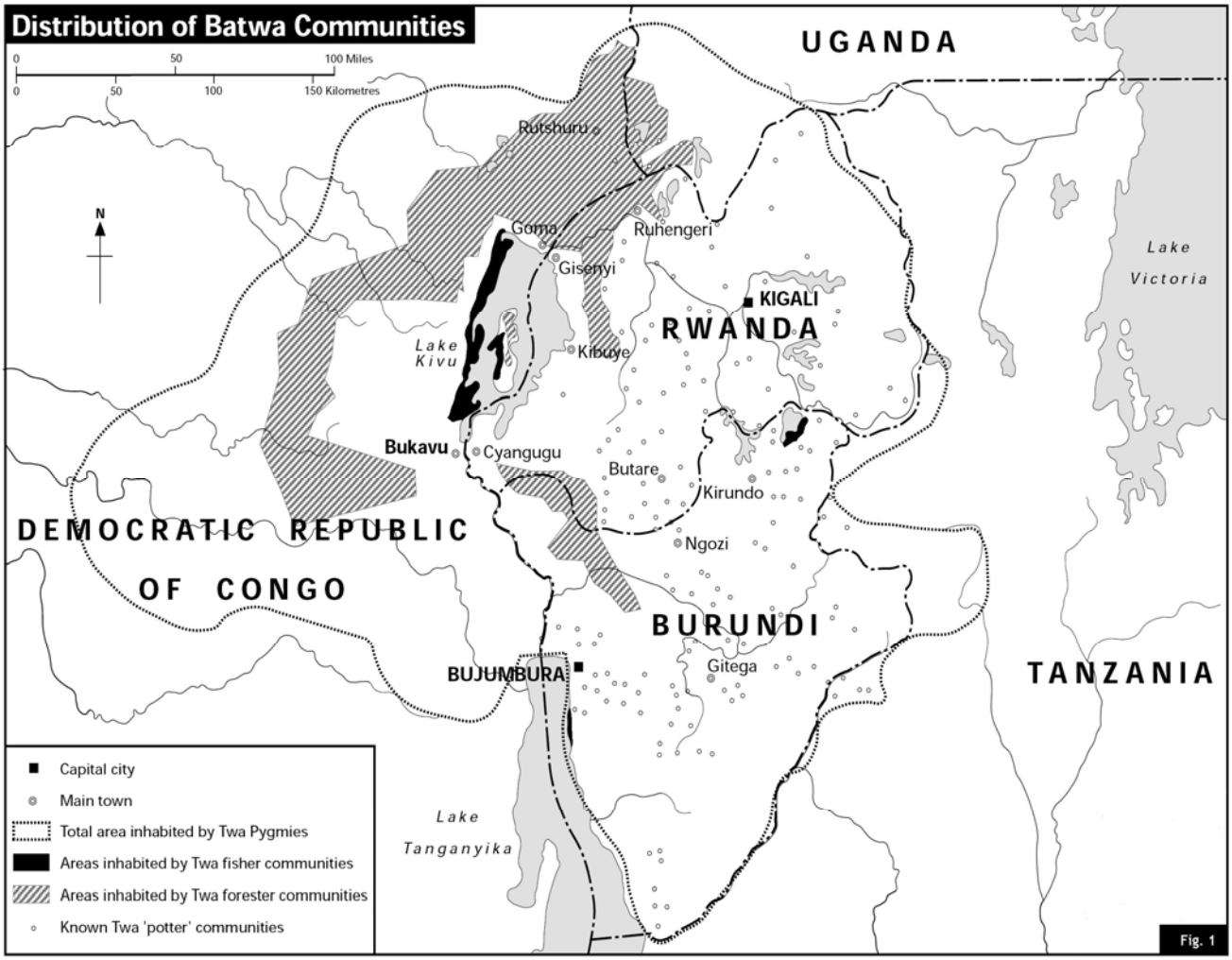
Figures 6.2 and 6.2 shows the areas of occupation by the Batwa in Rwanda, Burundi, Uganda and the Democratic Republic of the Congo (DRC) and the distribution of their population in the districts of Uganda. The opening of several conservation parks, including the Bwindi and Mgahinga in Uganda, succeeded in displacing the Batwa still living in forests. In 1991, forest life essentially came to an end for the remainder of Batwa. Before the opening of large parks in Uganda, the World Bank required an assessment of the challenges that would be faced by Batwa. Four years later, Uganda reported on those challenges and made several suggestions to aid the Batwa in transition. Among these suggestions was compensation for Batwa land and integration programs for Batwa. There are provisions for citizens who were displaced by parks to receive compensation or profit-sharing schemes did not include the Batwa.

Figure 6.1: Geographical Location of the Ik Communities in Uganda



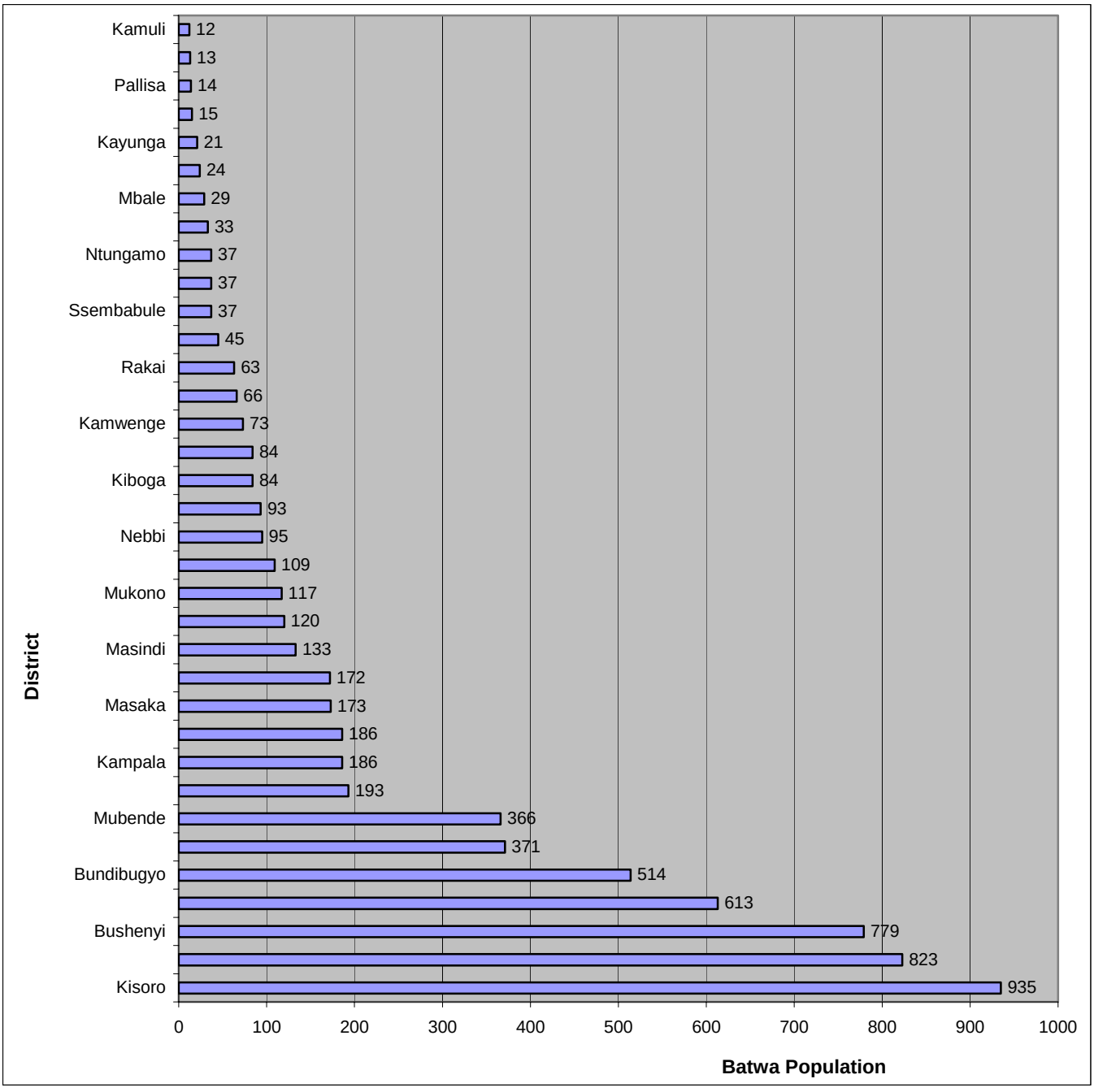
The Ik live exclusively in the northern part of Kaabong District, in Dodoth County, Kalapata and Kathile Sub Counties (Adopted from SIL Electronic Survey Report 2007-024, September 2007).

Figure 6.2: Geographical Location of the Batwa communities



Adopted from the Rwandese Community of Indigenous People Organization (CAURWA) 2007

Figure 6.3: Distribution of Batwa Population by District in Uganda



Adopted from CIA-World Fact Book, 2008

6.1.3 The Ik and Batwa Way of Life

The Ik are traditional cultivators who have developed a belief system that revolves around food crops. 'Itowes-es', one of the agricultural rituals, is perhaps the most important since it marks the beginning of the cultivating year. Other rituals include but are not limited to 'Iroilos', 'dziber-ikames', and 'inumes'.

During the Itowes-es (December or January), the Ik women must observe a number of restrictions such as the felling of trees, burning of the grass (in preparation for the new planting season) and quarreling. Violation requires the slaughtering of an animal, probably a goat by the offending party.

Male elders then perform a ritual at the male communal sitting place on a nearby hill called 'Diwa' with up to one kilogram of seeds collected from every homestead in gourds or calabashes. Here a branch of an *ibit* tree is cut and wrapped in leaves called 'emusia' and the elders announce "We have planted this branch of a tree as well as passing the year without problems," and the communal seeds are then sown.

The Batwa on the other hand are a highly marginalized community that used to live in Echuya and some of the neighbouring forests like Bwindi and Mgahinga on which they depended for all the basics of life. The Batwa were excluded from the forest at the time Echuya and the other forests were made reserves in 1992. They own no agricultural land outside the forest. Currently, they harvest bamboo stems for fuel wood and construction, and for sale to other communities. They hunt in the forest for wild game meat and also extract fibers, water, soil and wild plants as food. The forest is also of cultural importance to the Batwa.

6.2 Family and Social Welfare

Land is one of the major sources of livelihood for the Ik and is owned communally for agricultural purposes. The agricultural production has not been in their favour since their displacement from the current Kidepo Valley National Park to the current infertile and hostile famine-prone environment since 1960s. Like most minority groups, their survival amidst tribal wars and conflicts developed a culture where different categories of people form age bands and learn ways and methods of defending themselves as is the case with the Ik.

Children for example aged three years are at least or sometimes permanently expelled from the households and form groups called *age-bands.* The 'Junior Group' consists of children from the ages of three to eight and the 'Senior Group' consists of those between eight and thirteen. No adults look after the children as they teach each other the basics of survival. However, it is not certain whether this practice is typical Ik tradition or merely triggered by unusual famine conditions. According to Tainter this fragmentation ought to be an artifact of the circumstances where each person must depend on their own resources to find food and the age peers band together primarily to protect themselves from older stronger children who would take their food and resources[62]. The present social fragmentation and composition is the result of extreme deprivation on a more complex and functional culture.

6.2.1 Hunters

Hunting has played a vital role in the socio-economic life of the Ik for livelihood since time immemorial. This has been their traditional way of life despite having been displaced from the current day Kidepo National Park between 1946 and 1958. This activity occurs all the year round but its most popular in the dry season of November to February after grass burning. The Ik traditional hunting weapons include nets, neck snares (nyakola) and leg traps (nyalats), but this has advanced to include spears, pangas, knives, a fire-drill and possibly even automatic rifles.

During the hunting season the elders perform some traditional rituals together with the youthful hunters. The following are some of the rituals performed on reaching a promising site: Spears are placed between two bushes in a narrow place and everyone is requested to seat. Young hunters seat

[62] *Tainter, Joseph A. (2006). The Collapse of Complex Societies. UK: Cambridge University Press, 17-19, 210*

behind the elders as the elders begin blessing the spears for a successful mission with branches from a specified tree collected by the youthful hunters. One of the elders picks two stones, puts one down and cradles (covers) the other in his hands while saying: "Any animal around this bush being either small or big is to meet the spear of my children" and everyone then responds in chorus "yaaah!". Elders then bow down their heads while the hunters pick up their spears and proceed forward without looking back.

They divide into two groups to conceal themselves in a cow horn formation around the identified bush. When the two groups meet one person says loudly "we have met". Younger children venture inside the bushes to chase out any animals that might be there. If an animal does run out, a young boy gives an alarm by saying, "Ayaah!, kill from west (or from whatever direction the animal is charging from). It is coming."

When the first animal is speared, the hunter, if he is married, traditionally gives the buttocks to his in-laws and keeps the intestines and heart. If he is a bachelor he receives all three parts. The second hunter to spear an animal gets the hide and leg of the quarry. The third hunter also receives a leg, and the fourth gets the neck.

6.2.2 Batwa as a Hunter Community

The Batwa survive very much on hunting unlike their fellow marginalized Ik in North Eastern Uganda who hunt seasonally to supplement their protein needs. The Batwa survive by hunting small game using poison tipped arrows or nets and gathering various plants and fruit that the forest naturally supplies. Small temporary huts constructed with leaves and branches serve as their dwellings, which are abandoned after a few months when they relocate to another part of the forest in search of fresh supplies of food. Their tools remarkably remain pre-stone age. They use sharpened sticks for digging and cutting and arrow tips are just fire-hardened sharpened wood. Occasionally they utilize an iron knife for slashing the underbrush. Until recently these people seem to exist in forests much as they have for the last thousands of years.

6.2.3. Batwa Social Set-up

Anthropologists have referred to Pygmy societies such as the Batwa as being egalitarian 'immediate-return' societies. Their culture greatly differs from the other ethnic groups present in Uganda and Rwanda. They are mobile and flexible; they seek a direct and immediate return for their labour, they do not accumulate property or store surpluses, and are strongly orientated towards the present rather than the future. Obligatory sharing amongst the Batwa eliminates economic inequalities. Social inequalities are resolved with avoidance, teasing and joking. Collective decision-making eliminates the need for an overall leader, although, in some relevant situations, experienced and skilled individuals might be accepted as such. Conflicts, problems and embarrassing situations are avoided by moving away from the source of difficulty.

The forest is an important and integral part of the Batwa identity. Forest-based Pygmy peoples consider themselves to be in an intimate, nurturing relationship with the forest, the forest will always be there for them and provide what they need.

They believe that the forest is the source of all abundance, and this is maintained by proper sharing between people or between people and forest spirits, and by singing and dancing rituals which ensure the support of spirits to help them satisfy all their needs. Forest-based Pygmy peoples have a wide range of specialized skills and knowledge necessary to carry out their forest-based livelihoods, including an incomparable knowledge of plants and animals, and skills in medicine, music, dance and crafts.

The Batwa live in villages of ten houses populated by 20 to 30 people. The inhabitants are closely related men with their families, the parents of their wives and the husbands of their sisters. The huts are made of sorghum, dry banana leaves and spear grass. Women are in charge of building them. The

village chief is usually the oldest man of the clan and every visitor to the village has to make a courtesy call to him. They have profound knowledge of ecosystem; know many medicinal plants and other useful fruits of nature since the forest have always been their provider. As for dress, it was way back in the not-so-distant past that Batwa men used to wear a simple skin to cover their private parts and they decorated their arms. Their women wore neck beads and bangles. Today however, most Batwa have embraced modern clothes and skins are frowned upon.

6.2.4 Batwa Economy

On the other hand, the economy of the Batwa is quite simple. They have depended on hunting and gathering for millennia. They have had little value for land since they do not practice any farming. Mostly uninterested in subsistence strategies requiring long-term investments, many Batwa chose economic activities with quick returns on labor. They have become woodcrafters, tinkers, blacksmiths, potters, day laborers, bards and performers in the countryside. For their grain, they depend on the neighboring tribes like Bakiga and Bafumbira in exchange for wild animal skins, trophies, bows and arrows. Some Batwa depend on handouts for a living while for accommodation they have very simple grass-thatched huts which look more of hovels. Batwa were, and continue to be, good at basketry and pottery.

However, in all areas, the incoming agriculturalists established themselves in far greater numbers than the Batwa, who became incorporated into the locally dominant society at the very lowest level. This lowly status, their small numbers and the dispersal of their communities have contributed to their extreme political weakness and the serious difficulties they have in asserting their rights and resisting expropriation and violence. The Batwa have been dispossessed of almost all their lands and do not enjoy security of tenure for what remains. But this does not mean that their legal rights as owners of their lands have been extinguished. Where they have been deprived of their lands without due legal process, especially in recent times in the creation of game parks and conservation areas, their rights to their lands may well in future be asserted and tested both in political arenas and in courts of law.

A simple Mutwa hut on the slopes of a hill in South Western Uganda (Adopted from the Netherlands Centre for Indigenous Peoples, 2000)

6.2.5 Stereotypes

The Batwa are a minority in Bufumbira and other Banyarwanda communities. They are the most scorned, mainly because their culture is very little understood. It is said that no one ever saw a Mutwa‘s grave; no one knew when and how the Batwa organized their wedding ceremonies. Their

incessant begging from the Bahuutu and Batutsi increased the scorn and disrespect directed at the Batwa. The Batwa who lived in and around Chunya Bamboo forest reserve were experts at shooting with bows and arrows at the time and are still reserving the skill. They lived by hunting and gathering, eating and not only what they hunted and gathered but also what the Bahuutu and the Batutsi neglected. They are also reputed mutton eaters.

A Mutwa woman winnowing grain in the Virunga National Park where over 80 percent of the workforce is employed in agriculture

Among the Bahuutu and the Batutsi, the ownership of a Mutwa was a sign of wealth and security. The Batwa could, in addition to tobacco, smoke opium. The insecurity of Batwa subsistence strategies has contributed to their impoverishment and marginalization. In all places they are discriminated against. Their neighbours will not eat or drink with them, allow them in their houses, or accept them as marital or sexual partners. Their communities are segregated from other groups, forced to live on the edges of population centres. These practices are less rigidly adhered to in urban contexts but many underlying biases against Batwa remain. Many other communities hold negative stereotypes of the Batwa, despising them as an ‘uncivilized’ and ‘subhuman race’, who eat repulsive food and lack intelligence or moral values.

6.2.6 Marriage traditions among the Ik

In traditional communities like the Ik, the success of a harvest affects not only rituals related to cultivating but also other cultural events for the harvest and provides both the food and the new ingredients for beer, a vital component to any celebration in Karamoja, including weddings. A marriage ceremony follows an "engagement" when a girl, who may be little more than seven years old, is given a bracelet by an interested suitor, and taken under his watchful eye.

The first part of the wedding begins with a ritual called 'tsanes', or "smearing". Following the official handing over of a girl by her parents the couple is ceremonially anointed with oil by an old woman who is in charge of 'tsanes'. The following morning this same woman takes the bridegroom to a specific tree at which he is asked to throw a spear. This is to demonstrate his prowess as a hunter. If he misses he is said to become a poor hunter. The bride is then directed by the old woman to grind grain (using a traditional grinding stone) and to cook for her future husband's family: one calabash for the old men; one for the old women; another for relatives and friends; and a portion for her intended husband and herself. The remainder is given to the children.

In the following week the bride is supposed to serve her husband's clan as she fetches water, collects firewood and assists other women with their domestic chores. During this time her ability to co-operate with them is tested.

Preparing a meal for the family and clan members, 2006

The second part of the marriage ceremony is devoted to strengthening the social bonds between the future couple's families and clans. This involves the bridegroom's family paying a visit to the girl's parents. They take a bull, a goat, maize and fried sorghum or millet for brewing beer. The visitors are welcomed with beer and that evening a discussion takes place wherein any problems between the two families are settled. The following day the bridegroom's family brew beer and slaughter the animals they have brought. Two or perhaps three days later the visit ends and the bride is escorted by her sister to her new home. There then follows a series of minor ceremonies, which help to integrate the newly weds into Ik society.

Peaceful cultivators in a land of belligerent cattle keepers, the Ik are staunchly Catholic and largely monogamous. Divorce is prohibited and adultery is punished by death. Family prosperity in rural areas involves the acquisition of wives, which is accomplished through the exchange of bride wealth. The payment of bride wealth is connected to the fact that men "rule" women. Polygynous marriages have reinforced some aspects of male dominance but also have given women an arena for cooperating to oppose male dominance. A man may grant his senior wife "male" status, allowing her to behave as an equal toward men and as a superior toward his other wives. However, polygamous marriages have left some wives without legal rights to inheritance after divorce or widowhood.

An elder with family members during the ritual, 2005

Ornaments and handcrafts for the Batwa in Kanungu district. There were big wars between the Bakiga and the Batwa around the lake, where the latter proved the advantages of their bows against the Bakiga spears.

6.2.7 Socio-Economic Status of the Ik

Riding the wave of this new found self-reliance, tourism could well be a continual source of badly needed income in Ik-land. Some elderly Ik are highly skilled carvers and produce beautiful objects such as ebony stools, walking sticks and traditional spears. The Ik are also reknowned bee-keepers. However, it may be Ik-land's scenic beauty and ideal location of walking tours that will prove its main attraction.

6.2.8 Security among the Ik

The tribe has lost about a quarter of its population in the past 15 years, according to census figures. The Ik numbers are under threat of depletion. Since early 1960s, they have continuously suffered famine and other vagaries of nature and climate. Also, their weakness relative to other tribes meant they were regularly crushed between the raids. The group has to endure drought, disease and raids from violent semi-nomadic neighbours.

Heavily-armed warriors from Uganda's Dodoth and Jie and Kenya's Turkana tribes frequently rampage through the Ik's homeland in the hilltop Timu Forest, killing people and stealing their meagre supplies of food - particularly at harvest time. The tribe has retreated higher and higher into the hills, and now scrapes a living on the steepest slopes. Since then, they have been repeatedly attacked by their neighbours, none of whom understand their language.

A typical Ik homestead, Photos adopted from Brian Jones, 2004

Ik families live in maze-like villages clinging to the mountain sides. Their huts are fenced in with thorn branches nestled high in the mountains, which afford a bit of protection against neighbours who are known for their tendency to raid. The Ik have chosen not to keep livestock to reduce the risk of raiding but are often affected by the raids between the Turkana and Karamojong. They are often accused of not having warned a group that the other side was coming to raid them. As can be seen from the picture above, the villages are small and confined within a high fence from "neighborhoods" called *Odoks*, each surrounded by a wall. Each *Odok* is sectioned into walled-off households called *asaks*, with front yards and in some cases, granaries.

Visitors have to crouch and slide through tiny, low doorways into the homesteads, designed so club-wielding defenders can bludgeon invaders. One has to crawl through this doorway in order to enter the homestead for security related issues. Inside there are small *tukels* or huts and even smaller grannaries that are largely empty. However, these defences offer little protection from the assault rifles carried by the warriors who rampage through the mountain passes and sometimes follow the Ik up to their homes.
Houses are also built with small halls where the household members monitor their security during the night and other insecure periods. The entrances to these houses (like manyata) are made short that nobody enters without permission, especially if an enemy.

6.2.9 Education

The Ik community has just two primary schools and was recently able to construct a clinic that eliminated at least some of the need for the long trek on foot to the nearest medical facility more than 30km away. Diseases, particularly malaria, have taken a harsh toll on the Ik and in 1980s hundreds were killed in a cholera epidemic after which many able-bodied survivors left to seek labour intensive jobs across the border in Kenya. Only four (4) Iks have ever attended high school and none of them is employed, according to community leaders who said they know of only one Ik in Uganda who now holds a paying job and he lives and works in Gulu district.

"The Ik people are the real case of deprivation and social injustice, and the situation is still alarming in the areas of social facilities. They have been classified as the worst of the needy among the needy of Karamoja" though with their fierce adherence to Catholicism and a language not understood by any of the surrounding tribes. It is then clear that no program has ever been introduced among the Ik by authorities to assist in development since their language is not known by the neighbours as well as social workers in their locality.

A Social Worker in an educational session with Batwa Children in Kanungu district, 2006

The Batwa in a sensitization meeting, 2006

6.3. Role of Media in the Promotion of Cultural Beliefs and Practices

The media in this case, is looked upon as the medium of communication in view of the manner in which it has affected the erosion or promotion of cultural beliefs and practices among the Ik and Batwa. Communication channels consist of the mass media like radio, television, newspapers, magazines and journals.

Through the publications of groups and individuals, researches, organizations have been able to respond to the plight of the Ik and Batwa in and outside Uganda. They are a group of minorities that have continued to be marginalized and it is this marginalization that has brought their plight to the present response from Faith Based Organizations and NGOs. The Catholic Church and other organizations such as Humanitarian Relief Agencies like Oxfam, the World Food Programme, Minority Rights Group International, Community Development Resource Network (CDRN) etc responded to these groups' plight. The Minority Rights Group International (MRG) for example works to secure rights and justice for ethnic, linguistic and religious minorities. It is dedicated to the cause of cooperation and understanding between these communities around the world.

The role of the media is basically to inform and promote cultural diversity; local identity and surveillance of national social issues regarding minorities. Generally the media through telecommunication, mass media and training and sensitization of minority groups as well as their neighbors is important for their interaction and development.

6.4 Impact of Existing Policies and Liberalization of Communication

Tourism is not directed to commercial or population centres alone but also in most cases towards natural and cultural resources. Consequently, tourism has the power to play a significant role in areas of a country where other commercial activities are limited. This being a policy statement, the population within the tourist areas have been neglected and in some cases displaced in the name of tourism and income generation.

Environmental Mainstreaming occurs when conservation and the sustainable use of environment and natural resources is integrated into different levels of government, institutional or establishment legislations, policies, plans and programmes and relevant actions are taken at the national, sectoral, local and community levels to support their implementation.

NEMA, Greenwatch and the Uganda Police have worked together as government agencies to realize their dream of preserving and protecting the environment through displacing the minority groups especially the Ik and Batwa to previously uninhabitable lands for the Ik while for the Batwa, they were left landless after their forest homeland was gazetted in the name of environmental protection-as no-go areas.

Based on the above, the government agencies working on the environmental concerns consequently agreed to develop an integrated plan of action, a sustainable surveillance and monitoring system, 'indicators of enforcement', etc in order to ensure that social, economic, environmental and technical dimensions are taken into account.

In applying the provisions of this Convention, especially articles 6-8; 13 -16; and 33 state that governments shall: consult the peoples concerned, people can freely participate, establish peoples' own institutions and initiatives, decide their own priorities for the process of development, due regard shall be to their customs or customary laws, respect the cultures and spiritual values of the peoples, etc.

In articles 36-37 of the Constitution of the Republic of Uganda, the rights of minorities is recognized and shall participate in decision making for development plans. The right to culture and similar rights shall be enjoyed, practiced, maintained and promoted by citizens. With due respect to the ILO Convention 169 (1989) and the 1995 Uganda Constitution, the views of the affected minority groups and peoples have not been seriously taken into consideration.

6.5 Cultural Empowerment towards Development

The Batwa pygmies' fertility rate of 1.8% by the year 2000 was found so low given the fact that their population keeps getting decreased by vagaries of nature. This was compounded by the fact that the "pygmies" fertility rate is low for as hunter/gatherers they produce another child only when the youngest is a toddler.

The Bwindi Impenetrable Forest was gazetted as a national park and world heritage site in 1992 to protect the 350 endangered mountain gorillas within its confines. Good news for the gorillas but bad news for the pygmies, for in the process the 2000 Batwa pygmies who had lived within this area were evicted. It provided them with sustenance and medicines and contained their sacred sites.

The Batwa were integrated into society at the lowest level, although they were also important in the courts of the pre-colonial kings and chiefs, as performers, spies, hunters and warriors. The Batwa bear no malice toward those who removed them from their ancestral home but retain a very intact sense of community togetherness and have no interest in personal gains.

In a meeting organized by the Community Development Resource Network [CDRN] in Eastern Uganda, Kapchorwa district from 4th to 5th June 2008, which was attended by the Ik, Tepeth, Benet, Banyara, Bahehe and Babukusu representatives, to empower the minority groups and build their capacity for development, it was resolved that there is need to review the current Constitution of the Republic of Uganda (Articles 32, 33, 34, 35 and 36) to make mention of the minority groups without grouping them in 'others'. It was noted that Article 36 in particular protects the rights of the minorities but no minority representation in decision making at all levels of governance (Central and Local) for the last years of the enactment of the said Constitution has ever existed.

6.6 Conclusion

The fact that Minority communities in Uganda have been marginalized creates the need to improve greater awareness amongst policy makers and implementers of different programs and activities that can uplift the minority groups in the country. This will assist the government to identify closely the gaps and suggest interventions for empowerment of these communities. It is part of cultural heritage to preserve the beauty of our diversity by promoting positive beliefs and customs.

6.8 Policy Recommendations

1. Recommend translation of informational materials into the minorities local languages to be used in schools and the existing health centre, churches, mosques and other public places.
2. Capacity building and training of minority groups in the empowerment process and programs based on their cultural settings. This will increase their awareness and proper integration into the mainstream development process.
3. The extended family needs to be emphasized amongst these groups for it provides much support in looking after children and orphans but has been overburdened by the AIDS epidemic with the result that some care is being provided by the older orphans.
4. Participatory programs that involve minorities should be supported. These will ensure integration of the views of the minorities based on their positive cultural practices.
5. Researchers be encouraged to utilize the indigenous knowledge and skills in relation to the prevailing conditions while performing their roles and responsibilities.
6. Recommend for fresh registration of minority groups in the country and a survey be carried out to inform decision makers about their plight and subsequent planning for them.

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CHAPTER 7

THE CURRENT SITUATION OF WATER AND ENVIRONMENTAL SANITATION IN UGANDA: THE ROLE OF CULTURE, GENDER AND HUMAN RIGHTS

7.0 Introduction

Access to water is a basic human right, yet it is a right denied to millions of people everyday (Care, 2006). It is an essential element of human survival, and the combination of safe drinking water, adequate sanitation and hygiene is recognized as fundamental to human well being (UN Secretary General, 2003). Expanding access to water and sanitation is a moral and ethical imperative rooted in the cultural and religious traditions of societies around the world and enshrined in international human rights instruments. One of the main burdens of the poor population is the lack of sanitation facilities. Today, nearly one person in five cannot access safe water and two in five lack even basic sanitation (SIWI, 2004). Billions are denied access, not because of scarcity of water resources or lack of technical know-how, but because development finance for the sectors is not getting through to the authorities charged with delivering services (Water Aid, 2008).The majority of people, who have to struggle with contaminated drinking water and accompanying illnesses, live in Asia and Africa (UN, 2003).

The global importance of water, sanitation and hygiene for development, poverty reduction, education, gender equality, health and environmental sustainability is reflected in the United Nations Millennium Declaration, in particular its seventh Millennium Development Goal (Box 1); in the reports of the United Nations Commission on Sustainable Development and at many international fora (WHO, 2008). The UN declared 2008 as the International Year of Sanitation to break the silence and boost sanitation progress the world over.

BOX 1 MDGs requiring water

Target 2: Halve, between 1990 and 2015 the proportion of people who suffer from hunger
Target 5: Reduce by two-thirds, between 1990 and 2015, the under- five mortality rate
Target 10: To halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
Indicator 30: Proportion of the population without sustainable access to an improved water source
Indicator 31: Proportion of the Population with access to improved sanitation facility
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

7.1 The Right to Water and Sanitation

Lack of access to water is one of the most widespread human rights violations. At its core, this right requires that everyone has access to an adequate amount of drinking water to prevent dehydration and maintain basic health. The full enjoyment of this right means access to water that is affordable, clean, and physically accessible. The fulfillment of the right to water is crucial for the fulfillment of other rights; the right to health, food, and housing can not be achieved unless people have access to clean water (Box 2). A human right to water only gained explicit expression in several human rights treaties:

- the Convention on the Elimination of all Forms of Discrimination against Women (1979/80),
- the Convention on the Rights of the Child (1989),
- One regional treaty: the African Charter on the Rights and Welfare of the Child (1990).
- The Protocol on Water and Health to the 1992 Convention on the Use of Trans-boundary Watercourses and International Lakes
- The Geneva Conventions (1949, 1977) guarantee the protection of this right during armed conflict. In addition, the right to water is an **implicit** part of the right to an adequate standard of living and the right to the highest attainable standard of physical and mental health.

BOX 2 Numerous fundamental human rights can not be fully realized without water

- Right to life: Without water, no life can be sustained.
- Right to food: Water is essential for farming: almost 70% of all mobilized freshwater is used for agriculture[1] and it is estimated that more than one third of global food production is based on irrigation.
- Right to self-determination: this right also includes the right of all people to manage their own resources and is thus connected to a right to water
- Right to adequate standard of living, can not be realized without a secure access to water
- Right to housing: As the CESCR stated "the right to adequate housing should have sustainable access to natural and common resources, safe drinking water, sanitation and washing facilities".
- Right to education: The lack of proper supply of water forces children to walk long distances, often several times a day - thus missing school - to provide their families with water.
- Right to take part in cultural life: The destruction, expropriation or pollution of water-related cultural sites represents a failure to take adequate steps to safeguard the cultural identity of various ethnic groups

To mark the UN International Year of Freshwater in 2003, water was recognized, not only as a limited natural resource and a public good but also as a human right. General Comment 15 fleshed out in detail the right's content and clearly stated that the right to water emanated from and was indispensable for an adequate standard of living as it is one of the most fundamental conditions for survival. The International Committee on Economic, Social and Cultural Rights (ICESCR) formulated the right to water as follows:

- Water is a limited natural resource and a public good fundamental for life and health. The human right to water is indispensable for leading a life in human dignity. It is a prerequisite for the realization of other human rights.
- The human right to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses. An adequate amount of safe water is necessary to prevent death from dehydration, to reduce the risk of water-related diseases and to provide for consumption, cooking, personal and domestic hygienic requirements.

The ICESCR also provides guidelines for States Parties on the interpretation of the right to water under two articles - Article 11 (the right to an adequate standard of living) and Article 12 (the right to health). As for all human rights, State Parties have 3 types of obligation:

- **Respect**. Governments must refrain from unfairly interfering with people's access to water. For example, disconnecting their water supply.
- **Protect**. Government must protect people from interference with their access to water by others. For example, stopping pollution or unaffordable price increases by corporations. Contamination of drinking water sources, whether deliberate or through neglect, constitutes a violation of the right to water
- **Fulfill**. Take all steps with available resources to realize the right to water. For example, pass legislation, devise and implement programmes and monitor their progress.

The right to water also includes the access to basic sanitation. CESCR's General Comment (GC) 15 states that "Ensuring that everyone has access to adequate sanitation is not only fundamental for human dignity and privacy, but is one of the principal mechanisms for protecting the quality of drinking water supplies and resources. In accordance with the rights to health and adequate housing (see General Comments No. 4 (1991) and 14 (2000)) States parties have an obligation to progressively extend safe sanitation services, particularly to rural and deprived urban areas, taking into account the needs of women and children".

GC15 creates nine core obligations that have immediate effect and are "non derogable" - that is they must be met in full and on time and so cannot be delayed or diluted in their effect. These obligations can be arranged into three groups depending upon the level at which the States responsibilities are to have an effect (Box 3).

Box 3 The Right to Water Core Obligations At the National Level

- Adopt and implement a national water strategy and plan of action addressing the whole population; the strategy and plan of action should be devised, and periodically reviewed, on the basis of a participatory and transparent process; it should include methods, such as right to water indicators and benchmarks, by which progress can be closely monitored;
- Monitor the extent of the realization, or the non-realization, of the right to water
- Adopt relatively low-cost targeted water programmes to protect vulnerable and marginalized groups

At the Community Level

- Ensure the right of access to water and water facilities and services on a non-discriminatory basis, especially for disadvantaged or marginalized groups
- Ensure physical access to water facilities or services that provide sufficient, safe and regular water; that have a sufficient number of water outlets to avoid prohibitive waiting times; and that are at a reasonable distance from the household
- Ensure equitable distribution of all available water facilities and services.

At the Individual Level

- Ensure access to the minimum essential amount of water, that is sufficient and safe for personal and domestic uses to prevent disease
- Ensure personal security is not threatened when having to physically access to water
- Take measures to prevent, treat and control diseases linked to water, in particular ensuring access to adequate sanitation.

(Source: M. Woodhouse "Realizing the Right to Water, 2004)

The next section of this paper presents the state of the water and sanitation sector in Uganda. Specific attention is paid to the performance of the water and sanitation sector in the context of the 10 golden indicators. These are discussed from a cultural and human rights perspective. The last section examines the effects of the rural and urban water development programmes in improving the water and sanitation sector in the country. Finally the paper examines the cost effectiveness of programmes that aim at providing clean water in the country, the trade offs of providing clean water vs. cost of treating water bone diseases.

7.2 Water and Sanitation Sector in Uganda

Since 1990s the government of Uganda has identified water and sanition as major priorities in the national poverty reduction strategy. The organizing principle for water in Uganda is "some for all, not all for some and the 1999 water policy sets out a strategy and investment plan aimed at 100% water coverage by 2015. In the revised PEAP (MFPED, 2004), the water and sanitation sector falls under three pillars:

a) Pillar 2: Enhancing production, competitiveness and incomes (includes water for production and water resources management)
b) Pillar 3: Strengthening security, conflict resolution and disaster management (includes water for security in North Eastern Uganda and provision of water and sanitation services in IDPs; and
c) Pillar 5: Human Development (includes water supply and sanitation).

The right to water requires government activities to progressively increase the number of people with safe, affordable and convenient access to drinking water and to safe sanitation. This includes government policies and strategies that create economic, social and political conditions for such access including the obligation to ensure non-discriminatory access to water, especially of the marginalized and vulnerable sections of society. Since mid-1990's, the Government of Uganda has put in place comprehensive policies, legal and institutional frameworks that impact on the water and sanitation

sector (Box 4). Specific policy objectives of Government of Uganda for domestic water supply and sanitation are as follows:

a) To manage and develop the water resources of Uganda in an integrated and sustainable manner, so as to secure and provide water of adequate quantity and quality for all social and economic needs of the present and future generations with the full participation of all stakeholders;
b) To provide "sustainable provision of safe water within easy reach and hygienic sanitation facilities, based on management responsibility and ownership by the users, to 77% of the population in rural areas and 100% of the urban population by the year 2015 with an 80%-90% effective use and functionality of facilities.

Box 4: Key Events/Policies in the Water and Sanitation Sector in Uganda

- 1994 The National Environment Management Policy
- 1995 The Constitution of the Republic of Uganda - Art.14: 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, decent shelter, adequate clothing, food, security and pension and retirements benefits.
- 1997 National Gender Policy
- 1997 Local Government Act introduced to decentralize responsibilities for water and sanitation to District Administrations
- 1998 The Water Act Cap 152, and accompanying regulations [Water Resources and Discharge Regulations
- 1998 The Environmental Impact Assessment
- 1999 The Water Supply and Sewerage Regulations
- 1999 National Water Policy - The National Policy established for user management of rural water supplies
- 1999 The National Environment (Standards for Discharge of Effluent into Water or on Land) Regulations
- 1999 National Health Policy and Health Sector Strategic Plan
- 2000 The National Water & Sewerage Corporation Act
- 2000 Water sector reforms introduced to ensure that services are provided with increased performance and cost effectiveness. These include sector-wide approaches, decentralized service delivery models and the sector's full integration in PEAP3
- 2001 Introduction of annual joint technical review and annual performance reviews
- 2002 Adoption of donor financing through national budget support rather than the funding of individual projects
- 2003 Development of the water and sanitation sector gender strategy
- 2004 Fiscal decentralization is introduced and implemented in several districts. Revision of the water and sanitation sector investment plan
- 2006 Community Mobilization and Empowerment Strategy.

Source: Water Aid (2005) and GOU (2007)

The water and sanitation sector in Uganda is organized in two sub sectors

a) Urban Water and Sanitation Sector (UWSS). This is composed of two systems: 1) large systems for 22 urban centers with a population above 15,000; and, 2) small systems for populations greater than 5,000 but less than 15,000
b) Rural Water and Sanitation System (RWSS) – point sources and small systems serving population up to 5,000 people.

Table 8 shows that Uganda is relatively self sufficient in water resources. National and district access figures, however, hide the disparity in the country. There are wide variations and disparities in access to water coverage throughout the country ranging from 12% in the least served district (Kaboong), to 95% in the best served district (Kabale) (GOU, 2007). Similarly with access to safe sanitation, there are wide variations, with some districts being as low as 2% and others as high as 90% (MoH, 2004). Within districts, the variations are just as wide across sub-counties and parishes (Water Aid Uganda, 2005). The top 10 districts with the highest coverage are Kabale, Kanungu, Rukungiri, Ntungamo, Koboko, Kaberamaido, Kamwenge, Busiki (Namutumba), Bushenyi, and Kasese. The 10 least covered Districts with protected drinking water (coverage less that 40%) are Kaabong, Yumbe, Kotido, Isingiro, Kiruhura, Bugiri, Kisoro, Mayuge, Manafwa and Nakapiripit (GOU, 2007).

Table 8: Comparing Water Stress Index[63] (SWI) and Social Water Stress Index[64] (SWSI) for Uganda

Available renewable water	Available water per capita	WSI Water Stress Index	HDI Human Devel-opment Index	Social resource scarcity (rank)	SWSI Social Water Stress Index	WSI (rank)	SWSI (rank)	SWSI rank minus WSI rank
66.00	3,352	3	0.328	18	9	58	36	-22
standard hydrological indicators			HDI taken to indicate social adaptive capacity			Comparison between water stress and social water stress		

Source: http://www.africanwater.org/SoicalResourceScarcity.htm [Accessed on 30th August 2008)

Using target levels of performance for 10 'golden' indicators[65] in Uganda, one can observe that the deepest disparities in water and sanitation exist between urban and rural areas (Table 9).

Table 9: Target levels of performance for 'golden' indicators in Uganda.

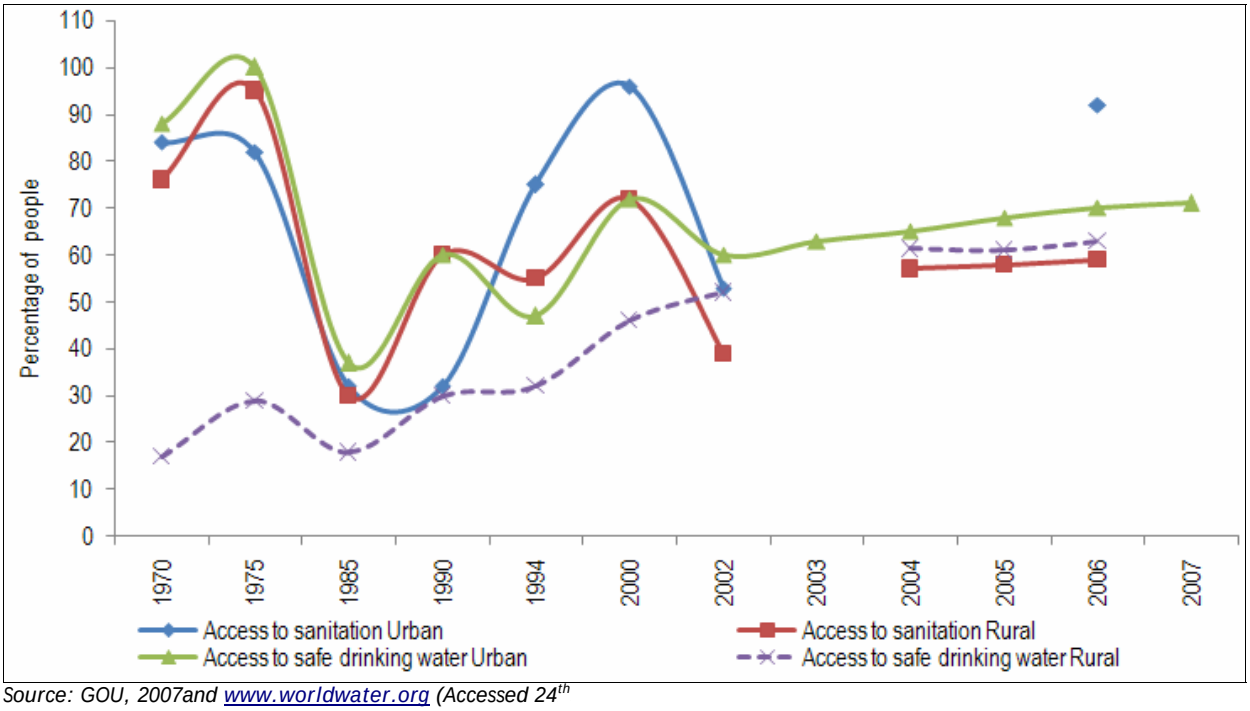
Golden indicators	Sub analysis	Achievements			Targets	
		2004/05	2005/06	2006/07	2006/07	2014/15
Access % of people within 1.5km (rural) and 0.2km (urban) of an improved water source	Rural	61.3	61	63	62	77
	Urban[66]	Data not combined	51	56	75	100
Functionality % of improved water sources that are functional at the time of spot check	Rural	82	83	83	85	90
	Small towns	No data	93	82	90	90
	Urban	83	87			95
	WFP	No data	No data	35	Targets to be set	
Investment Average cost per beneficiary of new water and sanitation scheme (USD)	Rural	31	35	38	40	40
	RGCs	56	No data	No data	55	50
	Small towns	72	93	58	75	75
Sanitation % of people with access to improved sanitation (household and schools)	Rural HHs	57	58	59	62	77
	Urban HHs	No data	No data	No data	92	100
	Schools	82	90			100
Pupil to latrine/toilet stance ratio in schools		57:1	61:1	69:1	40:1	40:1
Water quality % of water samples taken at the point of water collection, waste discharge point etc. that comply with national standards	Protected[67]- e.coli	Sample data only			95	95
	Treated - e.coli	No data	95	No data	100	100
	Treated - color	No data	No data	69		
	Wastewater ▪ BOD[68] ▪ Phosphorous ▪ TSS[69]	No data	No data	12 26 40	Targets to be set	
Quantity of water % increase in cumulative storage capacity availability of water for production		0	1.3	1	3.1	3.1
Equity Mean Sub-County deviation from the district average in persons per improved water point	Rural	These are District Local Government targets				
	Urban	n/a	n/a			n/a
Handwashing % of people with access to and using hand	HHs	No data	No data	14	23	50
	Schools	No data	No data	41	Targets to be set	

[63] *WSI is is measured by standard hydrological indicators (number of persons per flow unit*
[64] *SWSI is an index based on the adaptive capacity of a society. The UNDP Human Development Index (HDI) was used as a proxy, since it is generally accepted and at least contains the three important factors: life expectancy (as a proxy for general level of development), educational attainment (as a proxy for institutional capacity) and real GDP per capita. Combined with standard indicators for water scarcity, a social water stress index is then constructed*
[65] *Golden indicators cover outputs and outcomes aimed at efficient improvements and improved health and hygiene. They have been central to overall management of the water and sanitation sector*
[66] *Based on data for 168 out of 198 towns*
[67] *E.coli in 748 samples taken in 22 districts and NWSC towns*
[68] *Biological oxygen demand*
[69] *Total suspended solids*

washing facilities					
Management % of water points with actively functioning Water and Sanitation committees/Water Boards	Committees	No data	No data	63	Targets to be set
	Boards	No data	No data	No data	Targets to be set
Gender % of Water User Committees/ Boards with women holding key positions	Rural	No data	No data	87	Target to be set
	Urban	No data	21	18	Target to be set
	WFP	No data	No data	No data	Target to be set

Figure 7.1 shows that percentage of people with access to water and sanitation in Uganda has fluctuated over the last 40 years. This may, in part, be attributed to the political and socio-economic dislocations which have affected the country during this period. However, access to water in large towns has increased steadily from 60% in 2002 to over 70% estimated in 2007. The most affected districts in terms of percentage of sub-counties with coverage of less than 20% are Kaabong (88% of S/Cs), Yumbe (43%), Kisoro (31%) and Kitgum (28%). The least covered sub-counties are: Nyarusiza in Kisoro district; Omiya, Anyima, Lagoro, Padibe west, Paloga and Palabek Ogili in Kitgum district, Abongomola in Apac; Lolelia and Kaabong in Kaabong District (GOU, 2007).

Figure7. 1: Access to safe drinking water and sanitation 1970 – 2002

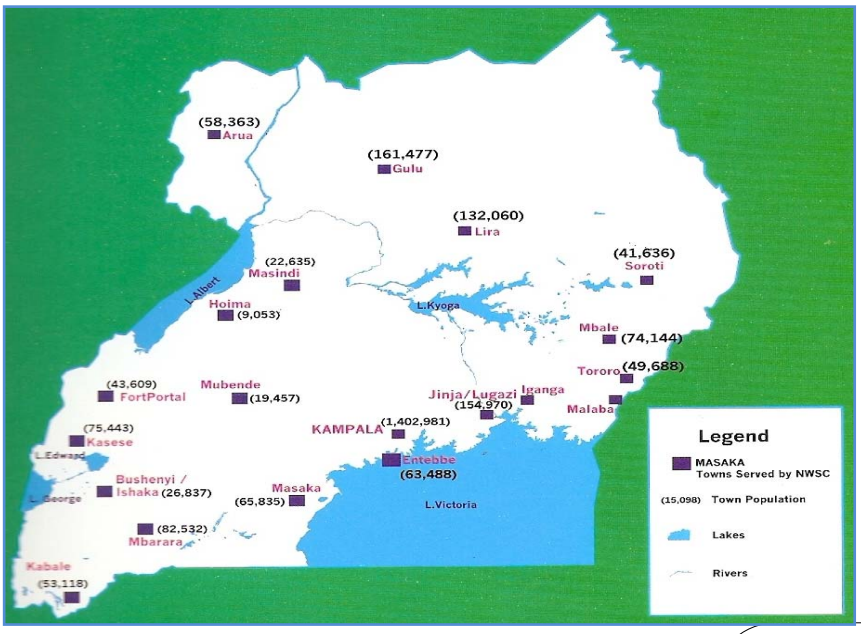


Source: GOU, 2007and www.worldwater.org (Accessed 24th

The urban water supply and sanitation sub-sector in Uganda is defined as service to gazetted towns with a population of more than 5,000 people. The total urban population in 171 towns (22 large towns and 149 small towns) is estimated at 4.4 million. These are sub-divided into 22 large towns (Figure 7.2) under National Water and Sewerage Corporation (NWSC), serving 2.1 million people and 149 small towns under Local Governments. In urban areas, close to 9 in every 10 households have access to improved water source. Tube wells or boreholes are still a major source of drinking water (31 percent), while protected wells and springs are the second most important source (20 percent). These two sources combined are used by just over half (51 percent) of households. Only 15 percent of households have access to piped water, mainly from a public tap (Uganda Demographic and Health Survey, 2006). The overall coverage of the large towns served by National Water and Sewerage Corporation (NWSC) was 71% as at June 2007. Eight of these (Kampala, Jinja/Njeru, Masaka, Mbarara, Gulu, Kasese, Lira

and Fort Portal) have coverage greater than or equal to the NWSC average. The towns of Bushenyi/Ishaka, Soroti, Hoima, Mubende and Masindi fall below the average (GOU, 2007). The smallest town served by NWSC is Hoima with a population of only 9,000.

Figure 7.2: Towns served by National Water and Sewerage Corporation (NWSC) 2007



1972
Kampala
Jinja
Entebbe

3 Towns

1980s
Kampala, Jinja
Entebbe, Mbale, Tororo,
Masaka, Mbarara

7 Towns

1990s
Kampala, Jinja
Entebbe, Mbale, Tororo,
Masaka, Mbarara, Gulu,
Lira, Kasese, Fort
Portal, Kabale

12 Towns

1990s

Kampala, Jinja, Mbale, Entebbe,
Tororo, Gulu, Masaka, Mbarara,
Lira, Kasese, Kabale, Soroti,
Lugazi, Bushenyi, Arua
Fort Portal, Malaba, Mukono,
Hoima, Masindi, Mubende, Iganga

22 Towns

The 149 small towns are categorized into: 1) 94 towns with piped water supply; and, 2) 55 towns with no piped water supply. All these small towns are not served by NWSC but have created Water Authorities, which contract out services to local private operators with technical support provided from the Ministry of Water and Environment. A study of 14 small towns revealed that on average, water schemes were providing water up to 57% of the required time (18 hours per day). Reliability of water supplies was affected by power blackouts, rising energy costs coupled with low tariffs, lack of competence of private operators and time required to obtain spare parts (GOU, 2006). Table 10 shows the urban population with access to various water sources in Uganda.

Table 10: Population with access to water sources in urban areas in Uganda, 2006

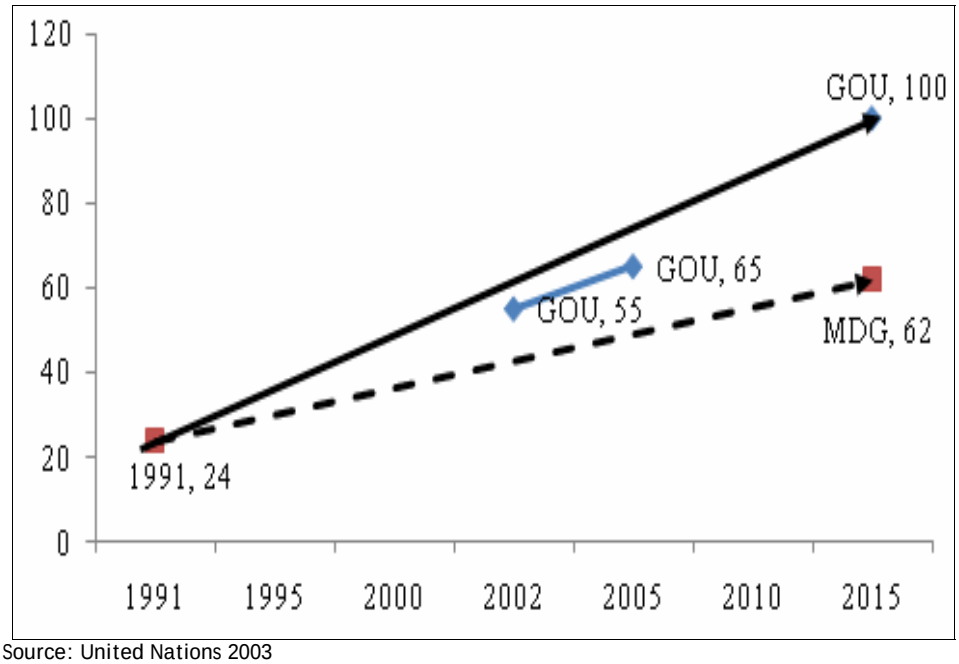
Type of water	No	Total urban population	Population with access to					
			Piped water supply		Other improved		Total improved	
		No.	No.	%	No.	%	No.	%
		[A]	[B]		[C]		[B+C]	
Large towns with piped water (NWSC)	22	2,540,325	1,791,890	71	Assumed to be 0	0	1,791,890	71
Small towns with piped water	94	1,115,823	477,886	43	103,835	9	581,720	52
Small towns with other sources only (deep boreholes and protected springs)	55	701,122	0	0	61,950	9	61,950	9
Grand total	171	4,357,270	2,269,776	52	165,785	4	2,435,560	56

Source: GOU, 2007

In smaller towns NWSC operates 15 sewage stabilization ponds. According to the MWE, an analysis of municipal effluents carried out in July 2007 revealed that NWSC's wastewater treatment facilities mostly do not meet national standards. Out of 223 data sets, 12% complied with Biological Oxygen Demand (BOD) standards, 26% with Phosphorus standards and 40% with total suspended solids standards. This leads to the pollution of water bodies from which in turn raw water is extracted. In a few cases sewage is disposed directly into the environment without any treatment. The lack of functioning wastewater treatment poses a threat on the environment and human health (UN-Water and World Water Assessment Programme, 2006).

The rural water supply and sanitation sub-sector is defined as rural communities of up to a population of 500 and Rural Growth Centers (RGCs) with a population of up to 5,000. RGCs are cultural and economic hubs which act as the first points of interaction between rural and urban economies, and the places where the rural entrepreneurs link up with their urban counterparts. The size and number of RGCs is growing rapidly and simple piped water systems are planned. Water services coverage in rural Uganda showed a positive trend between 1992 and 2002 though it was still below the desired target of providing safe water within reach of 65% of the rural population by 2005 and 100% of the population by 2015. The Uganda National Household Survey (UNHS) in 2006 indicated an increase in water service coverage nationwide from a little over 20% in 1991 to almost 68% in 2006. Equally the Uganda Population and Housing Census (UPHC) reported a rise in water service coverage from 26% in 1991 to 68% in 2002. The national safe water coverage figure for rural water supply is 63% and the main target for 2006/07 of 62% has been achieved (GOU, 2007). According to the United Nations (UN, 2003), Uganda Government's target as stipulated in the PEAP is to provide safe drinking water to 100% of the urban population by 2010, and 100% of the rural population by 2015. The MDG on water for Uganda translates into a rural target of 62% by 2015, which is much less ambitious than the PEAP target. Although lack of data for the 1990s prevented the calculation of the urban target for the MDG, based on a comparison of the rural targets for both goals, it is evident that Uganda will surpass the MDG target much earlier than 2015 (Figure 7.3).

Figure 7.3: Rural access to safe water in Uganda, 2003



Source: United Nations 2003

The GOU, 2007 reports that access to safe water in rural areas shows inequity of distribution between districts; is ranging from 12% to 95% coverage (Figure 7.4). It also highlights the fact that 5% of the sub-counties in Uganda have coverage of less than 20%. Currently, across rural Uganda, there is an average of 382 persons per improved water point but there is considerable variation:

a) A total of 49 districts out of 79[70] representing 62% are below this national average. The districts most affected are Kaabong (2,582 persons per improved water point), Kotido (1,243), Yumbe (1,318), Kiruhura (881), Bugiri (818), Isingiro (811), Mayuge (778), Nakapiripirit (772), Sembabule (727), and Pallisa (640).

b) The top ten districts in terms of the number of people per improved water point are: Kabale (124), Kanungu (138), Rukungiri (187), Koboko (197), Ntungamo (213), Kasese (215), Kamwenge (224), Bushenyi (231), Sironko (267), and Nebbi (269). Clearly these are also the ten Districts with the highest coverage rates.

Table 7.4 shows that the number of shallow wells in rural Uganda more than doubled from 281 in 1992 to 7,432 in 2003. Protected springs and boreholes remained the dominant water source. Protected springs increased by 24% from 17,282 in 1999 to 21,477 in 2003; while the number of deep boreholes rose by 24% from 15,224 in 1999 to 18,873 in 2003. When rainwater harvesting supplies were included for the first time in estimating access to improved water supplies in rural areas, access to improved water supplies in rural areas fell from 61.3% to 61.0% in FY 2005/6 (assuming 100% functionality). Rainwater tanks have been supplied to most schools and these account for 16.48% of the water sources in the country. Only 2,252 primary schools have piped water amounting to 14.28% (MoES, 2006) see table 11.

[70] *Various districts have been curved out in Uganda and data available is for 79 districts instead of the current 80 districts that presently exists in the country*

Figure 7.4: Safe water coverage in Uganda

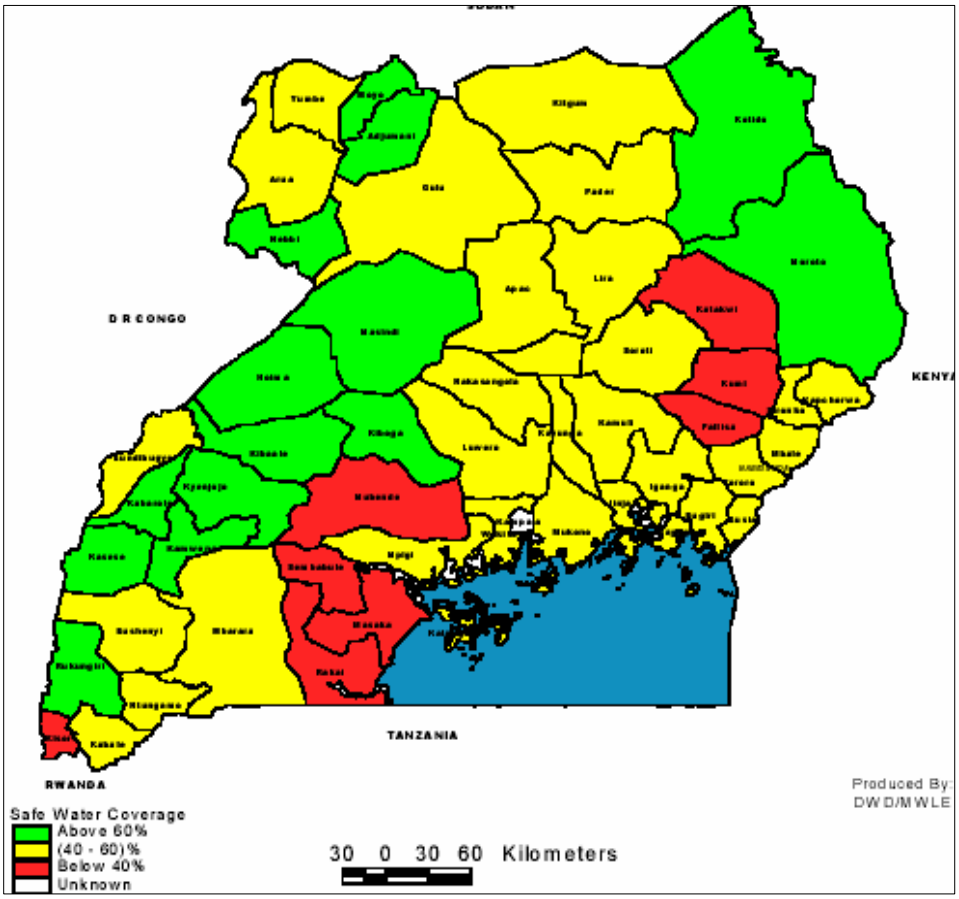


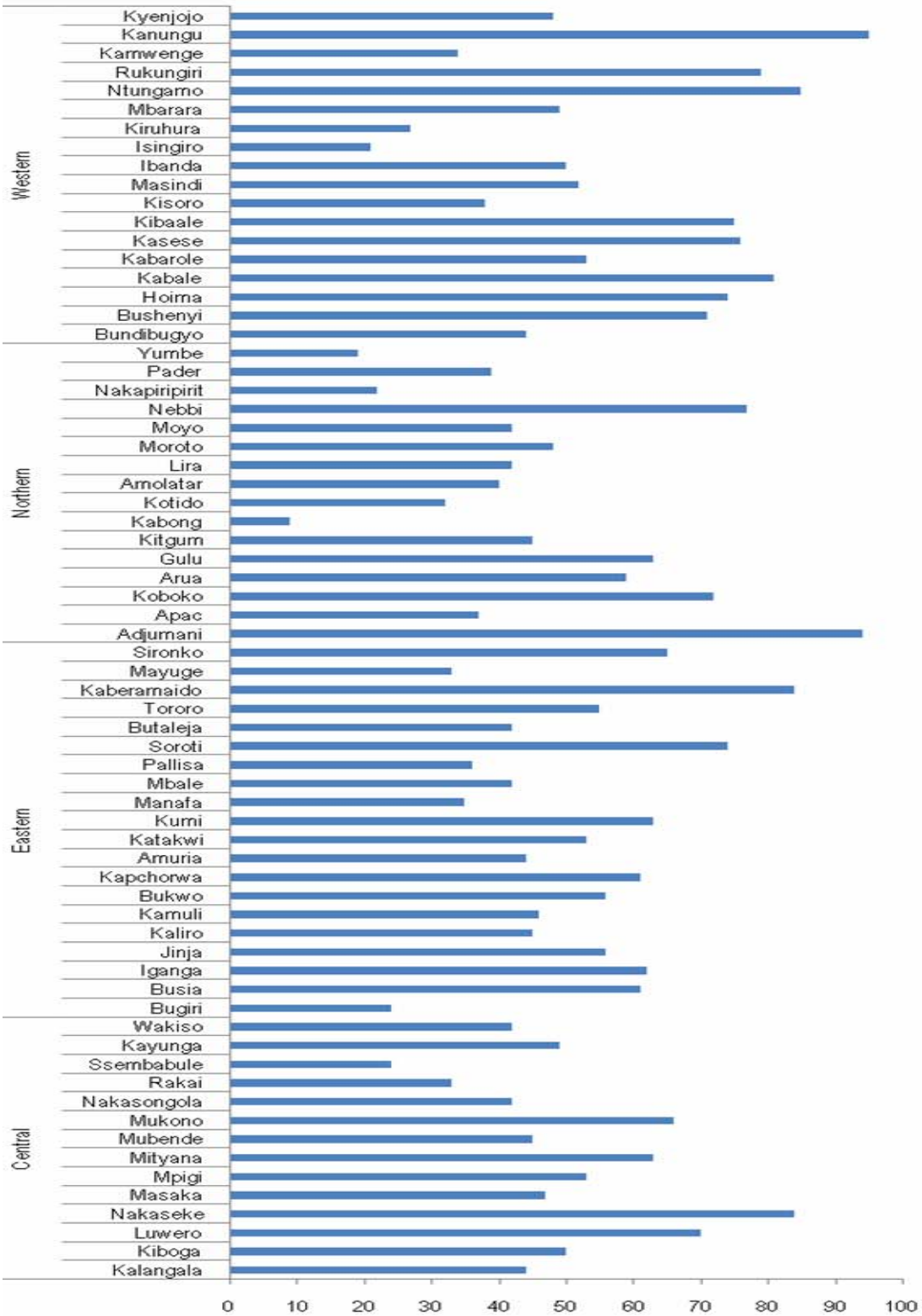
Table 11: Source of water by type in Ugandan Schools

Water source	Number of schools	Percentage
Piped water	2,252	14.28
Borehole	5,074	32.17
Well/spring	4,638	29.41
Rain water tanks	2,600	16.48
Lake/River	820	5.20
Other	371	2.35
Not reported	17	0.11
Total	15,772	100

Source: Ministry of Education and Sports Statistical Abstract, 2006

There is great disparity in the percentage of the population with access to functional water sources among districts in Uganda (Figure 7.5) although the average national functionality rate of rural water supplies increased gradually from 70% (2003) to 83% in 2006 (GOU, 2007). Of concern to the Directorate of Water Development is that the national estimate of non-functional water points is perhaps 20% at any one time.

Figure 7.5: Percentage of the population with access to functional water sources by district in Uganda



Source: Data from the UN, 2007

However, research by Water Aid Uganda concerning water point densities in two districts indicates that this figure may be conservative with around 30% of water points surveyed being non-functioning. Deep boreholes and springs show improving functionality trends since 2004/5 while functionality for dug wells is reducing. The increase for boreholes is attributed to increased expenditure on borehole rehabilitation and software activities. The following six districts still have the lowest functionality as reported in 2006: Nakapiripirit (49.6%), Abim (59.6%), Sembabule (62.7%), Koboko (64.5%), Kotido (64.7%) and Masaka (67.7%). Only 38% of the districts have improved their functionality while 66% have functionality levels above the national average of 83% and 28 districts had a functionality rate drop from the previous year. The districts that have made the highest improvements are Kamwenge (68-94%), Rakai (68-78%), Nakapiripirit (43-50%), Kisoro (89-95%) and Nakaseke (85-90%). Improved functionality is partly attributed to rehabilitation work undertaken during the fiscal year (GOU, 2007).

Table 12: Rural access to safe water (1991-2003)

Year	Population		Hand pumps		Protected Springs	Gravity flow scheme		Total water sources	Service coverage	
	Total	Rural	Bore holes	Spring wells		Scheme	Taps		People served	%
1991	16,671,705	13,905,863	7,613	-	4,329	6	22	11,964	2,553,369	18.4
1992	16,691,653	13,923,743	9,420	281	8,011	6	22	17,734	3,331,938	23.9
1993	17,144,283	14,316,145	9,865	517	9,846	41	41	20,269	3,813,090	26.6
1994	17,696,192	14,786,905	10,695	953	12,179	48	48	23,875	4,465,465	30.2
1995	18,248,105	15,257,667	12,432	1,045	14,111	61	61	27,649	5,194,510	34.0
1996	18,804,952	15,733,891	12,982	1,364	15,081	67	84	29,511	6,191,857	39.4
1997	19,467,841	16,305,398	13,515	1,586	15,791	73	889	31,781	6,544,095	40.1
1998	20,150,447	17,845,266	14,474	2,525	16,662	75	2,711	36,372	7,568,925	42.4
1999	21,619,692	18,188,941	15,347	2,774	17,282	82	2,893	38,323	8,518,090	46.8
2000	21,954,145	18,616,541	16,948	3,656	17,948	125	3,096	41,648	9,277,114	49.8
2001	22,461,731	19,055,188	17,894	4,984	19,146	129	3,384	45,408	10,243,883	53.8
2002	23,009,493	19,875,895	18,410	5,998	22,224	134	4,262	48,894	10,908,140	54.9
2003			18,873	7,432						

Source: UN, 2007

According to DWD (2001), a household is categorized as having access to safe and clean water if the water source is situated within the distance of 500 meters and 1.5km for urban and rural households respectively. Tables 12, 13 and 14 show that rural access to water within 1km and 0.5km is 48.9% and 33.8% respectively (GOU, 2006). The 2007 access figures for walking distance indicate an increase in coverage of 7.5% (1.5km); 7.2% (1km) and 5.2% (0.5km) from June 2006. Coverage for 1km distance is 56.1%, a difference of 4.1% from the current situation analysis figure of 60.2% (GOU, 2007).

Table 13: Distance to water sources (2005/06)

Distance (km)	Kampala	Central	Eastern	Northern	Western	Uganda
Less than1 km	95.9	72.3	67.9	72.7	67.5	71.6
1 – 5km	4.1	26.7	31.1	26.6	31.7	27.6
Less than 5 km	0	1.0	1.0	0.7	0.8	0.8
Average distance	0.2km	0.8km	0.8km	0.8km	0.8km	0.8km
Average waiting time (minutes)	10	16	32.6	53.8	18.1	28

Source: GOU, 2007

Table 14: Estimated Access to Improved Rural Water Supplies (June 2007)

	Coverage June 2006	Coverage June 2007
1. MWE – MIS Standard Approach[71] (assuming 100 functionality)	61%	63%
2. District Situation Analysis Approach[72] - Assumes that a water source in a given sub county or district cannot serve people in another sub county/district (coverage limited to 95% in each sub county)		
a) 100 functionality	58.5%	60.2%
b) Coverage based on functionality[73]	51.6%	53.1%
3. Walking distance approach[74] (assuming 100% functionality		
1.5km	51.7%	59.2%
1km	48.9%	56.1%
0.5km	33.8%	39.0%

Source: GOU, 2007

Figure 7.6 shows that in rural areas of the country, 69% and 28% of the population spends more than 30 minutes and less than 30 minutes walking to a water source respectively, while about 2% of the population has water within their premises. For some households, the distances and time are much longer; where households are spending 660 hours a year on water collection. There was little change in rural water collection times between 1995 and 2000; the median collection time remained at 30 minutes. The average water used per capita in Uganda is only half the recommended amount and some 30 percent of constructed facilities are not functioning properly. Average water consumption ranges from 12 to 14 litres/person/day in rural areas, compared to a national target of 20 liters/person/day. Average consumption is below 17 litres/person/day in urban areas. Shortage of water also affects the quality of health care and education (MFPED, 2004).

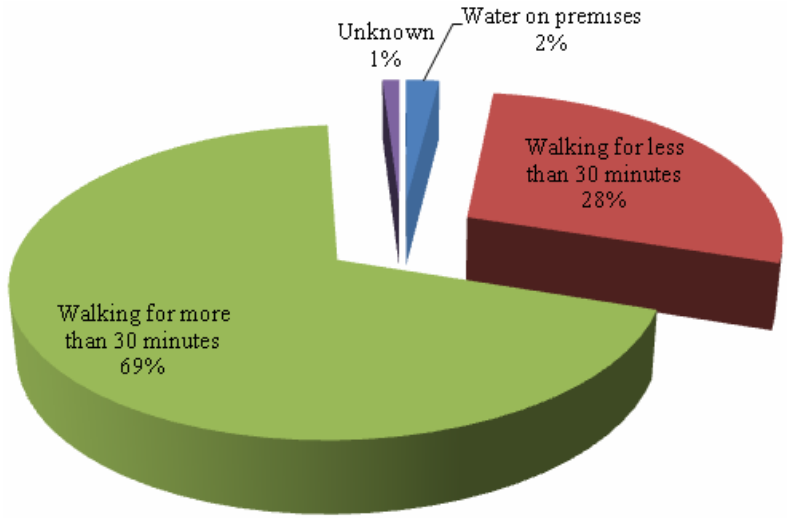
[71] *Access is estimated by assuming a fixed number of users for each source (Box 6.1), and dividing by the projected district rural population. Due to problems of data update, partly caused by the splitting of Districts, the national access figure using this approach is no longer broken down to District level. This approach assumes that all sources are functional. Calculated as follows: 2006 DWD-MIS Figure of 61% served: 15,104,045 users. Assumed increase for 2006/7: 643,826 for DWSCG (06/07); and 250,400 for UWASNET NGOs (50% of Jan to Dec 2006). Total Rural Population for June 2007 = 25,313,834.*

[72] *Uses data submitted by local Governments in their Annual District Situation Analysis Reports. Each improved source is multiplied by a set number of users. The total number of users per sub-county is divided by the rural sub-county population. An upper limit of 95% access is set for each sub-county to avoid high figures in one sub-county compensating for low figures in another. This approach considers (i) 100% functionality and (ii) functional sources only.*

[73] *Calculated using the GoU standard estimated number of water users for each functional water source as reported by District Government divided by the total rural population. Due to lack of data RGC schemes are assumed to be 100% functional.*

[74] *It estimates the effect on access of assuming different walking distances. It assumes a uniformly distributed population and water sources in each sub-county, and calculates how many people would live within a given radius of an improved water source (1.5 km, 1.0 km and 0.5 km). Maximum attainable access is limited to 100% of the projected population for each sub-county and assumes all improved water sources are functional.*

Figure 7.6: Walking times (in minutes) to water sources in rural Uganda.



The National Sanitation Guidelines (2000), define sanitation as a process where people demand, develop, and sustain a hygienic and a healthy environment for themselves erecting barriers to prevent the transmission of disease. The process thus involves building, use and maintenance of latrines and other sanitation facilities; and also involves learning, behavior change, organization, and collective action with other community members. According to the 2001 Poverty Status Report, only just over half of rural households have access to safe sanitary disposal facilities. Even, no single town in Uganda has a satisfactory sanitation management system. The worst hit areas include: 1) low income settlements, where the urban poor reside (Box 5); 2) fishing communities; and, 3) Internally Displaced Peoples Camps.

Sanitation coverage in Uganda is still low with only 42% of the rural population and about 26% of the urban population lacking adequate sanitation (i.e. household latrine). Table 15 shows that the main types of sanitation systems include: 1) traditional unimproved pits; 2) ventilated improved pit latrines; 3) septic tanks and soak-ways; 4) the bucket system; and 5) full water borne sewerage. Some of these systems are not adequate and are therefore discouraged, such as the bucket system. However, the traditional pit latrine is the most common but even then latrine coverage is less than 10% in some districts (Nakiboneka, 1998).

There is a wide variation of coverage from district to district (with 2% in Kotido District and over 94% in Rukungiri. Most North-eastern districts have very low coverage of less than 4% compared to the western districts with over 80%. The national latrine coverage stands at 59%. The 10 best performing districts are Rukungiri (98%), Bushenyi (91%), Kabale (89%), Kabarole (86%), Masaka (86%), Mukono (86%), Ntungamo (86%), Ibanda (80%), Kasese (80%) and Kaliro. Of the 69 districts in existence as of July 2005, 8 districts improved their latrine coverage by over 10%. Among them Kaliro had the highest increase of 23% followed by Pader with 22%. 17 districts did not experience any improvement or decline in their coverage. However, the districts of Kanungu (-20%), Kayunga (-15%), Isingiro (-15%) and Luwero (-11%) reported a decline in their performance (GOU, 2007). The situation is even grave in some peri-urban areas whereby the people have resorted to feaces disposal in “mobile toilets” or polythene bags which are discarded in banana plantations, drainage channels, or rubbish bins (GOU, 2006).

Box 5: Sanitation Crisis in Kampala

The state of sanitation in Uganda's urban areas is very poor. The situation is not any different in Kampala city, where the available sanitation facilities both in commercial and residential areas cannot meet the needs of the ever increasing population. Kampala's population stands at two million. While Kampala contains over 40% of the urban population, 60% of whom live in informal settlements; any infrastructure development initiatives largely exclude such areas. Basic services, where available, are over-stretched, leaving most residents no choice but to exit public provision: to fend for themselves and resort to rudimentary options for water and sanitation (Water Aid, 2006). Slum areas are the most affected where the urban poor live. Such areas are characterized by low latrine and safe water coverage, ill health fuelled by poor disposal of human waste and garbage. The Kampala Declaration on sanitation defines sanitation as personal hygiene and environmental cleanliness which involves observance of clean water chain and general improvement of the living conditions. About 6.2 per cent of households in Kampala lack toilets. It is also estimated that only 52 per cent of the city dwellers have access to clean water while 48 per cent of them use contaminated water. Poor disposal of human waste has left several water sources contaminated. Most of the affected areas are in city slums like Katanga, Ndeeba, Kibe Zone, East Nsooba in Kawempe Division, Kigagga zone, Nateete, Kasubi, Nakulabye, Kyiwunya in Rubaga Dvision, Kisenyi, Kamwokya, Kigugube, Katwe, in central and Nsambya central, Kanygoga, Namuwongo in Makindye Division (Nafula, 2008**).**

There is limited information available on hand-washing practice but available information from 10 districts (Kiboga, Kabale, Mpigi, Bushenyi, Lira, Mbale, Mayuge, Iganga, Masindi and Kawempe division of Kampala district) showed that only 14% of the population wash hands with soap after using the toilet (GOU, 2007). According to the Sector Performance Report (2005) this state of affairs seems to have improved considerably with rural access to a handwashing facility reported to be 25% and urban access to be 40%. A study conducted in Mukono, Mpigi and Katakwi, found out that close to 100% of people were still using the latrines that had been constructed. However, demonstration of hand-washing had fallen to between 30% and 50% (WaterAid Uganda, 2005).

A recent survey by the Ministry of Health in Ugandan schools suggested that there is only one toilet for every 700 Ugandan pupils, compared to one for every 328 pupils in 1995. Out of 8000 schools surveyed, only 33% of the 8000 schools sampled have separate latrines for girls and boys. The deterioration in sanitary conditions was attributed to increased enrolment in schools. For toilet facilities in primary schools, the pupil stance ratio is 61:1, which is higher than the set standard (40:1). Only 72% of schools provide separate facilities for boys and girls, which is inadequate, particularly when coupled with lack of privacy (GOU, 2006).

Table 15: Sanitation coverage in Uganda 1989 - 2003

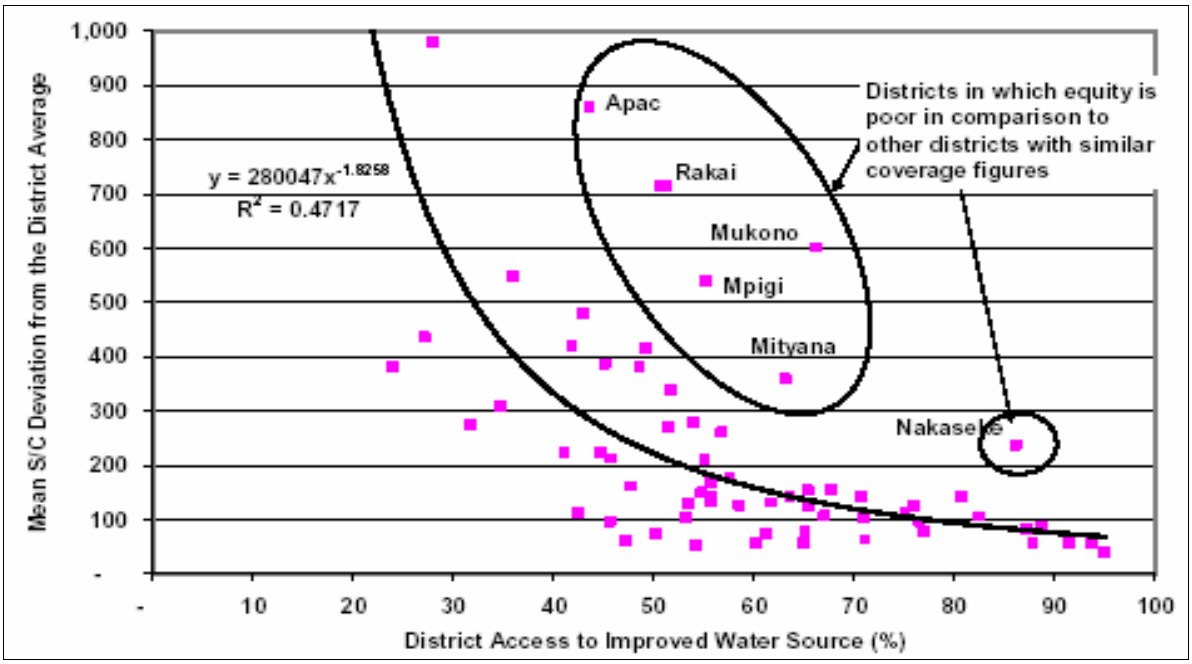
Sanitation variable	Uganda DHS, 1989		Uganda DHS, 1995		Uganda National Household Survey (UNHS), 1999/2000			UDHS, 2001		Uganda National Household Survey (UNHS), 2002/2003			UDHS 2006(UBoS & Macro-International Inc. 2007)	
	Urban	Rural	Urban	Rural	Urban	Rural	Total	Urban	Rural	Urban	Rural	Total	Urban	Rural
Flush toilet	33.7	0.4			8	0	2	9.1	0.5	6.0	0	1		
▪ Own flush toilet			6.3	0.1										
▪ Shared flush toilet			3.0	0.2										
Latrine, Pit	64.4	84.6			89	82	83			92	84	86	90	
Traditional pit toilet			80.1	76.2				79.9	78.3					
Ventilated Improved Pit Latrine (VIP)			6.2	0.9				7.9	1.1				15	8
Other	0.4	1.0	1.6	0.5	1	1	1	0.2	0.8	1	1	0		
No facility/bush/field	1.4	14.0	2.8	21.9	2	17	14	2.7	19.1	1	15	13		
Missing information/ Don't know	0.1	0.0	0.1	0.1				0.1	0.2					
Total	100	100	100	100	100	100	100	100	100	100	100	100		
Proportion VIP/all latrines								0.09	0.01					
Proportion of VIP of pit latrines based on DHS01					8.0	1.1				8.3	1.2			
50% of latrine/Pit considered improved	32.2	42.3	40.1	38.1	40.5	40.4		40.0	39.2	41.9	41.4			
Flush toilet corrected for proportion shared based on DHS 95	22.9	0.1			5.4	0.0		6.2	0.2	4.1	0.0			
Ratio of private flush			0.68	0.33										
Access to improved sanitation %	55	42	53	39	54	42		54	40	54	43		21.2	9.2

*Global Water Supply and Sanitation Assessment 2000. Water Supply and Sanitation Sector Questionnaire

A study of water quality in IDP camps found that drinking water in homes was heavily contaminated with faecal coliforms, even when the water sources used by the households had good water quality. Bacteriological water quality in 22 districts was reported to be good but water quality varies in space, time and by technology used for water supply. High levels of iron from boreholes and shallow wells are still a problem in some parts of the country (GOU, 2006).

On average, 50% of Water User Committee members are women. The gender indicator which emphasizes the number of women in key positions is generally not being considered by Districts. In the case of small towns, water boards are required to have at least one female member. Only 21% of Water and Sewerage Boards have women in key positions (GOU, 2006). Using the golden indicator of equity, Figure 7.7 shows that the mean sub-county deviation from the district average in persons per improved water point is also variable in Uganda. Nakaseke, Mityana, Mpigi, Mukono, Rakai and Apac are the districts in Uganda in which equity is poor in comparison to other districts with similar coverage figures.

Figure 7.7: Rural access to improved water supplies verses equity (GOU, 2006)



According to Advocacy Uganda (*online*) and the GOU (2007), the major constraints still hampering the provision of safe water and good sanitation include:

- Lack of sufficient ownership and knowledge on clean and safe water supply, proper sanitation and hygiene, and their relationship with poverty eradication. This is evidenced for example by resistance to capital contributions.
- Ineffective community mobilization and capacity building. Gender mainstreaming is also still very weak.
- Limited technical and functional capacities at sub-county level: most sub-counties lack a technical officer responsible for water matters.
- Poor coordination between Water officers and Health officers especially at sub-county level in line with the Sector Wide Approach.
- Community based maintenance systems / structures are weak or non-existent.
- Negative community habits and cultural values and beliefs that hinder provision of safe water supply and sanitation facilities, or their operation and maintenance.

- Construction of shallow wells is being undertaken by firms without adequate experience for the work. Additionally there has been a tendency for siting/construction of dug wells in valleys (distant from community settlement) and sometimes near open (swampy) water bodies. This has resulted in shoddy works, poor water quality and long walking distances and thus has a long-term effect on commitment of users to maintenance of the facilities.
- Lack of policy to regulate shallow well contractors: Unlike borehole drilling, shallow well construction in the sector has not yet been regulated. This has opened tendering of construction to non-qualified firms. The argument from districts has been that PAF funds should also trickle down to local contractors in order to alleviate poverty sometimes at the expense of quality of outputs.
- Technology choice not appropriate: High Functionality is reported in places where there are no alternative water supplies. The communities with low coverage areas (other than nomadic communities) care for their sources more than those that are less stressed, while low yielding wells are easily abandoned.

7.3 Culture and Gender Dimensions in the Water and Sanitation Sector

In the Uganda water and sanitation sector, gender mainstreaming is defined as the appropriate active involvement of women and men in the decision making process. Gender issues in the water sector are circumstances that arise from the distinctions made on what women, men and certain groups can do, have, or decide in the process of management and development.

- Women usually have the responsibility for water in their homes. They need to have water to do the cooking, washing, and cleaning. When it is not supplied they have to find it from somewhere: a distant well, standpipe or expensive vendor. This is the daily drudgery of many women in developing countries. It can dominate a woman's life, depriving her of energy and opportunity.
- Women are directly responsible for the health and welfare of their families. They are the first point of contact with water poverty.
- It is the women, and very often the young girls, who have to do most of the fetching from communal sources.
- In rural areas, they have to walk up to 8 hours a day, often bringing back a mere 15 to 20 litres which has to cover the needs of the whole family. Carrying this heavy load consumes much of their energy (requiring 600 to 800 K-calories of food per day). This chore often deprives girls of time to attend school or mothers a job. Reliable and accessible water gives women the opportunity to participate in the local economy.
- Lack of good sanitation in schools means less girls attend and more drop out.
- Lack of sanitation at home exposes women to harassment and attack, as they often have to walk some distance from the safety of their homes, simply to use the nearest toilet if there is one. Often there is not.
- When there is no proper sanitation the risk of disease is higher. It is the women who have to look after sick children, and the young daughters who lose out on education.

Access to water provides greater self esteem, reduced exposure to the threat of violence and health hazards, and increased time available for education, childcare, growing food and income generation (GWTF, *online*). Lack of water and sanitation also raises serious issues of personal safety and dignity, particularly in urban areas. Girls in both rural and urban areas drop out of school when they reach puberty, for instance, because toilets are not available that offer any privacy. Women may also drop out of the urban workforce for the same reason. In urban areas issues of personal safety mean that many people, particularly women and girls, cannot leave their houses at night to go to the toilet. As a result, they are forced to simply throw excreta into the dirty and poorly drained streets outside their homes.

Success in achieving the MDGs and targets on Water and Sanitation will require both gender mainstreaming and programmes targeted specifically at women in water management. In Uganda affirmative action programmes have been introduced in the water sector, to train women for water and sanitation related careers, including science and engineering. At the local level, women have found their voices and have now been trained to locate water sources in the village, decide on the location of facilities and to repair pumps. Gender mainstreaming efforts are best demonstrated at the Water and Sanitation Committee (WSC) level. Majority of Water and Sanitation Committees (73.3%) had women holding executive positions. About 63% of the committees had women treasurers and 10% had women

chairpersons. The majority (66.6%) of WSCs however had not received training in gender resource and gender task analysis (Water Resource and Environment Consultants, 2006). It is important to note that in Uganda, the Minister for Water and the Environment is a woman. Working closely with this dynamic minister will be important for advancing a gender perspective at the national level.

More often than not, it is believed that cultural beliefs have a strong impact on sanitation in that in some instances people would be uncomfortable talking about sanitation issues. It is believed that each society has its own way of dealing with sanitation which varies with age, gender, marital status, education level, religion, locality, income and physical capacity.

Several cultural practices in the country determine the acceptance, use, of water sources and thereby influencing various sanitation outcomes. These cultural factors may partly explain the lag behind sanitation in Uganda. The attitude and practice towards human waste disposal, water use and sanitation practices among communities include:

- People shunning water from safe sources like boreholes and drawing dirty water from unprotected wells, streams and rivers. There is the belief that the water from unprotected sources is thick and tastes sweet. The habit is noted to be common among old people and the illiterate, who even order their spouses to strictly serve them with water from wells or the river (Edyegu, 2008).
- The belief that when mothers use pit-latrines, they will not produce children. Some cultural beliefs bar pregnant women from using latrines. They will just relieve themselves in the open, which is a good breeding ground for the Hepatitis E virus (UN Integrated Regional Information Networks, 2008)
- Failure to wash hands after changing babies nappies, before handling food, before eating, after a visit to the toilet, after house cleaning and after work or rubbish disposal due to irregular water supply. Others do not wash food before eating, especially fruits. Men do not wash hands after urinating and they urinate in open spaces (e.g. behind houses, on streets etc.).
- Poor disposal of children faeces and solid waste because of lack of essential services for waste disposal. Most mothers who use disposable nappies throw them in the wild.
- Leaving water containers uncovered or half covered so as to ensure that they capture rain water
- Sharing water with animals because of lack of demarcation areas around households and water sources.
- Use of the bush for defecation in rural areas and polythene bags in urban areas due to lack of toilets
- During traditional ceremonies, people do not wash meat in order to retain its nutrients
- It is sometimes perceived as a disgrace for a father in law to use a toilet used by the daughter in law
- Sometimes, community members would not use toilet facilities because they are afraid there could be '*herbs'* on the toilet seat to bewitch them. Sometimes, one has to defecate outside in order to examine the feacal matter to determine whether s/he has been bewitched or not.
- In most communities, child faecal matter is not perceived as harmful. It is touched with statements like "*ngumtwana lo"* which literally means "*this is a child*"; thereby giving the impression that children faecal matter/stool is clean.

7.4 Water Development Programmes in Uganda

In Uganda the basic unit for planning, financing, building and maintaining sanitation facilities is the individual household. The household members are supposed to lay strategies to improve sanitary conditions, sometimes with the support and encouragement of community mobilizers, the WatSan (water and sanitation) committees and the LC1 executives. Other participants in the sanitation process are the service providers, e.g.; landlords, land owners, community health committees, NGOs, CBOs, contractors, Sanplat (sanitary platform) and masons; others are implementation agencies like the district, Sub-county and Parish Councils and committees and the National level institutions responsible for policies, planning, resource mobilization, training and co-ordination of all sanitation activities (Water Aid Uganda, 2002). Government policy is that households are responsible for their own sanitation and that the government will only provide sanitation in public institutions, urban areas and rural growth centers. However, household survey evidence reveals that increases in household incomes have not been spent on improving sanitation. Rather, it has been spent on improving the roofs, floors

and walls of their houses. This shows that households do not consider sanitation to be a priority (UN, 2003)

The stakeholders in the sanitation sub sector have different targets for the same goal, thereby complicating the monitoring of trends. While the health sector aims at increasing safe waste disposal in 60% of households and institutions in Uganda by end 2004, the water sector's objective is to ensure sustainable access to safe water and sanitation facilities of 65% by 2005 in rural areas, and 80% in urban areas. In an effort to clarify the roles of the different sectors responsible for sanitation, a Memorandum of Understanding (MoU) was signed by all actors at the beginning of 2002. The Ministry of Health was given the responsibility for household hygiene and sanitation, the Ministry of Education and Sports was charged with school latrine construction and hygiene education, and the Ministry of Water, Lands and the Environment mandated with the provision of public and institutional sanitation (UN, 2003). Examples of programmes and experiences of Uganda in the water and sanitation sector are spelt out in Table 16.

A rural water and sanitation reform process was initiated in 1999 in order to put into operation the principles of the new Water Policy. This culminated in the finalization of the Rural Water and Sanitation Sector Investment Plan setting out the investments required to meet sector goals by 2015. The objective of the rural water and sanitation sector as stated in this plan is:'*Sustainable safe water supply and sanitation facilities, based on management responsibility and ownership by users, within easy reach of the rural population by the year 2005 with an 80% - 90% effective use and functionality of facilities. Then eventually to...100% of the rural population by the year 2015'* (MWLE-DWD, 2000)

Table 16: Programmes and Experiences in Sanitation and Hygiene

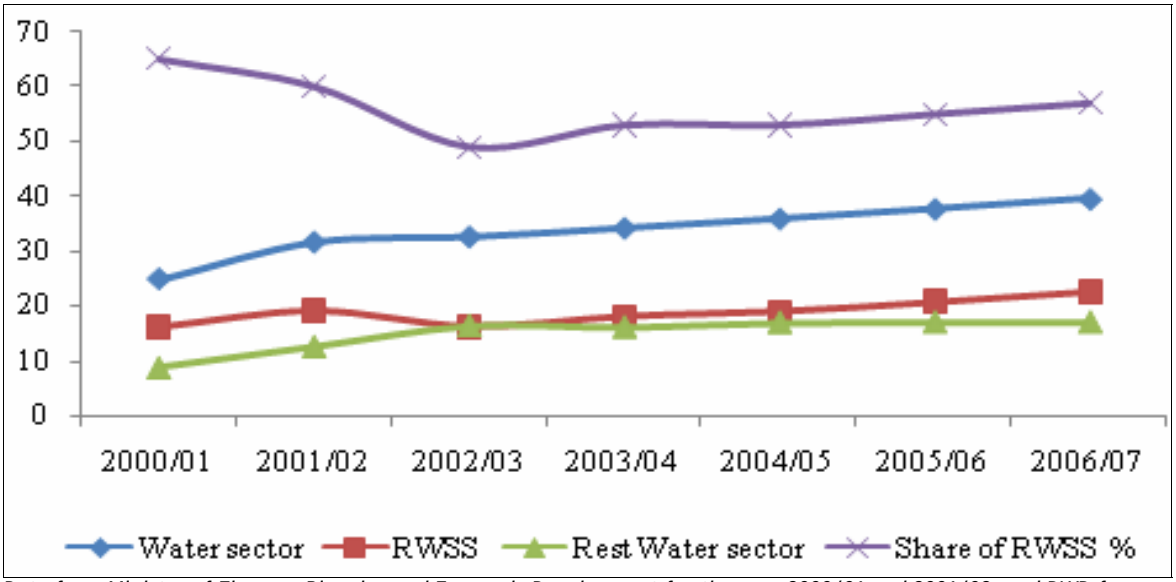
Programme	Operational areas
Water, Sanitation and Hygiene (WASH) in schools	The campaign has been started in the districts of Lira, Mbale, Kiboga and Kabale and would soon spread to other parts of the country.
Ecological Sanitation, WASH in emergencies and, Community-led total sanitation programme	These programmes are cautiously promoted as options for problematic environments such as collapsing soils, high rock or water tables. The current standpoint of the MoH is that - for health reasons and to prevent pathogen transfer - reuse of feaces should not be promoted until proper handling systems are established and widely disseminated. The Ministry of Water, Lands and Environment, through the Ministry's Directorate of Water Development (DWD) plays a leading role in promoting urine diversion toilets as a means of protecting groundwater and has constructed a number of these toilets countrywide.
National Hand Washing Campaign	Campaign is being piloted in 5 districts of Kabale, Mbale, Kiboga, Lira and Kawempe Division in Kampala
Small Towns Water and Sanitation Project	The project is a component of the Rural Towns Water and Sanitation programme jointly funded by the Government of Uganda and the International Development Agency (IDA). The project is intended to provide safe, clean and sustainable water and sanitation facilities in the 11 towns of Rukungiri, Ntungamo, Lyantonde, Rakai, Kyotera, Kalisizo, Busia, Malaba, Lugazi, Luwero and Wobulenzi.
South Western Towns Water and Sanitation Project	The project is funded by the Government of Uganda with support from the Austrian government. It implements water and sanitation activities in 49 towns in Kisoro District, Kabale District, Rukungiri District, Ntungamo District, Bushenyi District and Mbarara District.
Mid-Western Towns Water and Sanitation Project	The project aims at the improvement of water supply and sanitation facilities in the three towns of Hoima, Masindi and Mubende through rehabilitation and expansion of the existing infrastructure. The project is co-funded by the government of Uganda and the European Union. The project is also undertaking feasibility studies and designs for the water and sanitation schemes for the satellite towns of Bujenje, Bwijanga, Kakumiro, Kiganda, Kibaale, Kigorobya and Kyatiri through the GoU funding.
Southern Towns Water and Sanitation Project	This is a Government of Uganda (GoU) project with assistance from the French Government. The project was officially launched in September 2000 and is to benefit a total of 80,119 people in the towns of Nansana, Wakiso, Kakiri (in Wakiso District), Lukaya, Kinoni, Mbirizi, Kyazanga, Bukomansimbi, Kalungu (in Masaka District) and Sembabule (in Sembabule District). Project towns will be provided with piped water systems and improved sanitation facilities.

Small Towns Water and Sanitation Project***	The specific objectives of this project were to: (a) improve health conditions through better water supply, excreta disposal, waste management and public hygiene; (b) alleviate poverty and improve the lot of women; and (c) reduce environmental degradation through better waste management. The project was to provide improved and sustainable water supply and sanitation services in two groups of towns : (a) the 11 small towns (Busia, Kalisizo, Kyotera, Lugazi, Luwero, Lyantonde, Malaba, Ntungamo, Rakai, Rukunguri and Wobulenzi), where most of the town populations drew water from boreholes with hand pumps, springs and traditional sources such as rivers and lakes – this was to be implemented by the Directorate of Water Development (DWD); and (b) the rehabilitation of the water sewerage services in Jinja, to be expanded to include Njeru.- to be implemented by the National Water and Sewerage Corporation (NWSC).
North Eastern Towns Water and Sanitation Project -	The project focuses on the small towns in the North East of Uganda and consists of two components. Component A of the project covers the three towns of Soroti, Kaberamaido and Sironko. The part of the project aims at rehabilitating and expanding the existing water supply systems in the three towns. Component B addresses the eight towns of Kumi, Ngora, Moroto, Kotido, Kaabong, Abim, Suam and Namalu. It also focuses on a feasibility study and preliminary design of water supply and sanitation in the project component towns

*Source: *** World Bank, 2005 and DWD [http://www.dwd.co.ug/default2.php?active_page_id=325]*

The key development partners in the water sector include DANIDA, World Bank, EU, France (AFD), Germany (GTZ/KFW), Austria, SIDA, UNICEF, DfID, the Netherlands, Japan (JICA). This increased government funding for the sector is part of government's long-term commitment to fund most of the sector activities through locally generated resources as the economy improves as shown in figure 7.8. Most of the government funding to the sector is being channeled directly to the local governments as conditional grants for implementation of water supply and sanitation activities.

Figure 7.8: GOU Budget allocations and projections for Water Sector & Rural Water and Sanitation Sector (US$ millions)



Data from Ministry of Finance, Planning and Economic Development for the year 2000/01 and 2001/02, and DWD for the years thereafter (Cong, 2003).

7.5 Conclusions

Water is a limited natural resource and a public good fundamental for life and health. The human right to water is indispensable for leading a life in human dignity. It is a prerequisite for the realization of other human rights. The human right to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses. An adequate amount of safe water is necessary to prevent death from dehydration, to reduce the risk of water-related disease and to provide for consumption, cooking, personal and domestic hygienic requirements.

The right to water contains both freedoms and entitlements. The freedoms include the right to maintain access to existing water supplies necessary for the right to water, and the right to be free from interference, such as the right to be free from arbitrary disconnections or contamination of water supplies. By contrast, the entitlements include the right to a system of water supply and management that provides equality of opportunity for people to enjoy the right to water. The adequacy of water should not be interpreted narrowly, by mere reference to volumetric quantities and technologies.

Access to water is both a fundamental human right and an integral ingredient in the achievement of sustainable development and poverty alleviation. According to CARE, 2006; a rights-based approach to water programming means putting people and their rights, rather than technology, at the center. It means empowering poor people to make informed choices about accessing water and using it responsibly; analyzing the power structure and relationship between poor people and policymakers; assisting the policymakers and providers to fulfill their obligations to poor people as users; holding the policy-makers and providers accountable; understanding that lack of access to water is both a cause and a result of poverty; and promoting just and non violent means to settle water disputes that contribute to poverty and rights denial.

In Uganda, the challenge for water and sanitation improvement is enormous. The Government of Uganda has gone ahead to identify 10 'golden' water indicators in the water development strategies to address the different components of adequate water as well as assist the monitoring process. However, in all the data that was reviewed, there is significant discrepancy between water and sanitation provision in the country. There are disparities and inequalities in water and sanitation coverage throughout the country: between regions, within districts, and between urban and rural areas. This helps explain why average water collection times for the rural poor have not fallen significantly despite the rise in coverage. Combined with the slow progress in sanitation, it also helps to explain one of the anomalies of Uganda's human development record: the failure of child death rates to fall with declining poverty and high economic growth. These gaps are important because the benefits of improved access to water and sanitation are mutually reinforcing.

Although relevant and appropriate water policy and asoociated legislations are in place; their application is the issue. For example, it is the national policy target to achieve 100% water and sanitation coverage in large urban areas by 2015. The second Poverty Eradication Action Plan prioritizes water and sanitation, resulting in increases in resources for the water and sanitation sector; but it still receives by far the lowest share of national resources compared to other social sectors. Also it is widely held that coverage figures are often inaccurate as they do not account for non-functionality of facilities nor for distances that people will actually walk to a water point (Water Aid, 2006).

In urban areas, there is a clear commitment of Government and NWSC to develop criteria to identify poor communities as an entry point for providing services. However, these efforts are frustrated by the sheer size of informal settlements which make planning and construction complex, compounded by an unfavourable land tenure system and a lack of adequate information.

7.6 Policy Recommendations

- Women are strong pillars of community life, particularly in deprived areas. They are often more pragmatic than men. It is natural that they take part in the preparation and implementation of new water or sanitation projects. Women's important contribution is not always recognized by governments. However there are clear examples of how giving the power of choice to women has led to significant political and social improvements. In many cases, women take an active part in managing water, either at home or in the community. Increasingly they also participate as professionals in operators and in public authorities. They can be plumbers. They can maintain water networks. Some are managers of water service providers, either public or privately-controlled.

- Providing physically accessible clean water is also essential for achieving gender equality, freeing women and girls to devote more time to the pursuit of education, income generation and even the construction and management of water and sanitation facilities. Women are also a huge source of (often untapped) knowledge regarding the community and culture. Inappropriately designed programmes where key stakeholders, such as women and children, have not been involved can result in facilities not being used, or used incorrectly, putting whole communities at risk of epidemic disease outbreaks. There is a need to understanding the special needs of women and girls for sanitary facilities is essential in the selection and design of sanitation facilities and programmes, which are important aspects of promoting dignity. Water points and sanitary facilities should be as close as possible to shelters to reduce collection and waiting time and the risk of violence to women and children.

- The Ministry of Water and Environment has within the framework of the Rural Water and Sanitation Operational Plan (2002 – 2007) worked so hard to increase coverage of sustainable water supply and sanitation in the country, and also to build capacity. However, there still exist a high number of non-functioning schemes and the likelihood that these numbers will increase in future as the facilities age, unless there is more effective awareness and capacity to operate and maintain these facilities. Increasing coverage cannot be gained at the cost of sustainability of the facilities provided. Sustainable operation and maintenance should remain a prime objective of the water sector**.**

- Selling water is relatively easy, even to the poor – but selling sanitation is much harder, despite the clear public health benefits (Mutagamba, *online)*. Much more work therefore has to be done on sensitization and awareness campaigns to all citizens of the country. Climbing the sanitation ladder holds the prospect of large public health benefits, and advances in sanitation work best when associated with progress in water and hygiene (UNDP, 2006). Water and sanitation overlap with other sectors, such as occupation, energy and nutrition. The provision of water and sanitation is a shared responsibility and thus there is need to strengthen the interaction among various stakeholders; including the Ministry of Water and Environment, other line ministries and development partners in order to promote a sector-wide approach to developments in the sector. To prevent that part of the global disease burden associated with water, sanitation and hygiene, these actors must be engaged to act, including both at policy level and on their specific activities.

- Clean water, the sanitary removal of excreta and personal hygiene are the three foundations for any strategy to enhance public health and respect for human rights. Collectively, these are the most potent antidotes to the parasitic diseases and other infections transmitted through flies and other vectors that blight so many lives in areas where stagnant water is the primary source for drinking, cooking and washing. While clean water and personal hygiene can make a difference on their own, the benefits for public health will be diminished without adequate sanitation, drainage and wider infrastructure for disposing of excreta. That is why public policies for water and sanitation need to be seen as part of an integrated strategy. There is also a need to shift emphasis from the provision of facilities alone to the inclusion of information and education on behavior and practices.

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APPENDIX: DATA SHEETS ON DEMOGRAPHIC, SOCIAL AND DEVELOPMENT INDICATORS OF UGANDA

A: NATIONAL LEVEL INDICATOR

A1: Trends of Selected Demographic, Social and Development Indicators

Key Indicators	Year	
	2002	2007
Health		
Infant mortality rate (IMR) per 1,000 live births	88	76
Under five mortality rate per 1000	152	137
Maternal mortality ratio per 100,000 live birth	505	435
HIV Prevalence rate	6.4	6.4
Immunization rates for DPT3	72	85
Percentage of births delivered by a skilled provider	39	42
Immunization rates against measles	83	85
Total Fertility rate (TFR)	6.9	6.7
Children Age 6-59 months with Vitamin A deficiency	27.9	20.4
Social		
Literacy rate (Aged 10 Years and above)	70	69
Access to toilet facilities (% of Households)	83.8	88
Access to safe drinking water (% of Households)	60.9	68
Pupil teacher ratio (Primary School)	53	57
Pupil classroom ratio (Primary School)	87	72
Primary school Pupils with adequate sitting space		64
Orphanhood rates (Aged less than 18 years)	13.2	14.6
National Public Expenditure on Education as percent of GDP		4.0
Economic		
GINI Coefficient (Inequality measure in household consumption)	0.428	0.408
Urban Unemployment rate	12.2	6.9
Mean per capita consumption expenditure (1997/98=100)	26,663	29,280
GDP per Capita (US $)	280	370
Human Development		
Human development index	0.488	0.581
Literacy rate	65.3	
Life expectancy	50.4	-
Poverty Development		
Percentage of population below the poverty line	38.8	31.1
Human poverty index	36.0	25.2
Gender Empowerment		
Gender Empowerment measure	0.549	0.583
Female Adult literacy rate	59	58
Burden of Diseases		
Children age 6-59 months that are anaemic	65	73
Prevalence of fever in Children under five years	43.9	40.9
Prevalence of Diarrhoea in Children under five years	19.6	25.8
Children under five with symptoms of ARI	22.5	14.5

A2: Tracking Progress against ICPD Goals using selected indictors (ICPD+10 years)

Indicators		1995	2000/2001	2006
Mortality				
Infant Mortality Rate per 1,000 live births		81	88	76
Maternal Mortality Rate per 100,000 live births		527	505	435
Life Expectancy (years)	M	45.7	48.8	48.8
	F	50.5	52.0	52.0
Education				
Gross Primary enrollment	M	-	130	118
	F	-	124	117
Gross Secondary Enrolment	M	-	38.2	36.8
	F	-	30.4	33.3
Percent Illiterate (age above 15 years)	M	-	22.2	20.5
	F	-	42.3	41.3
Reproductive Health-				
Births per 1,000 women aged 15-19 years				203
Contraceptive Prevalence	Any method	15	23	24
	Modern Method	8	18	18
Unmet Need for Family Planning		29	35	41
HIV Prevalence Rate (%) 15-49 years	M	-	-	5.0
	F	-	-	7.5
Women Age 15-19 that have began child childbearing		42.9	31.4	24.9

A3: Tracking Progress against Millennium Development Goals (MDGs), 2001 - 2006

Millennium Development Goal (MDG)	Millennium Development Goal (MDG) Indicator	Progress since 2000			Millennium Development Goal (MDG) Target 2015
		2001	2003	2006	
1. Eradicate extreme poverty and hunger	Percent of Population that is living below the poverty line	38.8	38.8	31.1	-
	Percent of underweight children under 5 years	22.8	-	15.9	-
	Proportion of the working poor	35.9	35.9	28.6	-
2. Achieve universal primary education	Net enrolment ratio in primary education	86	86	84	100
	Literacy rate of 15-24 year olds	78.8	-	69	-
3. Promote gender equality and empower women	Percent of seats held by women in parliament	24.2	24.2	30.1	50
	Percent of ministerial posts held by women	-	-	19.4	-
	Ratio of girls to boys in primary schools	0.984	0.99	0.96	1.00
	Ratio of girls to boys in secondary schools	0.825	0.82	0.84	1.00
	Ratio of literate women to men, 15-24 years	-	0.99	0.92	1.00
	Percent share of women in non agricultural employment	-	-	37.0	-
	Percent share of women in wage employment in the non agricultural sector	-	30.7	28.9	-
4. Reduce/ child mortality	Infant mortality rate per 1,000 live births	88	-	76	31
	Under-five mortality per 1,000 live births	152	152	137	56.0
	Percent of 1 year old children immunized against measles	56.8	56.8	68.1	90.0
	Percent of 1 year old children with all basic vaccinations	36.7	36.7	46.2	-
5. Improve maternal mortality	Maternal mortality ratio per 100,000 live births	505	505	435	-
	Percent of births attended by skilled health personnel	39.0	39.0	42.1	-
	Unmet need for family planning	35	35	41	-
6. Combat HIV/AIDS, malaria and other diseases	HIV prevalence rate (aged 15-49 years)	-	6.4	6.4	-
	Percent of women who used condom at last high risk sex (population 15-24 years)	-	-	38.3	-
	Percent of men who used condom at last high risk sex (population 15-24 years)	-	-	54.5	-
	Percent of women aged 15-24 years with comprehensive knowledge on HIV/AIDS	-	-	31.9	-
	Percent of men aged 15-24 years with comprehensive knowledge on HIV/AIDS	-	-	42	-
	Contraceptive prevalence rate (any method among married women aged 15-49 years)	-	-	17.9	-
	Percent of children under five sleeping under Insecticide Treated Nets (ITN)	-	-	10	-
7. Ensure environmental sustainability	Percent of population using solid fuel	-	-	98.8	-
	Percent of population with sustainable access to an improved water source (Urban)	-	84.0	89.3	100
	Percent of population with sustainable access to an improved water source (Rural)	-	53.5	63.8	62.0
	Percent of population with access to improved sanitation	-	-	10.7	-

	Proportion of land area covered by THF forest	21.3	-	18.3	-
	Debt relief committed under the Highly Indebted Poor Countries (HIPC)	-	$86.6	-	-
8. Develop a global partnership for development	Debt service as percent of export of goods and services	-	-	15.8	-

A4: Trends and Projections of Selected Population Groups in Uganda, 2003 -2017

Indicator	Population Projection						
	2003	2005	2008	2010	2013	2015	2017
Population ('000)							
Total Population	25,089.4	26,741.3	29,592.6	31,784.6	35,357.0	37,906.4	40,578.7
Male Population	12,146.1	12,944.8	14,383.2	15,516,600	17,383.2	18,720.0	20,122.3
Female Population	12,943.3	13,796.5	15,209.4	16,268.0	17,973.8	19,186.4	20,456.4
Urban Population	3.3		3.9				
Implied Vital Rates							
Crude Birth Rate per 1,000	49.9	49.3	49.5	49.6	48.2	47.3	46.3
Crude Death Rate per 1,000	19.3	17.7	15.4	14.4	13.6	13.3	13.1
Rate of Natural Increase (%)	3.06	3.16	3.41	3.52	3.46	3.4	3.32
Population Doubling Time	23.0	22.3	20.7	20.0	20.4	20.8	21.2
Annual Births and Deaths							
Births ('000)	1,251.5	1,318.0	1,463.7	1,577.3	1,703.6	1,791.8	1,877.3
Deaths ('000)	483.9	474.0	455.7	457.8	481.6	504.7	531.0
Absolute Natural Increase ('000)	767.6	844.0	1,008.0	1,119.5	1,222.0	1,287.1	1,346.3
Sex Ratio	93.8	93.8	94.6	95.4	96.7	97.6	98.4
Dependency Ratio	1.15	1.17	1.15	1.14	1.11	1.09	1.07
Median Age	14	14	14	14	15	15	15
Special Interest Groups ('000)							
Children aged 5 years	873.0	930.5	1,029.7	1,106.0	1,230.3	1,319.0	1,412.0
Primary school going (6-12 years)	5,494.6	5,856.3	6,480.8	6,960.8	7,743.2	8,301.5	8,886.7
Secondary school going (13-18 years)							
Teenagers (13-19 years)	4,089.6	4,358.8	4,823.6	5,180.9	5,763.2	6,178.8	6,614.3
Young adults (10-24 years)	8,605.7	9,172.3	10,150.3	10,902.1	12,127.4	13,001.9	13,918.5
Children (less than 18 years)	14,075.1	15,001.9	16,601.5	17,831.2	19,835.3	21,265.5	22,764.7
Adults (18+ years)	11,014.2	11,739.4	12,991.2	13,953.4	15,521.7	16,640.9	17,814.1
Youth (18-30 years)	5,620.0	5,990.0	6,628.8	7,119.8	7,920.0	8,491.0	9,089.6
Working age (14-64 years)	11,014.2	11,739.4	12,991.2	13,953.4	15,521.7	16,640.9	17,814.1
Older persons (60+ years)	1,129.0	1,203.4	1,331.7	1,430.3	1,591.1	1,705.8	1,826.0
Women of reproductive age (15-49 years)	5,551.4	5,895.2	6,540.0	7,044.0	7,865.3	8,449.7	9,066.3
Selected Proportions of the Population							
Percent with age 0-4 years	21.0	20.8	20.6	20.6	20.5	20.2	19.9

Percent with age 5-14 years	30.9	31.5	31.6	31.2	30.8	30.7	30.6
Percent with age 15-49 years	42.3	42.2	42.8	43.4	44.1	44.6	44.9
Percent with age 15-64 years	46.5	46.2	46.4	46.8	47.5	47.9	48.4
Percent of female with age 15-49 years	42.9	42.7	43.0	43.3	43.8	44.0	44.3

B: REGIONAL LEVEL INDICATORS

B1: Sub-Regional Health, Demographic and Social Indicators 2006

Indicator	Urban	Rural	Central1	Central2	Kampala	East Central	Eastern	North	West Nile	Western	South West	IDPs	Karamoja	Uganda
Mortality														
Infant Mortality(per 1000 births)	68	88	102	67	54	74	70	106	98	76	109	123	105	76
Under five Mortality (per 1000 births)	114	153	159	129	94	128	116	177	185	145	181	200	174	137
Child Mortality	49	71	63	66	42	58	50	80	96	75	81	88	78	67
Fertility and its Determinants														
Total fertility Rate(TFR)	4.4	7.1	5.6	6.3	3.7	7.5	7.7	7.5	(7.2)[1]	7.3	6.2	(8.6)[1]	(7.2)[1]	6.7
Women(15-19) who are mothers or pregnant with first child	20	26	21	30	14	25	31	34	22	28	13	43	18	25
Percent Using any Family Planning method	43	21	34	36	48	23	20	11	14	21	27	12	1	24
% Using any modern method	37	15	25	30	40	17	17	8	11	14	18	8	0	18
% of women with unmet need for FP	27	43	36	36	23	44	46	46	47	41	37	58	24	41
Median Age at first sexual intercourse (women age 20-49)	17.2	16.5	16.4	16.0	17.3	15.8	16.2	16.7	16.9	16.1	17.9	16.4	18.8	16.6
Median Age at first marriage (women age 20-49)	19.4	17.6	18.1	17.8	a	17.0	17.4	17.6	17.6	17.3	18.4	17.2	19.9	17.8
Median Age at first child birth (women age 20 – 49)	19.7	18.6	18.5	18.3	a	18.1	18.6	18.9	19.2	18.2	19.5	18.6	a	18.7
Maternal and Child Health														
% women with ANC from a skilled birth attendant	97	93	90	93	97	93	95	94	99	94	91	93	92	94
Women with 2 or more doses of tetanus toxoid for last pregnancy	58	50	48	65	61	51	40	55	51	49	47	63	53	51
% births with assistance of a skilled birth attendant	80	37	52	51	90	56	41	31	35	31	32	34	18	42
Children 12-23 with all basic vaccinations	51	46	41	49	47	42	47	47	46	51	46	54	48	46
Children 12-23 with DPT-3	67	64	52	63	68	60	67	67	61	71	61	84	66	64
Percent of children under 5 with a fever(during last 2 weeks)	25	43	41	38	19	47	53	51	37	35	27	61	36	41

Among them % who received treatment	77	75	83	80	75	66	67	84	68	70	82	86	79	75
% of children under 5 with symptoms of ARI(during the last 2 weeks)	11	15	10	6	9	10	17	21	6	15	20	27	17	15
among them, % who received treatment	68	74	85	(85)	(72)	68	66	81	(72)	66	74	86	66	73
percent with diarrhea	20	27	23	21	17	23	26	36	22	21	31	44	29	26
Among % who received ORT	60	53	58	57	61	44	59	63	50	48	39	72	57	54
Nutrition														
Children under age five who are stunted (%)	26	40	39	30	22	38	36	40	38	38	50	37	54	38
Children under age five who are wasted	7	6	5	3	7	10	3	7	8	5	9	6	11	6
Children under age five who are under weight	11	17	13	8	10	23	11	22	17	15	19	20	36	16
Women 15-49 who are too thin (% BMI <18.5)	6	14	7	7	5	13	19	21	20	10	7	20	32	12
Children 6-59 months who received Vitamin A supplement in past 6 months (%)	34	37	23	29	30	41	29	48	31	49	30	51	47	36
% of Children with Vitamin A deficiency	15	21	23	24	12	32	22	20	20	15	15	9	6	20
% of women with Vitamin A deficiency	17	20	14	21	14	31	24	21	21	13	18	12	7	19
% of children with Anaemia	57	74	80	72	52	80	80	80	69	64	62	78	82	73
% of women with Anaemia	35	52	58	43	33	48	49	64	37	45	50	65	54	49
Median duration of exclusive breastfeeding (months)	2.8	3.1	3.2	2.9	2.6	1.0	3.1	3.2	4.6	3.8	2.8	3.1	4.0	4.3
Malaria														
% of households with any net	61	29	36	29	66	28	44	42	29	20	23	53	14	34
% of households with an ITN	26	14	8	11	23	11	18	29	22	11	11	42	6	16
% of children who slept under any net	49	18	23	17	55	14	34	25	18	10	14	33	12	22
% of children who slept under an ITN	21	8	4	5	16	6	13	18	14	5	7	26	7	10
% of pregnant women who take 2 or more of IPT	18	18	13	13	18	15	16	12	15	26	26	19	6	18

Children with fever who receive antimalarial drugs same day or next day	27	29	31	27	11	22	32	32	43	28	24	32	42	29
HIV/AIDS														
Women with comprehensive knowledge of HIV/AIDS	47	28	39	46	52	36	33	20	15	24	24	26	7	31
Men with comprehensive knowledge of HIV/AIDS	50	40	40	44	57	36	33	39	46	48	40	48	13	42
Women age 15-24 who had sexual intercourse by age 15	12	16	18	14	12	21	20	18	8	19	5	19	6	16
Men age 15-24 who had sexual intercourse by age 15	15	11	18	15	14	5	9	14	21	10	8	15	(7)	12
Sexually active women with higher risk sex in the last 12 months	30	13	25	17	36	15	11	10	9	17	11	11	4	16
Among them % who used a condom	48	29	39	31	52	37	26	16	(41)	33	29	16	*	35
Sexually active Men with higher risk sex in the last 12 months	47	34	49	57	54	30	29	29	35	33	22	35	18	36
Among them % who used a condom	76	53	67	64	80	61	38	45	*53	59	*32	51	*	57
Gender Violence														
Experience of physical violence (% of women 15-49)	54	61	59	59	52	66	76	54	64	56	54	52	49	60
Experience of Sexual violence (% of women 15-49)	31	41	46	32	28	53	43	32	25	43	41	28	33	39
Experience of violence during pregnancy	7	17	15	11	6	16	24	17	16	16	15	17	13	16

Sub-regions

Central 1: Kalangala, Masaka,Mpigi, Rakai, Lyantonde, Ssembabule and Wakiso,

Central 2: Kayunga, Kiboga, Luweero, Nakaseke, Mubende, Mityana, Mukono and Nakasongora,

Kampala: Kampala

East Central: Bugiri, Busia, Iganga, Namuumba, Jinja, Kamuli, Kaliro, and Mayuge

Eastern: Kaberamaido, Kapchiorwa, Bukwa, Kayakwi, Amuria, Kumi, Bukedea, Mbale, Bududa, Manafwa, Pallisa, Budaka, Sironko, Soroti, Tororo and Butaleja
North: Apac, Oyam, Gulu, Amuru, Kitgum, Lira, Amolatar, Dokolo, Pader, Kotido, Abim, Kaabong, Moroto, and Nakapiripirit (include both settled and IDP Populations)

Karamoja: Moroto, Kotido, Abim, Kaabong, Nakapiripirit

DP: IDP camps in Apac, Oyam, Amuru, Kitgum, Lira, Amolatar, Dokolo, and Pader districts
West Nile: Adjumani, Arua, Moyo,Koboko, Nyadri-Terego, Nebbi and Yumbe

Western: Bundibugyo, Hoima, Kabarole, Kamwenge, Kasese, Kibaale, Kyenjojo, Masindi and Buliisa.

Southwest: Bushenyi, Kabale, Kanungu, Kisoro,Mbarara,Ibanda, Isingiro, Kiruhura, Ntungamo and Rukungiri.

Note: An esterisk (*) indicates that a figure is based on very few observations and has been suppressed while figures in parentheses are based on few unweighted cases (25-49 in UDHS 2006)

C: DISTRICT LEVEL INDICATORS

C1: District Demographic, Social and Economic Indicators

Region/District	Projected Population 2008 ('000)			Projected Population ('000)		Growth Rate (%)	Total Fertility Rate	Literacy Rate			Measles Immunization 2007 (%)	Access to Toilet facilities (%)	Access to safe water (%)
	Male	Female	Total	2009	2010			Male	Female	Total			
Kalangala	30.3	20.5	50.8	53.3	62.0	6.5	5.3	81.9	82.4	82.1	82	73.0	35.3
Kampala	701.1	779.1	1,480.2	1,510.2	1,659.7	3.7	4.0	95.4	92.2	93.7	127	93.7	97.6
Kiboga	149.2	144.1	293.3	300.6	333.6	4.1	7.6	71.2	62.1	66.8	97	59.6	44.9
Luweero	194.2	202.2	396.5	399.7	429.0	2.5	6.9	80.0	73.9	76.9	65	78.9	76.2
Masaka	394.8	421.4	816.2	809.9	842.0	0.9	6.8	84.0	79.5	81.6	81	80.2	43.5
Mpigi	219.8	222.1	441.9	440.2	461.4	1.3	7.2	81.7	77.6	79.7	81	72.2	48.6
Mubende	260.3	265.0	525.3	535.7	588.3	3.6	7.3	78.9	71.2	75.1	86	66.1	26.9
Mukono	459.4	469.8	929.2	937.7	1,008.5	2.6	6.3	81.8	75.8	78.8	101	73.6	73.5
Nakasongola	72.0	71.6	143.6	144.1	153.2	2.0	7.4	75.0	66.1	70.5	73	56.9	48.6
Rakai	218.1	231.5	449.6	449.9	475.6	1.7	7.4	79.0	70.6	74.6	84	74.0	30.4
Ssembabule	99.6	102.8	202.3	202.8	215.2	1.9	7.6	75.4	67.6	71.5	91	58.7	17.0
Kayunga	159.1	171.7	330.8	331.5	351.6	1.9	7.3	73.5	61.7	67.3	96	71.8	70.1
Wakiso	554.3	603.9	1,158.2	1,186.7	1,315.3	4.1	4.9	92.0	89.5	90.7	88	85.9	76.6
Lyantonde	36.6	37.4	74.0	74.2	78.6	1.9	7.4	79.0	70.6	74.6	101	73.1	23.5
Mityana	144.7	147.2	291.9	291.4	306.7	1.5	7.3	78.9	71.2	75.1	60	72.2	36.0
Nakaseke	83.1	83.7	166.8	169.5	184.8	3.3	6.9	80.0	73.9	76.9	87	69.0	61.8
Bugiri	261.6	282.3	543.9	560.5	599.0	4.7	8.0	68.9	49.8	58.8	64	52.3	39.3
Busia	126.1	139.2	265.4	268.2	281.2	2.7	7.0	73.2	54.1	63.1	78	70.8	63.8
Iganga	312.9	348.5	661.4	672.8	709.6	3.4	8.0	72.9	58.7	65.3	89	67.5	74.3
Jinja	220.3	230.7	451.0	454.8	475.7	2.5	6.4	83.8	73.0	78.3	94	81.3	92.9
Kamuli	322.4	347.5	670.0	680.4	716.7	3.2	8.1	69.7	54.6	61.8	108	67.3	74.7
Kapchorwa	88.8	93.5	182.3	187.1	199.2	4.3	7.8	70.1	51.9	60.8	50	65.7	60.5
Katakwi	72.6	77.6	150.3	153.7	163.1	3.9	7.2	72.8	44.8	58.0	42	15.9	79.3
Kumi	166.4	179.1	345.5	354.8	377.9	4.3	7.6	73.9	52.3	62.3	97	46.3	57.8
Mbale	191.7	201.2	392.9	397.3	416.6	2.8	7.4	72.4	62.6	67.4	107	74.3	79.8
Pallisa	226.9	244.8	471.7	480.2	506.9	3.4	8.1	66.1	47.0	56.1	84	61.2	58.6
Soroti	244.4	255.4	499.8	517.2	555.1	5.1	7.3	76.6	54.1	64.9	148	40.4	68.1
Tororo	212.4	227.7	440.0	443.5	463.6	2.4	7.6	67.3	48.1	57.3	96	56.8	67.7
Kaberamaido	82.2	85.9	168.1	172.3	183.1	4.1	7.9	81.3	55.4	67.8	81	26.1	64.3
Mayuge	191.8	207.6	399.4	406.7	429.4	3.5	7.5	69.5	54.2	61.5	105	51.7	43.7
Sironko	160.5	168.3	328.8	331.5	346.6	2.5	7.0	68.3	55.9	62.0	105	71.2	62.8
Amuria	136.7	154.5	291.2	310.9	344.2	8.2	7.2	72.8	44.8	58.0	82	17.7	58.5
Budaka	76.7	83.4	160.1	161.6	169.3	2.6	8.1	66.1	47.0	56.1	76	61.7	61.0
Bududa	76.7	77.6	154.3	157.6	167.0	3.8	7.4	72.4	62.6	67.4	138	79.7	61.5
Bukedea	75.0	81.9	156.9	160.9	171.1	4.2	7.6	73.9	52.3	62.3	105	37.8	68.4
Bukwa	30.7	31.4	62.1	63.6	67.5	4	7.8	70.1	51.9	60.8	114	73.4	58.1
Butaleja	92.7	99.7	192.4	195.6	206.3	3.3	7.6	67.3	48.1	57.3	133	59.4	71.0
Kaliro	91.7	96.9	188.6	191.8	202.2	3.3	8.1	69.7	54.6	61.8	98	66.5	85.3
Manafwa	153.9	166.3	320.2	325.5	343.2	3.3	7.4	72.4	62.6	67.4	125	69.2	72.2
Namutumba	94.7	101.5	196.2	198.1	207.3	2.6	8.0	72.9	58.7	65.3	132	61.9	69.3
Adjuman	145.8	146.3	292.1	305.6	331.6	6.4	7.1	78.1	52.6	65.0	35	52.4	84.9
Apac	246.4	260.8	507.2	515.5	543.2	3.5	7.6	83.2	57.7	70.0	82	58.8	62.8

Arua	233.7	257.9	491.5	499.5	526.4	3.5	7.0	80.2	51.0	64.7	57	68.4	75.7
Gulu	173.5	180.1	353.5	357.4	374.7	2.9	7.0	77.7	47.2	62.0	123	59.8	61.1
Kitgum	177.5	179.5	357.0	365.1	387.1	4.1	7.1	77.4	45.4	61.1	84	25.9	50.0
Kotido	93.5	85.8	179.3	188.1	204.6	6.5	-	-	-	-	86	0.0	0
Lira	303.9	322.6	626.5	636.2	669.9	3.4	7.5	82.0	51.9	66.5	104	55.9	59.4
Moroto	131.1	134.2	265.3	276.0	297.7	5.8	6.5	14.8	8.6	11.6	91	8.7	73.4
Moyo	157.4	146.4	303.8	322.2	354.3	7.7	6.5	76.4	54.9	65.7	33	69.7	85.6
Nebbi	241.6	267.5	509.2	513.6	537.3	2.7	7.0	75.9	43.8	58.8	115	72.8	65.0
Pader	216.6	219.4	436.0	450.1	481.8	5	7.0	76.4	41.2	58.4	67	6.5	61.8
Yumbe	202.1	196.1	398.1	423.1	466.4	7.9	7.5	72.8	45.0	58.7	53	17.9	40.7
Nakapipirit	111.6	105.9	217.5	226.6	244.9	5.9	7.0	15.7	8.5	12.1	65	46.4	44.3
Abim	25.1	29.0	54.1	53.5	54.8	0.7	-	-	-	-	108	-	-
Amolatar	56.1	57.6	113.7	114.9	120.5	2.9	7.5	82.0	51.9	66.5	113	47.9	80.0
Amuru	102.0	106.3	208.3	210.4	220.4	2.9	7.0	77.7	47.2	62.0	85	54.5	35.2
Dokolo	76.8	82.4	159.2	162.0	171.0	3.6	7.5	82.0	51.9	66.5	110	58.0	66.5
Kaabong	150.4	150.8	301.2	316.6	345.2	6.8	-	-	-	-	34	-	-
Koboko	91.1	94.1	185.1	193.5	209.6	6.2	7.0	80.2	51.0	64.7	83	64.5	63.6
Maracha/Terego	174.0	190.0	364.1	369.2	388.2	3.2	7.0	80.2	51.0	64.7	N/A	58.6	69.7
Oyam	160.9	168.7	329.6	335.3	353.7	3.6	7.6	83.2	57.7	70.0	102	58.8	43.3
Bundibugyo	134.1	148.1	282.1	291.6	312.6	5.0	7.5	69.1	48.4	58.3	77	71.5	45.0
Bushenyi	394.1	429.7	823.7	825.9	858.7	2.0	7.0	82.3	71.4	76.5	88	91.5	53.8
Hoima	226.1	227.2	453.3	467.0	499.1	4.7	6.9	76.9	62.7	69.8	46	69.1	52.3
Kabale	223.8	257.9	481.7	477.2	490.2	0.8	6.9	80.2	65.9	72.4	62	93.7	84.0
Kabarole	195.1	195.4	390.5	389.6	403.1	1.5	6.7	77.6	68.3	73.0	78	81.8	54.6
Kasese	310.4	335.9	646.3	658.4	695.6	3.6	7.6	78.0	62.6	69.9	80	88.5	69.0
Kibaale	270.1	281.3	551.4	571.0	613.3	5.2	8.2	76.2	61.2	68.5	73	73.3	46.4
Kisoro	106.8	133.2	240.0	239.2	247.2	1.4	7.2	70.1	45.3	55.9	152	81.4	43.8
Masindi	269.1	271.4	540.5	560.1	602.1	5.3	6.9	70.1	49.4	59.7	76	61.4	63.7
Mbarara	199.6	209.5	409.1	410.5	427.2	2.6	7.0	79.3	67.9	73.5	104	91.6	61.0
Ntungamo	208.0	228.4	436.4	439.1	458.0	1.9	7.4	76.7	63.5	69.7	105	88.6	58.5
Rukungiri	143.0	158.7	301.7	301.0	311.5	1.5	6.6	81.9	73.3	77.3	72	92.5	66.1
Kamwenge	143.8	158.5	302.3	304.0	317.0	2.3	7.6	74.6	56.0	64.8	96	78.8	30.0
Kanungu	111.3	120.3	231.6	232.3	241.8	2.1	7.3	77.3	65.0	70.8	153	90.8	58.0
Kyenjonjo	231.0	237.1	468.1	477.2	504.6	3.7	7.7	74.8	59.5	67.0	73	79.3	21.2
Bulisa	35.3	37.9	73.2	73.7	77.0	2.4	6.9	70.1	49.4	59.7	88	42.9	65.2
Ibanda	112.4	118.2	230.5	232.3	242.8	2.5	7.0	79.3	67.9	73.5	118	89.0	47.5
Isingiro	180.7	193.4	374.1	378.3	396.7	2.9	7.0	79.3	67.9	73.5	110	77.0	25.4
Kiruhura	131.0	129.8	260.8	265.5	280.2	3.5	7.0	79.3	67.9	73.5	70	75.2	14.6

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