CITIZEN GENERATED DATA SURVEY REPORT ON SEXUAL REPRODUCTIVE HEALTH AND RIGHTS, GENDER BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN

Kasese, Tororo, Arua, Yumbe, and Terego districts

December 2025

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ACRONYMS AND ABBREVIATIONS

AGDHI	Advisory Gender and Data Hub Initiative
AIDS	Acquired Immune Deficiency Syndrome
CAO	Chief Administrative Officer
CDO	Community Development Officer
CEFORD	Community Empowerment for Rural Development
CGD	Citizen-Generated Data
CSBAG	Civil Society for Budget and Advisory Group
CSO	Civil Society Organization
CWD	Children with Disability
DCDO	District Community Development Officer
DEO	District Education Officer
DHO	District Health Officer
DLG	District Local Government
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender Based Violence
HH	House-H-Hold
HIV	Human Immune Virus
KIIS	Key Informant Interview
SDGs	Sustainable Development Goals
SRHR	Sexual Reproductive Health Rights
STI	Sexually Transmitted Infections
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Household Survey
UNHS	Uganda National Household Survey
VAC	Violence Against Children
VHTs	Village Health Teams

EXECUTIVE SUMMARY

The Sustainable Development Goals (SDGs) underscore the need for inclusive and participatory data systems that amplify citizen voices in monitoring development progress. In this regard, Citizen-Generated Data (CGD) defined as "data that people or their organizations produce to directly monitor, demand, or drive change on issues that affect them" (Data Shift, 2015) plays a vital complementary role to official statistics by addressing critical data gaps and providing timely, localized, and disaggregated insights, particularly on marginalized populations. By fostering community participation in data production and validation, CGD strengthens transparency, accountability, and evidence-based decision-making.

Building on this approach, the Advisory Gender and Data Hub Initiative (AGDHI), in partnership with the Civil Society Budget Advocacy Group (CSBAG) and with support from UN Women Uganda, is implementing the BRIDGE-U Project (November 2025–April 2026). As part of the project, a CGD survey was conducted to generate context-specific evidence to inform policy, programming, monitoring, and reporting on selected indicators under SDGs 3, 4, and 5.

Objectives of the survey

i. Collect household-level experiences and perspectives on SRHR, GBV, and VAC.
ii. Generate citizen evidence data for advocacy, planning, and community feedback.
iii. Strengthen community voice and accountability on national SDG commitments.

Methodology

The study employed both quantitative and qualitative techniques in the collection, compilation, and analysis of survey data. The quantitative component consisted of a household (HH) survey, while the qualitative component included Focus Group Discussions (FGDs), Key Informant Interviews (KIIs), and impact stories. A stratified random sampling design was used, with each of the five districts treated as a stratum. Two sub-counties were randomly selected from each of the districts of Kasese and Tororo, while three sub-counties were selected from each of the West Nile districts of Arua, Terego, and Yumbe to capture communities around refugee settlements. From each selected sub-county, two parishes were randomly chosen, and 15 households were randomly sampled from each parish to form the study sample.

FINDINGS

3.2 SDG3: Ensure Healthy Lives and Promote Well-Being for All at All Ages

Indicator 3.7.1 Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.

84% of the respondents were aware of modern family planning methods. Of these, 54% reported having used at least one family planning method in the last 12 months. These methods included Injectables, Implants, Pills, Male Condoms, Emergency Contraception, and IUDs.

Among those who used modern Family Planning (FP) methods, 49% used injectables, 38% implants, 21% pills, 16% used male condoms with Emergency contraception, and IUDs at 4%

and 3% respectively. Of those who do not use any modern FP method, 27% attributed it to side effects, 21% to lack of information, and 15% to partner refusal.

Indicator 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group.

Overall, 64 girls aged 10-14years had given birth in the past 12 months, while 242 girls aged 15-19 years had given birth in the past 12 months across the five districts. Notably, Kasese district had the highest births among the girls aged 10 -14years and 15 -19 years. The most SRHR services accessed were ANC (83%), Delivery care (69%), and postnatal care and family planning (39%). The leading causes of adolescent pregnancies were peer pressure (21%) followed by lack of parental guidance (20%) and dropping out of school (19%).

2.9.2 SDG4: Ensure Inclusive and Equitable Quality Education and Promote Lifelong Learning opportunities for All

Indicators 4.5.1 Parity indices (female/male, rural/urban, wealth, disability, and other factors) for all education indicators that can be disaggregated.

School attendance levels were nearly equal between boys and girls across households. Overall, 60% of households reported that all their children of school-going age boys were attending school. Of these, 60% were boys while 61% were girls, yielding a Gender Parity Index (GPI) of approximately 1.02. The GPI of 1.02 signifies a slight advantage for girls in school attendance.

The findings reveal that financial hardship was the primary barrier to households sending their children to school. However, girls faced additional gender-specific challenges, including pregnancy and early marriage, which further limited their educational opportunities. While some boys were reported as being too young or uninterested in schooling, girls were disproportionately affected by social factors that significantly disrupted their education and long-term prospects.

The survey findings also showed that both structural barriers (assistive devices, infrastructure, transport) and social barriers (bullying and lack of trained teachers) continue to limit school access for Children with Disabilities. The most commonly reported barrier is the lack of assistive devices, cited by 55% of respondents. This implies that many children lack access to essential learning aids, such as wheelchairs, hearing aids, or visual support tools, needed to participate effectively in school.

2.9.3 SDG5: Achieve Gender Equality and Empower All Women and Girls

Indicator 5.2.1 Proportion of ever-partnered women and girls aged 15+ subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age.

Kasese district reported the highest number of cases for sexual and psychological violence at 24 HHs and 60 HHs respectively, while Arua and Kasese recorded the highest levels of physical violence (15HHs each)

Of the 144 households reporting violence against a girl or woman, 57% sought help mainly from community leaders and family, while 40% did not seek support. Formal services, particularly rendered by CSOs/NGOs/CBOs, were least utilized.

Indicator 5.2.2 Proportion of women and girls aged 15+ subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
Eleven percent (11%) of the households reached reported having a girl or woman aged 15 years and above who had experienced sexual violence by a non-intimate partner. Forty-one percent (41%) of the sexual violence incidents occurred within the home. The home incidents were followed by cases in the community (30%) and along roadsides (23%). This outcome is evidence that sexual violence occurs across both private and public spaces.

Indicator 5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18.
Forty percent (40%) of the households had at least one woman aged 20–24 years. Among these, 43% were married or began living with a partner before the age of 18, indicating a high prevalence of child marriage. The leading drivers of early union were pregnancy (34%) and poverty (33%). These were closely followed by lack of schooling (23%). These three factors underscore the strong link between economic vulnerability, limited educational access, and early marriage.

Indicator 5.3.2 Proportion of girls and women aged 15–49 years who have undergone FGM, by age.
Less than 1% of the HHs were aware of any woman or girl aged 10-14 or 15–49 in the household that had been a victim of Female Genital Mutilation (FGM).

Indicator 5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care.
While nearly half of households (48%) reported that women independently make decisions about their health care, family planning decisions are more commonly made jointly with partners (41%), with a smaller proportion (8%) controlled solely by men or other family members (1%).

Most households reported joint (47%) or independent decision-making (43%) on women's health facility visits. While seven out of every 10 women can access reproductive health services, significant barriers remain particularly distance, limited information, stigma, and partner restrictions.

2.9.4 SDG16: Peace, Justice and Strong Institutions

Indicator 16.2.1 Proportion of Children Aged 1–17 Years Who Experienced Any Physical Punishment And/or Psychological Aggression by Caregivers in the Past Month.
Physical punishment was the most prevalent form of discipline used by adults on children, with 59% of households reporting that a child had been beaten, slapped, spanked, or hit with an object at some point.

Sixty-six percent (66%) of households had the physical punishment occasioned by a parent or guardian, followed by siblings (19%), teachers (18%), other adults in the household (16%), and community members (11%), while 27% reported no physical punishment.

Psychological or emotional violence was also common, including shouting or screaming (58%), threats of harm (33%), and offensive name-calling (25%).

Parenting support or guidance was identified by 83% of households as the most important service needed to reduce Violence Against Children (VAC). Additionally, 81% of the households were aware of safe reporting mechanisms within their community, the most common reporting mechanisms were the Local Council (LC1) (70%), followed by the police or child desk (40%), and the Community Child Protection Committee (31%).

CHAPTER ONE: INTRODUCTION

1.1 Background

The Sustainable Development Goals (SDGs) emphasize inclusive and participatory data ecosystems where citizens and local actors actively contribute to data production and accountability. Citizen-Generated Data (CGD) plays a critical role in SDG reporting by filling data gaps, offering timely insights, and ensuring marginalized groups are not left behind. Produced directly by citizens or civil society, these data complement official statistics, enhance accountability, and provide the granular, contextual information needed to track progress on the SDGs. However, in many districts of Uganda, CGD remains fragmented, unharmonized, and insufficiently integrated into formal monitoring systems. Persistent data gaps exist, particularly for SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), and SDG 5 (Gender Equality), especially at the subnational level. Challenges include inconsistent tools, limited coordination, a lack of standard indicators, and weak data quality assurance.

The Advisory Gender and Data Hub Initiative (AGDHI), in collaboration with the Civil Society for Budget and Advisory Group (CSBAG), with the support of UN Women Uganda, is implementing a Bridging Gender Equality Gaps through Budgeting and Data for evidence-based planning and decision making in Uganda (Bridge-U) project from November 2025 to April 2026. The project aims to improve the availability, quality, and use of data on Sexual and Reproductive Health and Rights (SRHR), Gender Equality, Gender-Based Violence (GBV), and Violence Against Children (VAC) to inform decision-making, interventions, monitoring, and reporting on selected indicators of the Sustainable Development Goals 3, 4, and 5.

1.2 Purpose of the survey

The survey aimed at generating citizen data for tracking SDGs 3, 4, and 5 with a focus on SRHR, GBV, and VAC.

1.3 Objectives of the survey

i. Collect household-level experiences and perspectives on SRHR, GBV, and VAC.
ii. Generate citizen evidence data for advocacy, planning, and community feedback.
iii. Strengthen community voice and accountability on national SDG commitments.

1.4 The process

The survey process followed systematic steps in ensuring that all the study objectives are achieved. The first step was defining the Goal of the survey. The next step was to choose the data collection methods and design data tools that best captured questions aligned to the goal and objectives of the survey. These included a household tool for quantitative data, FGD and KII for qualitative data. The data tools were reviewed and refined by the team to ensure logical flow of the questions. Once the paper-based tools were ready, the quantitative tool was programmed in KOBO-Collect to enable electronic data collection. After developing the survey tool, the team conducted an elaborate sampling process, distributing interviewers across the five study districts. The sampling process was collaboratively done by technical personnel from AGDHI and CSBAG. The technical team conducted a Training of Trainers (ToT) for researchers who would

subsequently conduct training at the local government level. These researchers were also responsible for recruiting, training, and supervising data collection teams within their respective districts. The Training of Trainers (ToT) incorporated a pilot data-collection exercise in Nakifuma and Kangulumira to assess the effectiveness, comprehensiveness, and quality of the data-collection tools. Data collection teams were trained within their respective districts, with participants selected in consultation with CSBAG field teams. The training was conducted over one day, followed by two days of field data collection.

Data collection was monitored and verified at the end of each day to ensure accuracy and completeness. Subsequently, the collected data were cleaned and analyzed to generate frequencies and means for report writing. The results were then presented using graphs, charts, and distribution tables.

1.5 Scope and coverage

The study was conducted in five of the six districts where the Bridge-U project is being implemented. Training for CSO representatives and district local government officials was held at the district headquarters in the study districts of Arua, Terego, Yumbe, Kasese, and Tororo.

District local government and CSO officials included service providers delivering SRHR, GBV, and VAC services within communities across their respective districts. The data collection exercise was conducted at the household level among community members receiving these services. The survey monitored the following indicators.

1.5.1 SDG3: Ensure Healthy Lives and Promote Well-Being for All at All Ages

- Indicator 3.7.1 Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.
- Indicator 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group.

1.5.2 SDG4: Ensure Inclusive and Equitable Quality Education and Promote Lifelong Learning opportunities for All

- Indicators 4.5.1 Parity indices (female/male, rural/urban, wealth, disability, and other factors) for all education indicators that can be disaggregated.

1.5.3 SDG5: Achieve Gender Equality and Empower All Women and Girls

- Indicator 5.2.1 Proportion of ever-partnered women and girls aged 15+ subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age.
- Indicator 5.2.2 Proportion of women and girls aged 15+ subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
- Indicator 5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18.
- Indicator 5.3.2 Proportion of girls and women aged 15–49 years who have undergone FGM, by age.

- Indicator 5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care.

1.5.4 SDG16: Peace, Justice and Strong Institutions

- Indicator 16.2.1 Proportion of Children Aged 1–17 Years Who Experienced Any Physical Punishment And/or Psychological Aggression by Caregivers in the Past Month.

1.6 District characteristics

Arua District has a total population of 159,722 people, comprising 74,949 males and 84,773 females, with women representing 53.1% of the population [1]). Located in the West Nile sub-region, Arua serves as a key urban, administrative, and service hub for surrounding districts, including districts of Terego and Yumbe, which host significant refugee populations. Although Arua hosts comparatively fewer refugees, it experiences substantial spillover effects, particularly increased demand for health, education, and protection services.

According to the Uganda Demographic and Health Survey 2022, the West Nile region continues to record relatively high levels of Gender Based Violence (GBV), particularly Intimate Partner Violence (IPV). For instance, about 44% of women in the region aged 15-49 had experienced physical violence since age 15, while 39.5% of ever-married women aged 15-49 had ever experienced physical violence committed by their current or most recent husband/partner. Violence against Children (VAC), including defilement and early marriage, also remains a persistent concern in many communities, particularly in peri-urban areas and informal settlements where social and economic vulnerabilities heighten the risk of abuse and exploitation.

While Sexual and Reproductive Health and Rights (SRHR) services are relatively more available in Arua District due to its urban infrastructure, adolescents and vulnerable populations, including both refugees and host communities, continue to face barriers such as stigma, discrimination, language constraints, and limited access to youth-friendly services. These challenges often discourage young people from seeking SRHR care and information at health facilities. As a result, many adolescents remain at heightened risk of poor sexual and reproductive health outcomes, contributing to persistently high rates of teenage pregnancy in the district and across the wider West Nile sub-region.

Terego District has a population of 323,253 persons (153,873 males and 169,380 females), with females accounting for 52.4% [2] Located in the West Nile region, Terego is a major refugee-hosting area and is home to settlements such as Imvepi and Rhino Camp, which significantly shape its demographic and social profile. The presence of large refugee populations places additional pressure on already limited resources, including land, health services, and education systems. Recent operational data from the UN indicates that 1,480 GBV incidents were reported in a single

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[1] Uganda Bureau of Statistics 2024: The National Population and Housing Census 2024 – Final Report - Volume 1 (Main), Kampala, Uganda.

[2] Uganda Bureau of Statistics 2024: The National Population and Housing Census 2024 – Final Report - Volume 1 (Main), Kampala, Uganda.

quarter of 2025 across refugee settlements, including those in the West Nile[3]. These vulnerabilities, coupled with limited access to services in remote areas, contribute to poor Sexual and Reproductive Health and Rights (SRHR) outcomes, including high rates of teenage pregnancy among adolescent girls. Violence Against Children (VAC) also remains prevalent, with cases of early marriage, child labour, and abuse reported in both refugee and host communities.

Yumbe District, located in Uganda's West Nile sub-region and bordering South Sudan, has a population of 945,100 people, with a slight male majority[4]. Similar to Terego district, Yumbe is one of Uganda's largest refugee-hosting areas, accommodating a significant number South Sudanese refugees, which substantially shapes its demographic composition and places increased demand on public services. The refugee context amplifies vulnerabilities, particularly Gender-Based Violence (GBV), sexual exploitation, and Violence against Children. Additionally, access to Sexual and Reproductive Health and Rights (SRHR) services remains limited due to overstretched health facilities. Evidence from the UDHS 2022 highlights the limited use of modern contraceptives among women in West Nile (25%).

Kasese District, located in the Rwenzori sub-region along the border with the Democratic Republic of Congo, has a population of 853,831 (408524 males and 445307 females), with females accounting for 52.2%[5]. Unlike districts in West Nile, Kasese is not a major refugee-hosting district, but it experiences significant internal displacement due to recurrent natural disasters such as floods and landslides. These displacement dynamics create conditions similar to humanitarian settings, heightening vulnerability to GBV and VAC. Results of the 2022 UDHS show that 55.3 % of ever-married women aged 15-49 had ever experienced emotional, physical, or sexual violence committed by their current or most recent husband/partner in the Tooro region inclusive of Kasese district. VAC, including child labour and early marriage, is also prevalent, particularly in disaster-affected communities. Access to SRHR services is uneven, with rural and disaster-prone areas facing significant barriers. These factors contribute to high teenage pregnancy rates, especially among adolescents in vulnerable households.

Tororo District, situated in the Bukedi sub-region in Eastern Uganda near the Kenya border, has a population of approximately 609,939 persons, with a slight female majority (53.1%)[6]. While the district is not a major refugee-hosting area, cross-border dynamics with Kenya, influence population movement and service delivery.

According to the 2022 UDHS, Bukedi region, had highest rates of teenage pregnancies (25.9%). Violence Against Children, including early marriage and defilement, remains significant, often driven by poverty and social norms. Access to SRHR services is limited, particularly for

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[3] Gender-Based Violence Dashboard, UNHCR Quarter 2, 2025

[4] Uganda Bureau of Statistics 2024: The National Population and Housing Census 2024 – Final Report - Volume 1 (Main), Kampala, Uganda.

[5] Uganda Bureau of Statistics 2024: The National Population and Housing Census 2024 – Final Report - Volume 1 (Main), Kampala, Uganda.

[6] Uganda Bureau of Statistics 2024: The National Population and Housing Census 2024 – Final Report - Volume 1 (Main), Kampala, Uganda.

adolescents, due to stigma and gaps in youth-friendly services. These constraints contribute to very high teenage pregnancy rates, reinforcing cycles of vulnerability in the district.

1.7 Report structure

The report is structured into four main chapters. It begins with the Executive Summary, which provides an overview of the survey's purpose, methodology, and key findings. This is followed by Chapters 1 through 4, organized as outlined below.

Chapter One: Introduction presents the background, purpose, and objectives of the survey. Chapter Two: Methodology describes the study scope, design, sampling procedures, data collection methods, data management, and analysis approaches aligned to selected SDG indicators (3, 4, 5, and 16).

Chapter Three: Survey Findings details the socio-demographic characteristics of respondents and presents results according to the relevant SDG indicators, including SRHR, education, gender equality, and violence against children, supported by tables, figures, scorecards, and qualitative findings.

Finally, Chapter Four: Conclusions and Recommendations synthesize the key insights from the study and presents actionable recommendations. The report concludes with annexes, which include data collection tools, guides, participant lists, and other supplementary materials.

CHAPTER TWO: METHODOLOGY

2.1 Overview of the Chapter

This chapter presents the methodology adopted for the study, which was guided by the principles of the Data Value Chain (DVC).

2.2 Study Design

The study adopted a mixed-methods design combining quantitative and qualitative approaches. The quantitative component involved a household survey to generate measurable indicators, while qualitative methods included Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and impact stories to provide contextual insights.

2.3 Target Population and Sampling Design

2.3.1 Target Population

The household survey prioritized adult women, preferably spouses, as the primary respondents, recognizing their central role in maternal health, reproductive health, childcare, and overall family welfare. Where possible, men were also interviewed to provide complementary perspectives on gender dynamics and access to services.

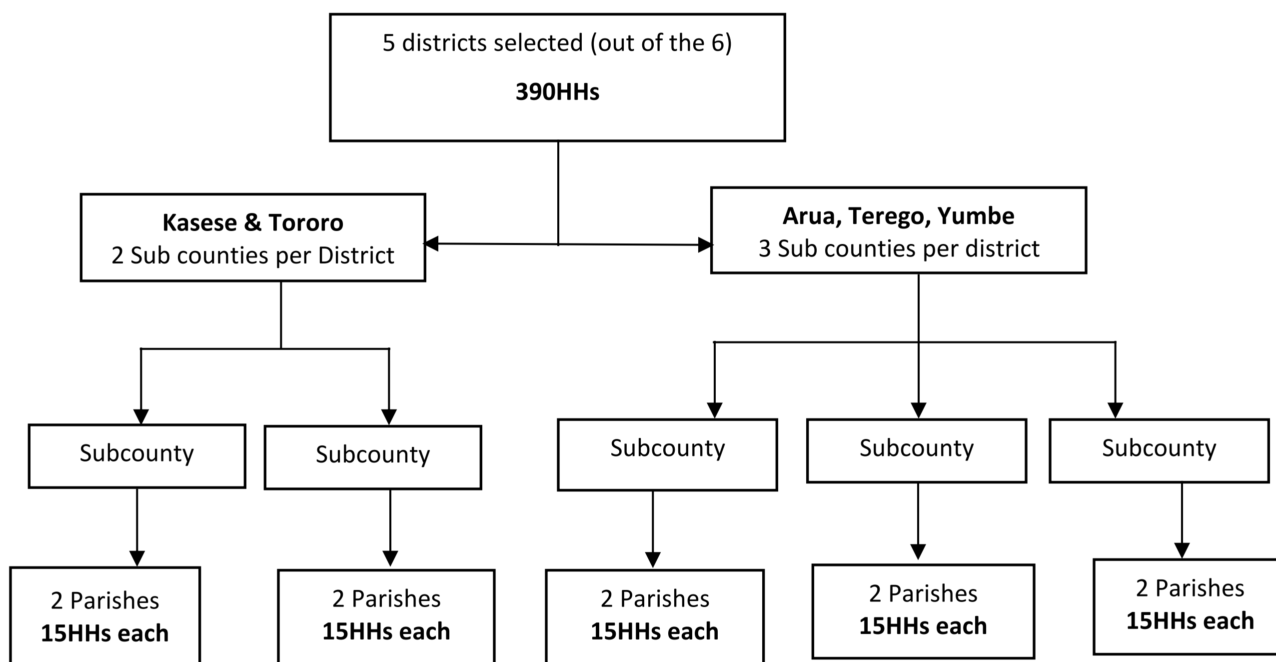
2.3.2 Sampling method and procedure

A combination of purposive and stratified random sampling was used. Purposive sampling guided the selection of districts, key informants, and impact stories, while stratified random sampling was applied at the community level to ensure representation. Sub-counties and parishes were randomly selected, and households were sampled with support from Local Council leaders.

Each of the five districts was a stratum with two sub-counties selected from Kasese and Tororo, while three sub-counties were selected from each of the three districts of Terego, Yumbe, and Arua. From each subcounty, two (2) parishes were randomly selected, and from each parish, a total of 15 households randomly sampled were considered a good representative sample of the study.

2.3.3: Sample size and coverage

The study covered five districts: Kasese, Tororo, Arua, Terego, and Yumbe. A total of 390 households were initially planned as illustrated; however, 550 households were reached to enhance representativeness.



2.4 Data Collection Methods

Data collection employed multiple Citizen Generated Data (CGD)-aligned approaches, including Household Surveys, Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and Impact Stories. This multi-method approach promoted inclusiveness and captured diverse perspectives at both the community and household levels.

Household survey: A household survey was conducted across a representative sample of households in the study districts of Arua, Terego, Yumbe, Kasese, and Tororo to assess community knowledge, access, and utilization of services within the thematic areas of SRHR, GBV, and VAC. In each parish, 15 households were surveyed regarding their knowledge, access, and utilization of these services. A total sample of 550 households was interviewed during field work.
Key Informant Interviews (KIIs): The study involved KIIs with District Heads of Departments, Probation Officers, Police/Criminal Investigations Unit, Headteachers, CSO/CBOs, and VHTs.

Focus Group Discussions (FGDs): Participants of the Focus Group Discussions included: adolescent girls 10-19 years, adolescent boys 10-19 years, female youth 20-29 years, male youth 20-29 years, Women 30-49 years, men 30-49 years, Elderly Women 50+, Elderly men 50+. Each FGD had an average of 6-10 participants.

2.5 Instrument Design and Tools

Data collection tools were collaboratively developed by AGDHI and CSBAG to ensure precision, completeness, and elaboration. The quantitative data collection tools were programmed onto the Kobo Collect platform to facilitate timely, accurate, and efficient collection of the respondents' opinions and perspectives. Copies of these tools are provided in Annex 1 of this report.

2.6 Pretesting of Tools

Pretesting was conducted in Nakifuma and Kangulumira in Mukono district. Feedback from the pretest informed refinement of tools to improve reliability, validity, and clarity. Following the pretest, data collectors participated in a debrief session, and each completed at least two questionnaires to assess both the time required and the quality. The pretest feedback was discussed, and tools were improved in preparation for the main fieldwork.

2.7 Training of Trainers and Data Collectors

The Training of Trainers (TOT) targeted AGDHI staff. AGDHI staff who were subsequently deployed to the study districts to recruit, train and coordinate the data collection exercise. Subsequently, the AGDHI team conducted a two-day training for data collectors in the participating districts. The training covered the study objectives, ethical considerations, and the use of digital data collection tools to ensure quality and consistency in the field.

2.8 Fieldwork and Data Collection Process

Fieldwork was carried out over three days using mobile-based data collection tools. Daily submissions and review meetings facilitated real-time quality control and ensured adherence to Citizen Generated Data (CGD) principles.

2.9 Household Listing and Mapping

Local leaders supported the identification and mapping of households, thereby enhancing community participation and ensuring the accuracy of data collection.

2.10 Data Management and Processing

Data were collected using Kobo Collect, then cleaned and managed in Excel. Qualitative data were transcribed and analysed using NVIVO to ensure systematic interpretation of themes and insights.

2.10.1 Data Analysis and Interpretation

Quantitative data were generated using descriptive statistics. In particular, categorical variables, frequencies and percentages were computed and results presented using graphs and charts. For continuous variables, means, standard deviation minimum and maximum were computed and results presented in tables. Qualitative data (FGD and KIIs) was analysed thematically and the results supported the indicators tracked under each SDG.

2.10.2 Quality Control and Assurance

Quality control measures were implemented across the Data Value Chain, including tool validation, comprehensive training, close supervision, and daily data reviews. Ethical

considerations such as confidentiality, informed consent, and data protection were strictly observed at all stages of the study.

CHAPTER THREE: SURVEY FINDINGS

This chapter presents the findings from a household survey conducted across five districts in Uganda: Arua, Terego, Yumbe, Kasese, and Tororo. The analysis integrates quantitative household data with qualitative insights from Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). Where relevant, findings are triangulated with national statistics to enhance validity and contextual interpretation.

3.1: Socio-economic and demographic characteristics of participants

Understanding the socio-economic and demographic characteristics of respondents is critical for interpreting development outcomes and informing responsive policy design. . This section presents the demographic profile of the 550 households interviewed across the five districts of Arua, Terego, Yumbe, Kasese and Tororo.

3.1.1: Demographic characteristics

Table 1 shows the demographic characteristics of the survey respondents as described below;

Women made up the majority of survey respondents, accounting for 85%, while men represented 15%. This distribution reflects the survey design, which intentionally targeted women as primary respondents due to their central role in household and community welfare.

Education levels were generally low, with 52% having completed primary education and 25% having no formal education. Only 5% had attained tertiary education. The majority of respondents (79%) were married, and 13% reported living with a disability, predominantly physical impairments (59%). The population was largely youthful, with 57% aged between 20 and 39 years and farming was the primary livelihood for 90% of households as described in table 1. The findings are consistent with national patterns reported in the Uganda National Household Survey (UNHS) which showed that over half (55%) of the rural persons in employment were in agriculture, forestry and fisheries sectors.[7]

The findings highlight structural vulnerabilities characterized by low education levels, limited livelihood diversification, and high dependence on agriculture. Such factors constrain access to services, limit economic resilience, and reinforce gendered inequalities in access to information and decision-making.

Table 1 Socio-demographic characteristics of respondents at Household

Variables	Freq (n=550)	Overall (%)
Sex		
Female	465	85%
Male	85	15%
Education level completed		
None	140	25%

[7] Uganda Bureau of Statistics (UBOS), 2025. Uganda National Household Survey 2023/24. Kampala, Uganda; UBOS.

Primary	288	52%
Secondary	92	17%
Tertiary	30	5%
Marital status		
Married	437	79%
Cohabiting	19	3%
Divorced	23	4%
Single	46	8%
Widowed	25	5%
Disability		
Yes	74	13%
No	476	87%
Form of Disability		
Physical	44	59%
Hearing	13	18%
Visual	12	16%
Other	5	7%
Main income source		
Farming	493	90%
Business/enterprise	21	4%
Casual labour	12	2%
Formal employment	16	3%
Informal trade	7	1%
Age		
Below 20	35	6%
20-29	158	29%
30-39	155	28%
40-49	79	14%
50+	123	22%

3.2 SDG3: Ensure Healthy Lives and Promote Well-Being for All at All Ages

Sexual and Reproductive Health and Rights

Sexual and reproductive health and rights entail a set of freedoms and entitlements. The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health[8]. These rights have been reaffirmed through the International Conference on Population and Development, the Beijing Platform for Action and the 2030 Agenda for Sustainable Development, and recognized by international, regional and national human rights mechanisms and jurisprudence.

This section presents findings on family planning awareness and use, adolescent pregnancy, availability of SRHR services and barriers to accessing these services.

Family Planning Awareness and Utilization

[8] https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights)

Indicator 3.7.1 Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.

Awareness of modern family planning methods was high (84%), yet only 54% of respondents reported using one in the past 12 months. (**Table 2**). The gap between awareness and utilization indicates that barriers are not primarily informational but structural and socio-cultural. These include distance to health facilities, stigma, and partner influence.

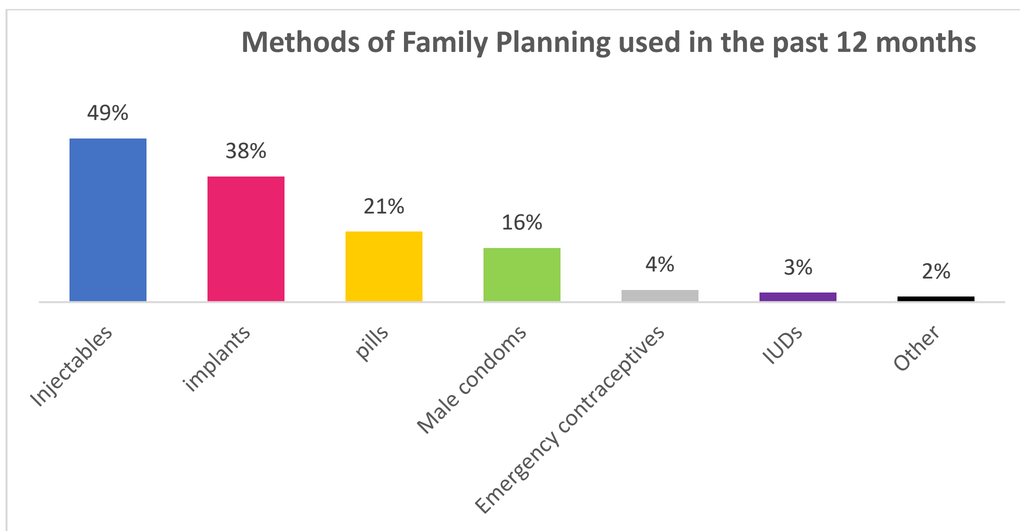
National data shows a similar pattern. According to the UDHS 2022, 66% of currently married women aged 15-49 demand family planning, yet only 58% have their needs satisfied by modern methods

Table 2 Women in HHs are aware of and use modern FP in the last 12months

No. of Households	**550**	
Aware of modern FP Methods	461	84%
Used modern FP for 12 months	247	54%

Among those who reported to have used modern Family Planning methods, nearly half (49%) had used injectables, followed by those that had used implants (38%), pills (21%) and male condoms (16%). A few had used emergency contraception (4%) and IUDs (4%) **(Figure 1)**.

Figure 1 Methods of FP used in the past 12 months



Adolescent Pregnancy

Indicator 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group.

Adolescent pregnancy remains a significant concern across the surveyed districts. This survey found that 35 households reported girls aged 10–14 years who had given birth in the past 12 months, while 133 households reported girls aged 15–19 years who had given birth, with Kasese district recording the highest number of adolescent births across both age groups. (Table 3).

These findings are consistent with national-level evidence, which indicates persistently high levels of adolescent childbearing in Uganda. According to the 2024 National Population and Housing Census (NPHC), 7% of girls aged 10–19 had begun childbearing (either already mothers or pregnant) at the time of the census. The survey findings and national data demonstrate a consistent and concerning trend; despite variations across districts, adolescent pregnancy remains widespread, particularly among girls aged 15–19, underscoring persistent gaps in access to sexual and reproductive health information and services).

Table 3 Adolescent girls' birth rate by district

	Girl 10–14 given birth in past 12months			**Girl 15–19 given birth in past 12 months**		
District	**Prefer not to answer**	**Yes**	**No**	**Prefer not to answer**	**Yes**	**No**
Arua	3	6	114	2	33	88
Kasese	4	16	102	2	48	72
Terego		1	92		12	81
Tororo		5	115	1	21	98
Yumbe		7	85		19	73
Total	**7**	**35**	508	**5**	**133**	412

Citizens identified the major causes of adolescent pregnancies in the community as: peer pressure (21%), lack of parental guidance (20%), and dropping out of school (19%).

Brenda's (not real names) experience reflects this reality. Left to navigate early pregnancy on her own at the age of 16, she struggled until she accessed skills training through CEFORD, which enabled her to earn an income and care for her child.

"………I lacked school fees. I was staying at home. I stopped in Primary three. So, when I was at home, I got a man who impregnated me. I conceived, gave birth to a child, and the man failed to take care. …… I didn't get any help, not even from a relative, not even from a friend. I was stressed, staying at home. ……life was not okay for me; I was living a miserable life. But with time, I got a chance and heard of an organization called CEFORD, which was looking for young mothers who were staying at home. So, I got a chance, applied, and was approved. ……. Now, at the Atizan, doing hairdressing, I can get someone, plait her, or do a hot comb and get some money…..and that money is used to take care of my child. I am no longer suffering like I used to……''

Impact story, Kasese district

Brenda's story proves that with the right support, young mothers can overcome adversity and thrive.

Availability of SRHR services

At the household level, the availability of services was relatively good, rated at (48.9%). FGDs affirmed these findings and reported that several SRHR services were available within communities. These included:

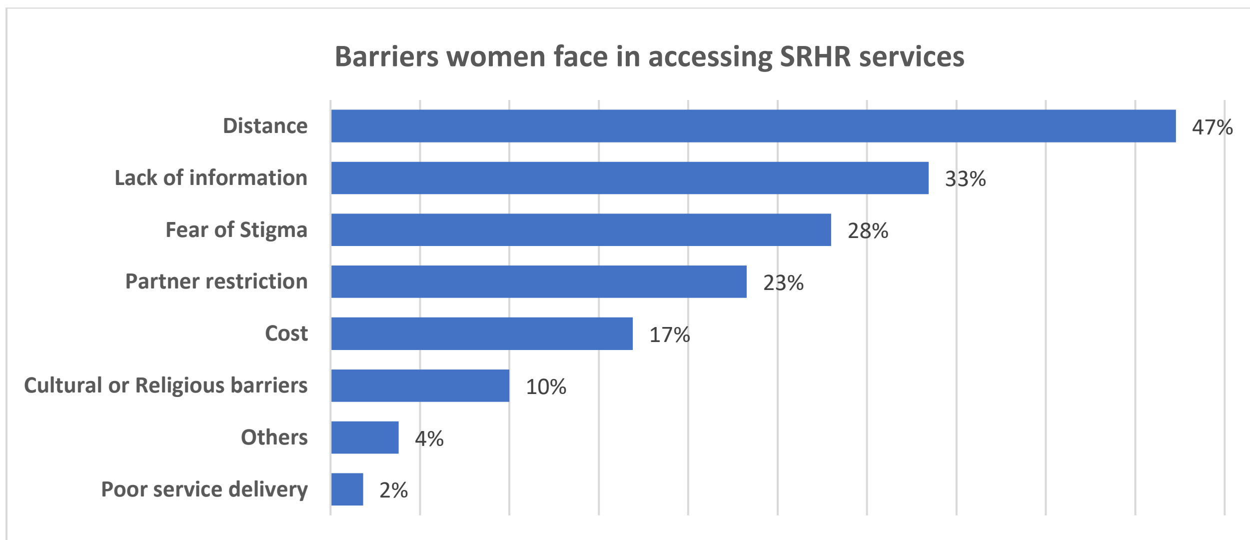
- Family planning services
- Antenatal care (ANC)
- Postnatal care (PNC)
- Child delivery services
- HIV counselling and testing
- Cervical cancer screening
- Youth-friendly services
- Community health education
- Health outreach services

Village Health Teams (VHTs) were identified as important providers of health education, referrals, and community outreach services. However, while community members were generally aware of the available services in their communities, many lacked detailed knowledge of how to access them, referral pathways, and reporting mechanisms.

Barriers to Accessing SRHR Services

The survey identified several barriers that prevent women from accessing SRHR services.
The most frequently reported barriers included: distance to health facilities (47%), lack of information (33%), fear of stigma (28%), and partner restrictions (23%), as shown in Figure 3 below.

Figure 2. Barriers women face in accessing SRHR services



Other impediments mentioned in the FGDs were: Infrastructure challenges such as poor road networks and lack of bridges further limit access, particularly in remote communities, stockouts of essential SRHR commodities such as contraceptives, testing kits, maternal health supplies, and poor mindsets where some community members perceive SRHR services as costly or unaffordable, even when services are subsidized or free.

An additional barrier identified from household impact stories relates to health-related complications from contraceptive use, which can lead to discontinuation. One respondent shared her experience with a three-month injectable, which she stopped using after developing ovarian problems.

"I got some problems in my ovary inside. It was big. And they told me that the eggs are getting something inside, then I stopped."

The UDHS 2022 report mirrors these patterns, identifying health concerns or side effects as the leading cause of discontinuation (16%). This highlights that even when contraceptives are accessible, side effects and inadequate medical guidance can prevent women from continuing their use, underscoring the need for improved counselling, follow-up support, and access to alternative contraceptive options to ensure women can safely and effectively manage their reproductive health.

3.3 SDG4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Education

Education is a key driver of social and economic development. Sustainable Development Goal 4 (SDG 4) seeks to *"ensure inclusive and equitable quality education and promote lifelong learning opportunities for all."* Central to this goal is the principle of equity, ensuring that no child is excluded from education on the basis of sex, disability, socio-economic status, or other structural vulnerabilities. Indicator 4.5.1 specifically calls for monitoring parity indices across key dimensions, including gender (female/male), wealth status, disability, and other relevant characteristics, to assess whether education systems are truly inclusive. This section presents household-level findings from five (5) districts in Uganda: Arua, Terego, Yumbe, Kasese, and Tororo.

The analysis examines household child composition, patterns in school attendance, reasons for non-attendance, and the specific challenges faced by children with disabilities (CWDs).

Household child composition

Forty-one percent of households had four or more children, while households with one child and those with no children at all accounted for 11%. Further analysis showed Kasese district having the most households (10%) with four or more children, followed by Arua and Yumbe at 9%. Households with one child or none each accounted for 11% **(Table 4)**.

Table 4 Number of children in households by district

District	Number of children in HH			
	1	2-3	4 +	None
Arua	9 2%	46 8%	52 9%	16 3%
Kasese	14 3%	40 7%	57 10%	11 2%
Terego	10 2%	44 8%	26 5%	13 2%
Tororo	19 3%	43 8%	42 8%	16 3%
Yumbe	8 1%	32 6%	47 9%	5 1%
Total	60 11%	205 37%	224 41%	61 11%
HHs with CWD	5 8%	19 29%	42 64%	0 0%

Indicators 4.5.1 Parity indices (female/male, rural/urban, wealth, disability, and other factors) for all education indicators that can be disaggregated.

School attendance Gender Parity Index (GPI)

UNESCO defines the Gender Parity Index (GPI) as a socioeconomic index that measures the relative access to education for males and females. Based on the survey findings presented in Table 4, school attendance levels were nearly equal for boys and girls across all visited households. Analysis of school attendance by household size reveals strong gender parity. The GPI shows that:

- Single child households have a GPI of 0.96 (22 girls to 23 boys), indicating a slight male advantage.
- Households with 2–3 children report have a GPI of 1.05, reflecting a modest advantage for girls.
- Households with four or more children have perfect parity (GPI = 1).
- Overall, the sample GPI is 1.02, suggesting that girls are slightly more likely to attend school than boys

These patterns align with national statistics reporting a GPI of 1.02 for primary school enrolment.[9] Although gender parity in primary education has been achieved, 11% of the households were unable to send any of their children to school, implying that access challenges are indiscriminate for both boys and girls.

[9] Uganda Bureau of Statistics (UBOS), 2025. Uganda National Household Survey 2023/24. Kampala, Uganda; UBOS.

Table 5. School aged Children in Household attending school

Number of children in HH	Boys			Girls			
	No	Some	Yes	No	Some	Yes	Total
1	18	3	23	14	2	22	60
	30%	5%	38%	23%	3%	37%	11%
2-3	29	14	142	23	19	149	205
	14%	7%	69%	11%	9%	73%	37%
4 or more	27	30	165	28	25	165	224
	12%	13%	74%	13%	11%	74%	41%
None			`				61
							11%
Total	74	47	330	65	46	336	550
	13%	9%	60%	12%	8%	61%	100%

Reasons for Not Attending School

The study results also show that several children remain out of school due to financial and social barriers; For boys, the main reasons included: school fees (32%), being too young (24%), lack of interest (21%) while for girls, the reasons included: school fees (39%), pregnancy (16%) and early marriage (13%). Additionally, Children with Disabilities face barriers such as: lack of assistive devices (55%), bullying and discrimination (33%), and physical inaccessibility of school (20%) as described in Table 7 and Figure 3 below;

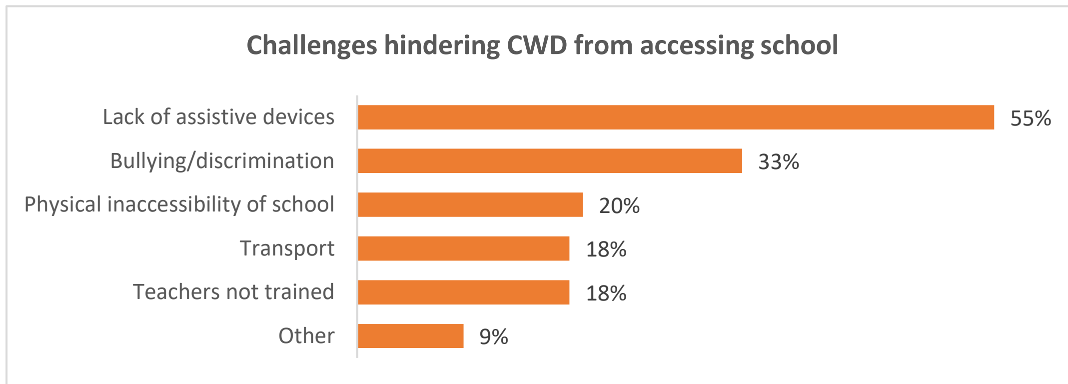
Table 6. Reasons for boys and girls aged 3-18 years not attending school

Boys		Girls	
Reason	%	Reason	%
Fees	32%	Fees	39%
Too young	24%	Pregnancy	16%
No interest	21%	Too young	16%
Peer influence	10%	Early marriage	13%
Other	7%	GBV	8%
Labour	6%	Other	5%
		Chores	2%

Challenges hindering CWD from accessing school

Results show that both structural barriers (assistive devices, infrastructure, transport) and social barriers (bullying and lack of trained teachers) continue to limit school access for Children with Disabilities (CWDs). The most commonly reported barrier was the lack of assistive devices, cited by 55% of respondents, indicating that many children lack access to essential learning aids, such as wheelchairs, hearing aids, or visual support tools, needed to participate effectively in school.

Figure 3 Challenges hindering Children With Disabilities (CWD) from accessing school



Additionally, significant barriers persist in ensuring access, retention, and quality education for CWD. Evidence from some Key informant Interviews showed that dropout rates for CWD are particularly high in early primary levels due to limited teacher capacity and lack of specialized support**.**

"When they reach P3… they realize they are not achieving anything and tend to drop out because they are not handled the way they are supposed to be handled".

Operational challenges at the district level also continue to constrain effective service delivery. Limited funding, lack of transport, and the absence of decentralized coordination structures reduce the ability to monitor schools and follow up on vulnerable learners as explained by one of the Officials at the district.

"As a Special Needs Officer, I don't even have the means of transport… the facilitation is too little, so you find you reach fewer schools than expected. Previously, we had sub-county coordinators who would reach most schools, but now that structure is no longer there."

Lastly, while administrative data systems such as EMIS are in place, they do not adequately capture learners with disabilities. As a result, additional effort is required at the district level to manually collect and track this data across learning institutions, according to a district official.

"Most of the data we collect as a district is on EMIS… but the system does not give provision for learners with special needs, so I move to all institutions to collect data on learners with disabilities." ***KII, Kasese district***

Despite the challenges, some district officials noted ongoing efforts to strengthen inclusive and quality education systems:

> *"……………………Our plan as Education department is to engage our stakeholders to understand the value of education and have a follow-up mechanism to ensure all children are taken to school. We are unsure quality of education by building capacity of teachers, school management and PTA members to ensure they are able to monitor school activities"* ***KII, Arua district***

3.4 SDG5: Achieve Gender Equality and Empower All Women and Girls

Gender equality and Gender-Based Violence

Sustainable Development Goal 5 (SDG 5) seeks to *achieve gender equality and empower all women and girls* by addressing the social, economic, and structural barriers that limit their opportunities and rights. Gender equality is both a fundamental human right and a critical driver of sustainable development as it seeks to ensure equal access to education, healthcare, economic resources, and decision-making for women and girls.

Gender-Based Violence (GBV) remains one of the most widespread human rights violations affecting women and girls. GBV is any act of violence that results in physical, sexual, economic, psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. (United Nations). Consequently, this section examines the prevalence of intimate partner violence, harmful practices such as early marriage, and women's decision-making power within households, as well as access to Reproductive Health Services, which include information on Family planning.

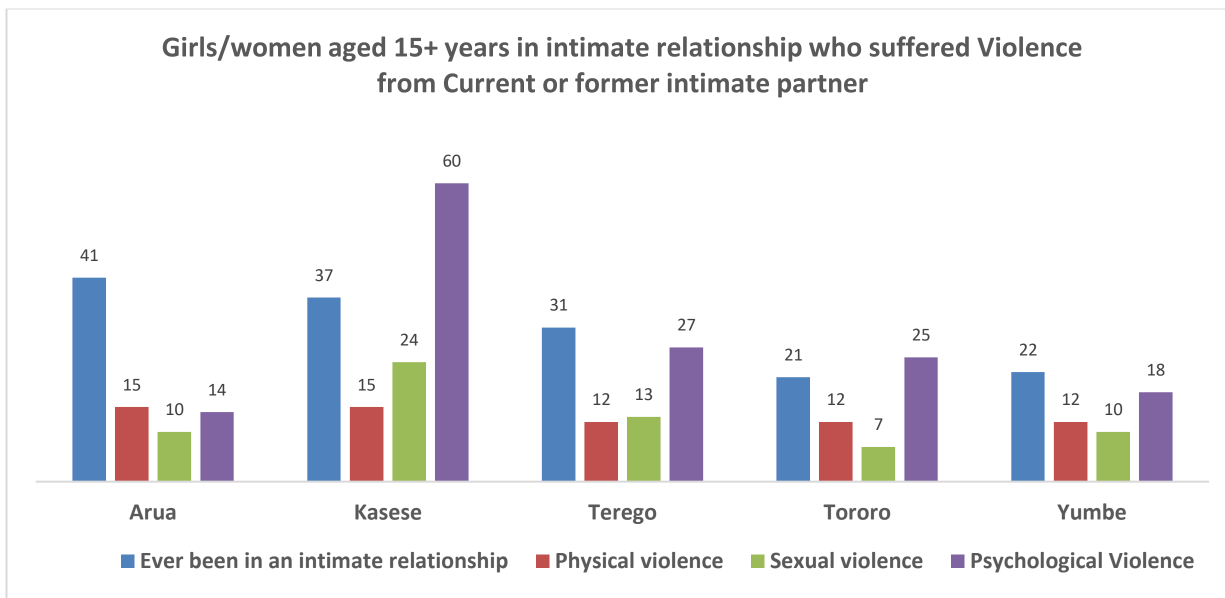
Intimate Partner Violence

Indicator 5.2.1 Proportion of ever-partnered women and girls aged 15+ subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age.

Kasese district reported the highest number of cases for sexual and psychological violence at 24 HHs and 60 HHs, respectively, while Arua and Kasese recorded the highest levels of physical violence (15HHs each), as shown in Figure 4. When situated within the national context where 54% of ever married women had experienced spousal physical, sexual, or emotional violence [10]These findings underscore that GBV is not only pervasive but also geographically concentrated, with certain districts experiencing overlapping and compounded forms of violence.

[10] Uganda Bureau of Statistics 2023. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS.

Figure 4. Girls/Women aged 15+ years in Intimate relationship who suffered Violence by a current or former partner



Help self-seeking behaviour for GBV survivors

Of the 144HHs that had a girl or woman affected by any form of violence, 57% reported that they sought help or support, while 40% did not seek any support. Notably, 3% were not sure if the girl sought any form of support.

The most common sources of support were community leaders (66%) and family members (65%). FGD participants confirmed this pattern, particularly Local Council leaders and clan structures: "*Mainly it's the LC and then the clan leaders.*" Community leaders and family members often serve as the first point of support for survivors because they are accessible and trusted more than formal institutions. While these networks are important, overreliance on them can limit access to adequate protection and justice. Strengthening survivor-centered formal services, especially in high-prevalence districts, alongside ongoing community engagement, is therefore essential for effective GBV prevention and response.

Table 7 Where affected woman or girl sought help or support

Source of Support	Freq	%age
Community leader/ LC	54	66%
Family members	53	65%
Police	25	30%
Counsellor / Social worker	17	21%
Health facility	12	15%
Religious leader	11	13%
CSO/NGO/CBO	5	6%

Community-Based GBV Response Mechanisms

A Key Informant explained the community response process as follows;

> "*Any form of violence by a partner is usually reported by the victims themselves or other persons such as relatives or community members. We usually do counselling and guidance to both parties involved in violence, and if it fails, we take the case or the suspect to court for justice to prevail." (***Key Informant, Yumbe district)**

Participants highlighted several community-based GBV response mechanisms that support prevention and response efforts. These include community dialogue forums, where leaders and community members discuss GBV, challenge harmful norms, and promote peaceful conflict resolution; psychosocial support services provided by civil society organizations, police family units, and probation officers to help survivors cope with trauma; and community policing initiatives that strengthen collaboration between residents and local security structures to improve reporting and survivor protection. In some instances, conflict resolution was framed as a process of constructive communication within families, with participants describing it as "*you share, and you laugh, and you continue with the marriage,"* indicating that such mechanisms may foster increased dialogue and reconciliation.

Participants also noted the use of community bylaws and enforcement mechanisms to discourage GBV and hold perpetrators accountable. In addition, cultural rituals and traditional practices are sometimes used to promote positive values and support healing, while counselling and guidance services from probation officers, Village Health Teams (VHTs), Local Council leaders, and Para-social workers help survivors access legal, medical, and social support.

Broader efforts, such as community sensitization and awareness campaigns, and long-term mindset-change initiatives were also reported as important strategies for transforming harmful gender norms and promoting respect, equality, and non-violence within communities.

From Abuse to safety: A case of Fionah (Not real names)
Fionah, a widowed mother of seven and caregiver to four grandchildren, experienced severe abuse after her husband's death when she was "inherited" by her brother-in-law, a local practice where a male relative assumes control over the widow and household.

> *"…….. I was married, but my husband got an accident and died. The brother to my husband inherited me. He really tortured me, beat me to an extent that I could not tolerate…. My land was grabbed by my late husband's brother who had inherited me until when I ran for support to FIDA and together with PLAN International sent people to intervene. The Paralegals rescued me and got me a home here with my children. Up to now, I am just here… with the fear to go there because the man is still threatening., I stay alone with my children, there's no person who disturbs me''*
>
> ***Impact story, Tororo district.***

Fionah's story demonstrates how formal support structures, when linked with community-based mechanisms, can provide critical protection and recovery for GBV survivors. It also illustrates the continuing risks posed by entrenched gender norms and harmful cultural practices, emphasizing the need for integrated, survivor centred GBV interventions that combine legal, psychosocial, and community-based strategies.

Sexual violence by persons other than an intimate partner
Indicator 5.2.2 Proportion of women and girls aged 15+ subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
Approximately 11% of HHs had a girl/woman aged 15 years and above who experienced sexual violence by persons other than an intimate partner.

The most common locations where sexual violence occurred were within the homes at 41%, within the community (30%), and on the roadside (23%). Of those affected, 61% sought help. The main sources of help were family members (32%), community leaders (30%), health facilities (16%), and the Police (14%).

FGD participants noted that stigma, family pressure, and lack of awareness about legal protection often discourage survivors from reporting sexual violence, particularly when perpetrators are known members of the community.

Harmful practices

a. Early marriage
Indicator 5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18.
The survey revealed that 43% of households with women aged 20–24 had at least one woman who married before age 18. Among those who were married, 90% were married before age 18, and 47% before age 15. This signals not only high prevalence but also extreme early vulnerability,

far exceeding national averages reported in the UDHS 2022, where 34% of girls in Uganda marry or enter a union before age 18, and 7% marry before age 15.

The main drivers for getting married or living with a partner before age 18 years were: pregnancy (34%), poverty (33%), and lack of schooling (23%). FGD participants emphasized that economic hardship and school dropout significantly increase the risk of early marriage, particularly in rural communities where families may view marriage as a coping mechanism. The findings also align with national evidence from the UNHS 2022, where girls in the lowest wealth quintiles have higher rates of early marriage (54%).

b. Female Genital Mutilation

Indicator 5.3.2 Proportion of girls and women aged 15–49 years who have undergone FGM, by age.

Less than 1% of the HHs were aware of any woman or girl aged 10-14 or 15–49 who had undergone Female Genital Mutilation, while 7% HHs were unsure whether the practice existed in their communities, suggesting possible underreporting or limited awareness.

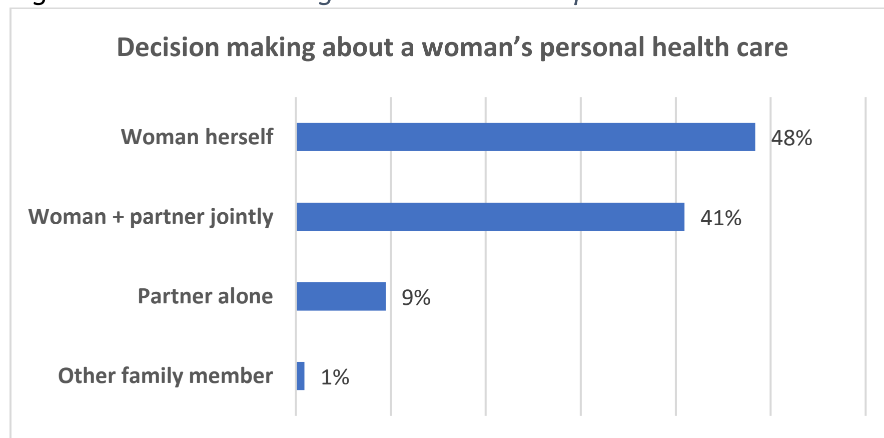
Decision-Making on Reproductive Health

Indicator 5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care.

The survey findings indicate that nearly half of households (48%) reported that women make decisions about their personal health care independently, suggesting a growing level of agency among women on matters related to reproductive health.

In addition, 41% of households reported that health-related decisions are made jointly between women and their partners, indicating a level of shared decision-making within households.
However, the findings also reveal that 9% of households reported that male partners make decisions about women's health care alone. This highlights the persistence of gender power imbalances that may restrict women's autonomy in accessing reproductive health services.

Figure 5 Decision making about a woman's personal health care



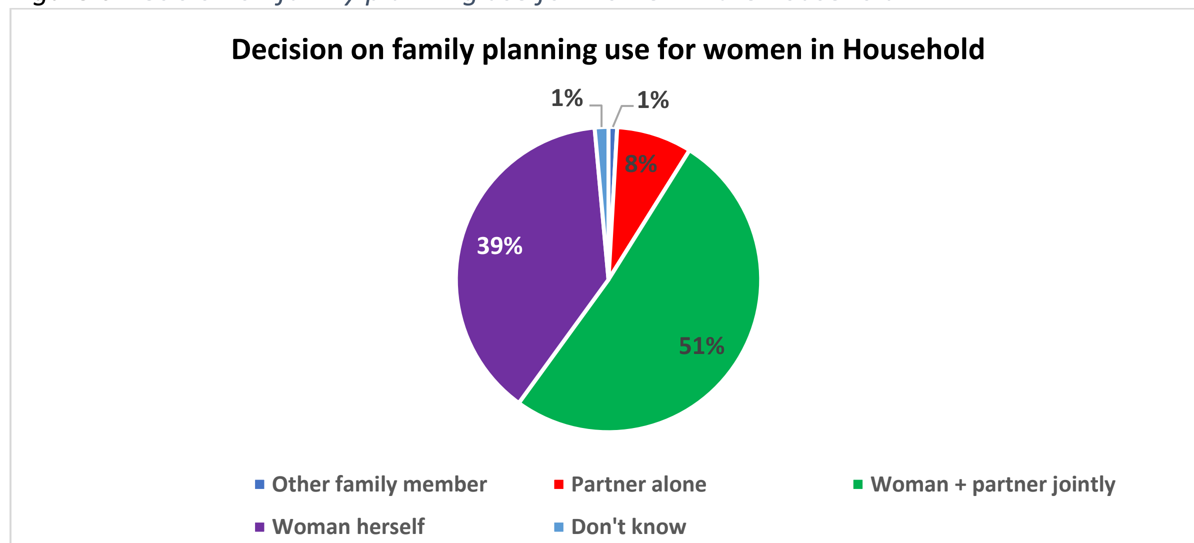
Women across the study districts indicated a gradual shift towards joint decision-making within households, driven largely by community sensitization and SRHR programmes. FGD Participants noted that *“those are things in the house you solve by yourselves,”* highlighting that dialogue and mutual understanding are increasingly used to navigate household decisions. While these programmes have fostered greater collaboration between partners, traditional gender norms continue to shape the extent and equity of decision making within some households.

Impact story findings reinforce this trend, demonstrating how targeted interventions can strengthen couple-level communication and shared decision-making. A participant from Arua District shared her experience:

> *; ‘……. It was not easy to convince my husband. One of the most important changes was my husband's involvement. Through the programme, he also learned and became supportive. For the first time, we talked openly and made decisions together about our family. This support gave me strength and confidence……….”*
> ***Impact story, Yumbe district***

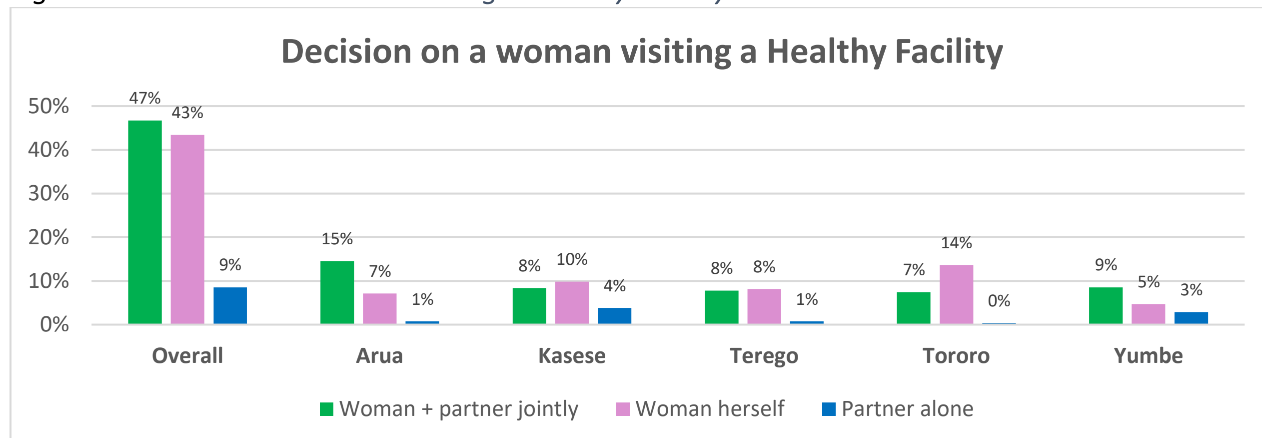
A similar trend was observed for family planning decisions, where; 51% of HHs jointly made decisions with their partners while 39% made decisions by themselves (Figure 6).

Figure 6 Decision on family planning use for women in the household



Regarding visits to health facilities: Overall, 47% of households reported joint decision-making, 43% reported women deciding independently, and 9% reported male partners deciding alone (Figure 7).

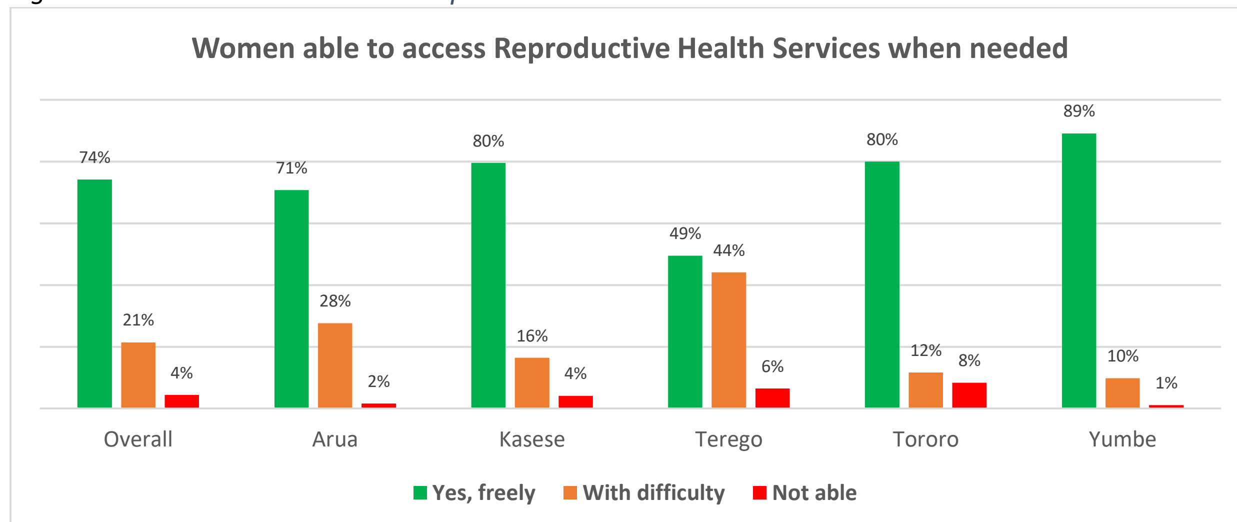
Figure 7 *Decision on a woman visiting a Healthy Facility*



Access to Reproductive Health Services

Overall, 74% of women reported being able to access Reproductive Health Services (RHSs) freely when needed. Yumbe reported the highest level of access (89%), jointly followed by Tororo and Kasese (80%), suggesting relatively better service availability or outreach in these areas. On the other hand, 21% experienced difficulties accessing services and 4% reported being unable to access them at all (Figure 8). Terego reported the highest proportion of accessing services with difficulties (44%), indicating potential barriers such as long distances to health facilities, limited health personnel, or weak outreach services.

Figure 8. *Women able to access Reproductive Health Services when needed*



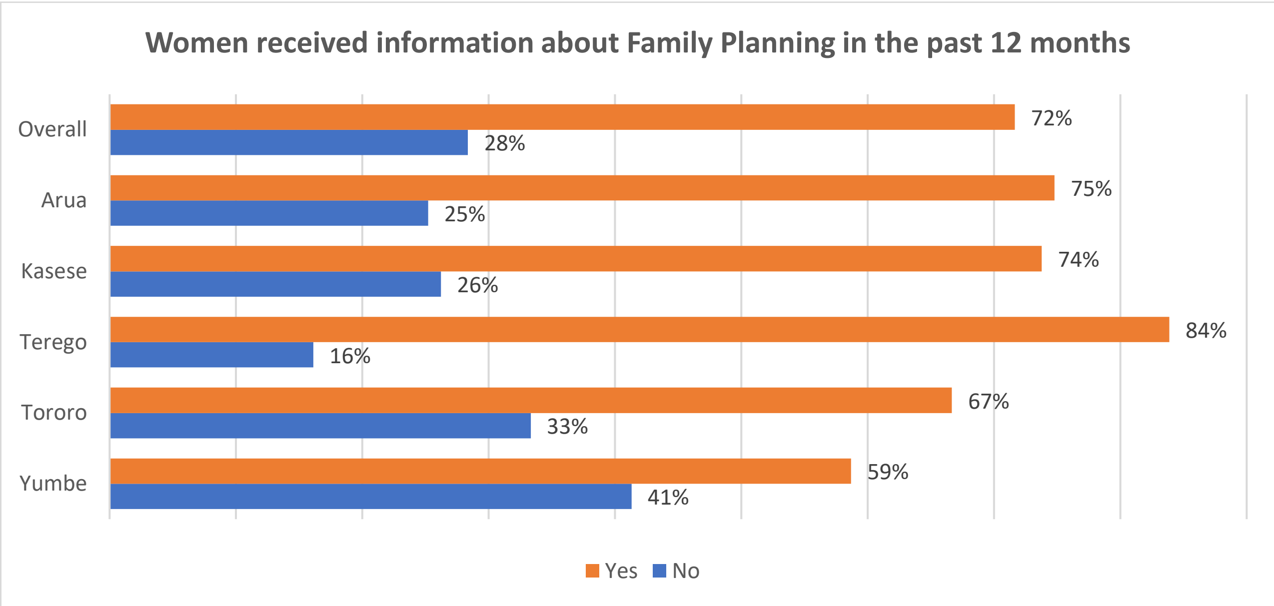
Access to Family Planning Information

Access to accurate and timely information about family planning is critical for enabling women and couples to make informed decisions about reproductive health. Information dissemination

also plays a vital role in increasing the uptake of modern contraceptive methods and reducing unintended pregnancies.

The survey findings indicate that a majority of women (72% of HHs) across all districts reported receiving information on family planning within the past 12 months. This suggests that health promotion efforts through health facilities, community health workers, and outreach programs are reaching a significant proportion of women. However, the findings also reveal notable information gaps across districts. In Yumbe District, 41% of households reported that women had not received any family planning information in the past year, representing the largest information gap among the surveyed districts. Similarly, Tororo District reported that 33% of households had not received family planning information during the same period, as shown in Figure 9. These findings suggest that information dissemination efforts remain uneven, particularly in districts where communities may be geographically dispersed or where health promotion programs are limited.

Figure 9. Women received information about Family Planning in the past 12 months



An impact story from Yumbe District illustrates how community programmes are helping to improve SRHR knowledge and decision-making among couples, enabling women to access family planning services and make informed reproductive health choices.

> *"Before I received support, I did not have enough information about sexual and reproductive health. I did not know family planning or why spacing children is important. These things were not openly discussed in my home or in my community.*
> *Because of this lack of information, I gave birth to children very close together. My body was tired, and life became difficult. I felt overwhelmed, but I did not know where to go for help or what choices I had. Decisions about my reproductive health were not easy to make, and I did not feel confident to speak up.*
> *Everything started to change when I joined an SRHR programme in my community. I visited the health centre, where I received education, counselling, and support. Health workers explained family planning in a way I could understand and helped me see how child spacing can protect both a mother and her children…………''*
> ***(*Impact story, Yumbe district)**

3.5 SDG16: PEACE, JUSTICE AND STRONG INSTITUTIONS

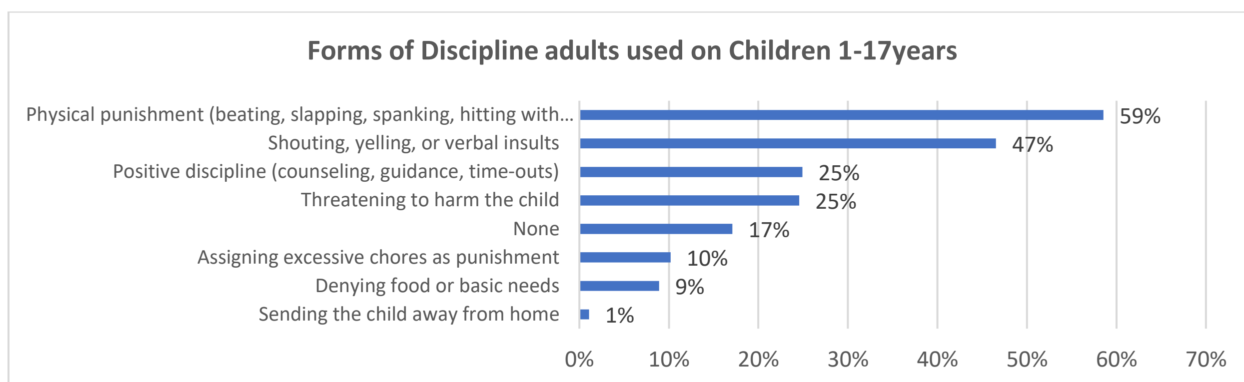
Violence Against Children (VAC)

Violence against children remains a critical protection concern affecting children within households and communities. It undermines their development and well-being. This section examines disciplinary practices and experiences of violence among children aged 1–17 years.
The analysis aligns with SDG Indicator 16.2.1, which measures children's exposure to violent discipline within the home.

Indicator 16.2.1 Proportion of Children Aged 1–17 Years Who Experienced Any Physical Punishment And/or Psychological Aggression by Caregivers in the Past Month.

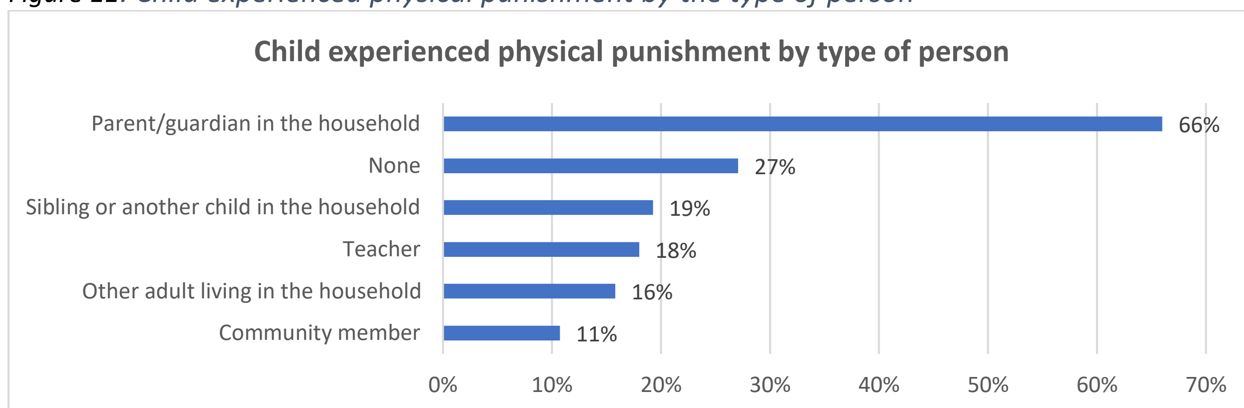
Approximately 59% of households reported that children had been beaten, slapped, or hit with an object, making physical punishment the most common form of discipline. Other common forms included: shouting or verbal insults (47%), positive discipline such as guidance and counselling (25%), threatening harm (25%) and excessive chores (10%). On the other hand, 17% of HHs reported never disciplining a child in the past month (Figure 10).

Figure 10 Forms of Discipline adults used on Children 1-17years



Parents or guardians were identified as the main perpetrators of physical punishment (66%), followed by siblings (19%), teachers (18%), and other adults in the household (16%) (Figure 11). This is consistent with the Uganda Violence Against Children Survey, which reports the highest levels of violence by parents or adult relatives. (45.3% for girls and 48.5%)[11]

Figure 11: Child experienced physical punishment by the type of person



The most common form of physical violence experienced by children was slapping or pulling ear at 59% as shown (Table 8).

Table 8. Types of physical violence children experienced in the past month

Types of physical violence	Freq	Percentage
Slapping or pulling ear	327	59%
Hitting with stick, belt, or another object	173	31%
None	151	27%
Hitting with hand	143	26%
Kicking or pushing	52	9%
Burning or scalding	21	4%
Locked out or confined	5	1%

[11] Ministry of Gender, Labour and Social Development. Violence against Children in Uganda: Findings from a National Survey, 2015. Kampala, Uganda: UNICEF, 2015.

Additionally, psychological or emotional violence was also common, including shouting or screaming (58%), threatening to beat or harm (33%), calling offensive names (25%), among others (Table 9).

Table 9 Forms of psychological or emotional violence have children experienced in the past month

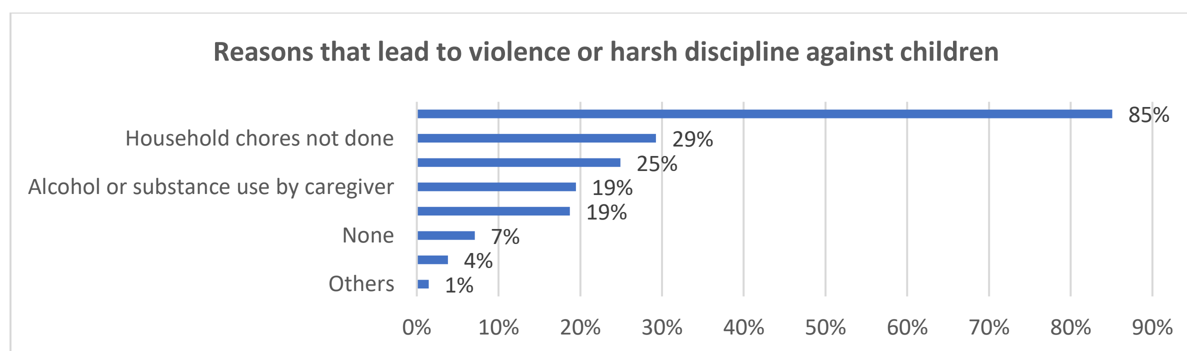
Forms of psychological or emotional violence	Freq	Percentage
Shouting or screaming	321	58%
Threatening to beat or harm	180	33%
Calling offensive names	137	25%
None	135	25%
Humiliating the child in public	62	11%
Threatening abandonment	37	7%

Drivers of Violence Against Children

The main reasons cited for harsh discipline included: child disobedience (85%), failure to complete household chores (29%), poor school performance (25%), caregiver stress or economic pressure (19%). (Figure 12).

FGD participants indicated that harsh punishment is often justified as a way to correct children's behaviour, particularly in cases of disobedience or poor school performance. This implies that violence is socially normalized, undermining child protection efforts and contributing to cycles of vulnerability, including school dropout, early pregnancy, and economic dependency.

Figure 12. Reasons that lead to violence or harsh discipline against children



Support Services for Children

Households identified several key services needed to reduce violence against children. The majority (83%) of the respondents mentioned parenting support and guidance. It was followed by counselling and psychosocial support (46%), school-based support programs (35%), and community awareness programs (31%) (Table 10).

Table 10 Support or services children need to reduce violence

Support	Freq	%
Parenting support or guidance	459	83
Counselling / psychosocial support	253	46
School-based support	190	35
Community awareness programs	171	31
Access to child protection services	116	21
Reporting channels/helplines	52	9

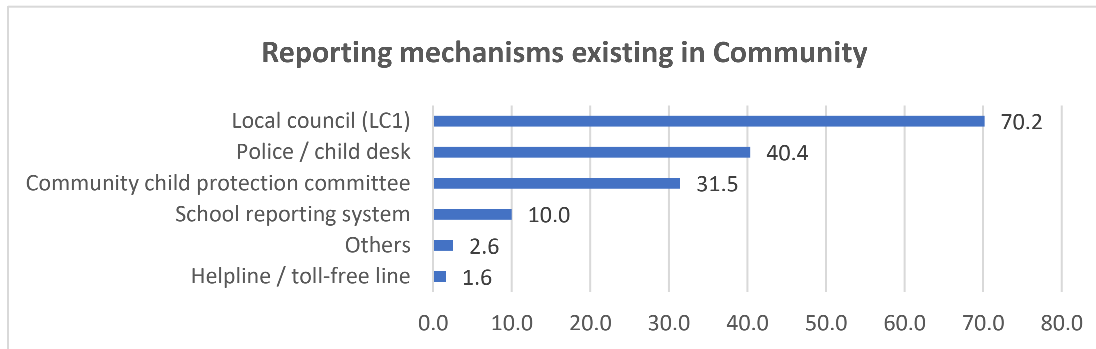
FGD reinstated Child protection services, mostly provided by LC1, LC2, LC3, Education services, among others, as available services in the communities that help in reinforcing VAC.

VAC services available in the community

- Child protection services, mostly provided by LC1, LC2, LC3, and police, ensure children are safe from abuse, neglect, and exploitation by identifying cases of violence, responding to them, and linking affected children to appropriate support and legal services.
- Education services, including schools and vocational institutions, provide children with access to learning in a safe environment, helping them gain knowledge, life skills, and awareness of their rights, which reduces their vulnerability to violence and exploitation.
- Foster parenting offering temporary or long-term care for children who cannot live with their biological parents, ensuring they grow up in a safe, supportive, and nurturing family environment. Orphans and neglected children are taken up for care by well to do families and foster homes.
- Children are immunized routinely to protect them from preventable diseases, promoting good health and reducing illness-related neglect, disability, or death.
- Provision of preventive and curative malaria services. These services include malaria prevention methods such as mosquito nets and health education, as well as diagnosis and treatment to protect children from malaria-related illness and complications.
- Counselling and psychosocial support. These services help children who have experienced violence or trauma to cope emotionally, rebuild confidence, and regain mental well-being.
- Health outreaches bring medical services closer to communities, especially hard-to-reach areas, ensuring children receive healthcare, screenings, and health education.
- Community policing involves collaboration between community members and law enforcement to prevent crime, report abuse, and promote child safety through awareness and early intervention.

About 81% of households reported being aware of safe reporting mechanisms for child violence, with the most common being Local Council leaders (70.2%), police child desks (40.4), and community child protection committees (31.5%) (Figure 13).

Figure 13. Reporting mechanisms existing in Community



Barriers to Reporting Violence Against Children (VAC)

Focus Group Discussions (FGDs) with community members and key stakeholders highlighted several social, institutional, and cultural barriers that prevent children from reporting cases of violence. These barriers limit the effectiveness of child protection mechanisms and allow abuse to remain hidden within families and communities. The barriers include;

a) **Fear/stigma**. Many children are afraid of punishment from parents, caregivers, or perpetrators, and some fear that reporting abuse may lead to retaliation or more severe forms of violence. This fear is particularly strong when the perpetrator is a family member or someone in a position of authority.

b) **Corruption within some government institutions.** Participants also highlighted corruption within some government institutions that would otherwise have been the primary reporting mechanisms. This vice weakens the response to cases of violence against children. Other unethical practices, such as bribery or interference by influential individuals, may lead to cases being ignored or dismissed, thereby reducing trust in the justice system.

c) **Weaknesses of the legal and child protection systems include slow legal processes, poor follow-up of reported cases, and limited enforcement of child protection laws**. These challenges discourage both children and community members from reporting abuse, as they get frustrated by the delayed dispensation of justice, let alone the impunity of perpetrators.

d) **Limited knowledge and harmful social norms**. In many communities, harsh punishments, child labour, and silence around family matters are normalized, leading to indifference among some caregivers and community members. This “don’t care” attitude reduces collective responsibility for child protection.

e) **Limited availability of psychosocial support services for children who experience violence**. The lack of trained counselors, safe spaces, and emotional support systems makes it difficult for survivors to report abuse and recover from trauma.

3.6 Community Service satisfaction

The Community Service Satisfaction Scorecard was designed to assess the perceived quality and responsiveness of key community-level services related to SRHR, GBV, and VAC. Drawing on the same household respondents, the tool captured user perspectives on service delivery, recognizing that community perceptions are a critical dimension of accountability and system performance.

The findings suggest a moderately positive perception of service delivery, with most services predominantly rated as "Good." For instance, nearly half of respondents rated the availability of family planning and maternal health services as good (48.9%), reflecting relatively strong awareness and presence of SRHR services at the community level. Similarly, local leadership responsiveness to GBV and VAC cases (47.5%), safe learning environments in schools (46.4%), and the availability of community awareness programmes (44.7%) were also largely perceived as functioning adequately. Police handling of GBV cases (43.1%) and the presence of active child protection mechanisms (43.6%) further reinforce this pattern of moderate system functionality.

Table 11 Community Service satisfaction Score card

Services Area	Excellent	Good	Fair	Poor	Very Poor
Health Facilities (SRHR)					
Availability of family planning and maternal care.	**10.9%**	**48.9%**	**26.9%**	**9.5%**	**3.8%**
Accessibility of youth-friendly services.	**5.1%**	**39.5%**	**34.0%**	**14.7%**	**6.7%**
GBV Response Services					
Timeliness of response for survivors.	**5.1%**	**41.3%**	**37.6%**	**12.4%**	**3.6%**
Availability of counselling and psychosocial support.	**4.4%**	**38.4%**	**39.8%**	**13.6%**	**3.8%**
Police handling of GBV cases (sensitivity and confidentiality).	**6.5%**	**43.1%**	**34.0%**	**12.9%**	**3.5%**
Education & Child Protection (VAC)					
Safe learning environment.	**8.7%**	**46.4%**	**31.8%**	**11.3%**	**1.8%**
Active child protection or guidance mechanisms.	**4.4%**	**43.6%**	**37.6%**	**9.5%**	**4.9%**
Support for pregnant girls or survivors of abuse.	**4.2%**	**40.7%**	**34.0%**	**14.7%**	**6.4%**
Community Leadership & Coordination					
Responsiveness of local leaders to GBV/VAC cases.	**5.5%**	**47.5%**	**35.6%**	**9.5%**	**1.6%**
Availability of community awareness programs.	**3.8%**	**44.7%**	**37.5%**	**10.0%**	**3.3%**
Inclusiveness of women, youth, and PWDs in decision-making.	**7.3%**	**42.4%**	**32.5%**	**13.6%**	**3.1%**

Overall, the results point to a system that is present but not yet fully effective, highlighting the need to shift focus from service availability to service quality, inclusiveness, and accountability, particularly for adolescents and other vulnerable populations.

3.7. Challenges during data collection and mitigation measures

During the training of the data collection teams and the conduct of key informant interviews, FGDs, impact stories, and the household survey, the team encountered some challenges. The team, however, put in place measures to mitigate the challenges, ensuring the exercise continued unscathed.

Table 12 Challenges and mitigation measures

Challenge	**Mitigation measure**
Officials earmarked for the key informant interviews were highly engaged in other tasks at the district.	In cases where an official's schedule did not allow for the interview session to take place, such an official was requested to delegate the duty to staff who served similar roles or under their supervision. This helped to ensure that officials who were eventually interviewed effectively represented the views and interests of the target offices.
Some people mobilized to join the data collection team were too old and not agile enough to traverse the village terrain.	Teams were screened to ensure that only those who were energetic, agile, and tech-savvy were recruited. This went a long way in achieving the high response rate realised in such a limited timeline.
Some smartphones were not compatible with Android technology suitable for the Kobo Collect app.	Role plays were performed to, among other things, test the functionality of the enumerators' smartphones. It was at this point that some enumerators learned that their phones were incompatible and quickly arranged replacements.
Submission of interviews was deterred by internet connectivity.	In instances where network was a challenge, the affected enumerators were hot-spotted with a stronger network. This helped to ensure that all interviews were eventually submitted in real time.
Failure of some devices to capture GPS coordinates which inhibited the completion and submission of interviews.	It was discovered that the failure of some enumerators' devices to capture coordinates was because of weak internet connectivity and the type of devices. Trouble shooting was done for each of these devices.

CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

This chapter synthesizes the key findings of the survey and presents actionable recommendations to inform policy, programming, and future research.

4.2 Conclusions

The findings highlight that low educational attainment, heavy reliance on subsistence livelihoods, and minimal income diversification continue to limit development outcomes across the surveyed districts. These conditions increase exposure to gender inequalities, GBV, early sexual debut, adolescent pregnancies, and other sexual and reproductive health challenges.

A key insight emerging from the analysis is the disconnect between service awareness and effective utilization, particularly in the area of sexual and reproductive health. While knowledge of family planning is relatively high, uptake remains constrained by a combination of supply-side barriers, such as limited access, quality concerns, and inadequate youth-friendly services, and demand-side factors, including stigma, misinformation, health concerns, and gendered power dynamics.

Adolescent vulnerability emerges as a critical cross-cutting issue, underscoring the interconnected nature of school dropout, early pregnancy, and economic dependency. The evidence points to the need for a life course approach to programming that addresses these risks in a holistic and sustained manner. Once girls exit the education system often as a result of pregnancy, their prospects for socio-economic advancement become severely limited, reinforcing cycles of marginalization with long-term consequences for individual well-being and the perpetuation of intergenerational poverty.

In the education sector, although gender parity in school attendance has largely been achieved, the persistence of out of school children indicates that the central challenge has shifted from parity to equitable access, retention, and completion. This is particularly pronounced among children from poor households and children with disabilities, who continue to face structural and social barriers to participation.

The findings further reveal that violence against women and children remains pervasive and socially normalized. The widespread use of physical punishment as a disciplinary method for children coupled with the prevalence of intimate partner violence, reflects deeply entrenched social norms. While community-based structures play a critical role in providing initial support, their limited capacity and weak integration with formal systems constrain effective prevention and response.

Service delivery systems, while present, are often not sufficiently responsive, accessible, or inclusive, particularly for vulnerable populations. Geographic disparities, especially in border and refugee-hosting districts, further exacerbate inequities in access to health, education, and

protection services. These contexts require tailored, integrated approaches that bridge humanitarian and development responses.

Importantly, the study highlights the added value of Citizen-Generated Data (CGD) in capturing localized realities and amplifying community voices. Integrating CGD into the National Statistical System, led by the Uganda Bureau of Statistics, presents a strategic opportunity to enhance the granularity, timeliness, and policy relevance of data used for planning and monitoring.

4.3 Recommendations

i. Expanding Access to Quality Sexual Reproductive Health and Rights Services

There is a need to shift from awareness-focused interventions to those that address access, quality, and acceptability of services. Expanding community-based delivery mechanisms, such as Village Health Teams and outreach services, will be critical to reaching underserved populations. Health systems should strengthen adolescent-friendly services, ensuring the availability of a full range of contraceptive options, accurate information, and follow-up support to address concerns related to side effects. Engagement of cultural and religious leaders as informed advocates can play a transformative role in addressing harmful norms and misconceptions.

ii. Strengthening Education Access and Retention

Efforts should prioritize ensuring that all school-age children are not only enrolled but also retained and supported in completing their education. This requires targeted interventions for vulnerable households, including financial support for school supplies and other school-related costs. Particular attention should be given to adolescent girls and children with disabilities, through strengthened re-entry policies, inclusive education systems, and provision of assistive devices. In parallel, community sensitization should address the underlying socio-economic drivers of school dropout, including large household sizes and limited livelihood options.

iii. Preventing and responding to GBV and Violence Against Children

Addressing GBV and VAC requires a dual focus on prevention and response. Community-based interventions should target harmful social norms that normalize violence, including the use of physical punishment. At the same time, there is a need to strengthen formal referral systems to ensure that community-level actors are equipped to link survivors to appropriate health, legal, and psychosocial services. Expanding access to survivor centred services, including safe shelters and counselling, remains essential.

iv. Promoting Economic Empowerment and Livelihood Diversification

Economic vulnerability is a key driver of many of the outcomes observed in this study. Expanding access to skills development, vocational training, and financial inclusion opportunities, particularly for adolescent mothers and young women, can significantly enhance resilience. Integrating livelihood support within GBV and child protection programmes can further address the root causes of vulnerability and dependency.

v. Strengthening Service Delivery Systems

Improving outcomes across sectors will require strengthening the quality, accessibility, and coordination of service delivery systems. This includes expanding last-mile service delivery, enhancing inter-sectoral coordination, and ensuring that services are inclusive and responsive to the needs of vulnerable groups. Targeted strategies are needed for refugee-hosting and border districts, where pressures on services are particularly acute.

vi. Enhancing Data Systems and Evidence Use

To improve planning and accountability, it is essential to support the integration of Citizen-Generated Data (CGD) into the national data ecosystem. Strengthened collaboration between the Uganda Bureau of Statistics and civil society actors will enhance data quality, coverage, and utilization. Greater emphasis should also be placed on using disaggregated data to inform targeted interventions and track progress among vulnerable populations.

Annexes

Annex A1: CGD Household questionnaire

Introduction to Respondents

Hello, my name is…………., and I am working with the Civil Society Budget Advocacy Group (CSBAG). We are conducting a survey to understand the experiences and perspectives of women, girls, and the community on sexual and reproductive health, gender-based violence, and related issues.

Your participation is voluntary, and you may choose not to answer any question or stop the interview at any time. The information you provide will be kept strictly confidential and used only to improve programs and services in your community.

The interview will take approximately 10-15 minutes

Do I have your permission to proceed with the interview? Yes No

No	Questions	Answers	Status
	Section A: Household Background Information		
A1	District / Municipality	☐ Yumbe ☐ Arua ☐ Terego ☐ Kasese ☐ Tororo	
A2	Subcounty / Division		
A3	Parish		
A4	Village		
A5	Sex of Respondent	☐ Female ☐ Male	
A6	Age of respondent		
A7	Marital Status	☐ Single ☐ Married ☐ Cohabiting ☐ Divorced ☐ Widowed	
A8	Highest Level of Education Completed	☐ None ☐ Primary ☐ Secondary ☐ Tertiary	
A9	Do you have a disability?	☐ Yes	

		☐ No	
A10	If yes	☐ Physical ☐ Visual ☐ Hearing ☐ Other	
A11	What is the main source of livelihood for this household	☐ Farming ☐ Informal trade ☐ Formal employment ☐ Casual labour ☐ Business/enterprise ☐ Other	
	Section B: SDG 3: (Ensure Healthy Lives and Promote Well-Being for All at All Ages) **3.7.1 Proportion Women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.**		
B1	Are you aware of modern family planning methods?	☐ Yes ☐ No	
B2	Have you used modern Family Planning in the past 12 months?	☐ Yes ☐ No	
B3	If yes, which methods? (Tick all that applies)	☐ Male condoms ☐ Female condoms ☐ Pills ☐ Injectables ☐ Implants ☐ IUDs ☐ Emergency contraception ☐ Other	
B4	If no, why?	☐ Lack of information ☐ Stock-outs ☐ Partner refusal ☐ Cultural norms ☐ Side effects ☐ Distance ☐ Other	
	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group.)		

B5	In the past 12 months, has any girl aged 10–14 in this household given birth?	☐ Yes ☐ No ☐ Prefer not to answer	
B6	If yes, how many girls aged 10–14 gave birth:		
B7	In the past 12 months, has any girl aged 15–19 in this household given birth?	☐ Yes ☐ No ☐ Prefer not to answer	
B8	If yes, how many girls aged 15–19 who gave birth		
B9	Are there any girls aged 10–19 in this household who currently have a living child	☐ Yes ☐ No ☐ Unknown	
B10	If yes, record how many girls aged 10-19 currently have a living child?		
B11	Were the mothers able to access any SRHR or maternal health services?	☐ Yes ☐ No	
B12	If yes, which SRHR or maternal health services were the mothers able to access?	☐ ANC ☐ Delivery care ☐ Postnatal care ☐ Family planning ☐ Other:	
B13	What do you think is the main reason for adolescent pregnancies in this community?	☐ Lack of access to SRHR information ☐ Early marriage ☐ Poverty Sexual violence/abuse ☐ School drop-out ☐ Peer pressure ☐ Lack of parental guidance ☐ Other	
Section C: SDG4: Ensure Inclusive and Equitable Quality Education and Promote Lifelong Learning Opportunities for All **Indicators 4.5.1 (parity indices (female/male, rural/urban, wealth, disability, and other factors) for all education indicators that can be disaggregated.)**			

C1	How many school-aged children (5–24 years) live in this household?	☐ None ☐ 1 ☐ 2–3 ☐ 4 or more	
C15	Please indicate how many are:	Girls: _________ Boys: CWD:	
C3	Are all school-aged boys in the household currently attending school?	☐ Yes ☐ No ☐ Some	
C4	Are all school-aged girls in the household currently attending school?	☐ Yes ☐ No ☐ Some	
C5	What is the main reason for children 3-18 years not attending school?	Girls: ☐ Pregnancy ☐ Early marriage ☐ Fees ☐ GBV ☐ Chores ☐Too young ☐ Other Boys: ☐ Labour ☐ No interest ☐ Fees ☐ Peer influence ☐ Migration ☐Too young ☐ Other	
C6	Do children with disabilities in this household face challenges accessing school	☐ Yes ☐ No	
C7	If Yes, what challenges hinder CWD in this household from accessing school?	☐ Lack of assistive devices ☐ Teachers not trained ☐ Physical inaccessibility of school ☐ Bullying/discrimination ☐ Transport	

		☐ Other	
	SECTION D: SDG 5 – (ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS) **SDG 5.2.1 (proportion of ever-partnered women and girls aged 15+ subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age.) For all Women & Girls 15+**		
D1	In the past 12 months, has any girl/women aged 15 years and above in this household ever been in an intimate relationship (married, cohabiting, dating, or formerly partnered)?	☐ Yes ☐ No	

D2	If yes, in the past 12 months, are you aware of any woman or girl (15+) in this household who was physically harmed by a current or former intimate partner?	☐ Yes ☐ No ☐ Don’t know	
D3	If yes, how many experienced physical violence?		
D4	In the past 12 months, are you aware of any woman or girl (15+) who was forced or pressured into sexual activity by a partner?	☐ Yes ☐ No ☐ Don’t know	
D5	If yes, how many experienced sexual violence?		
D6	Are you aware of any woman or girl (15+) who has been insulted, humiliated, threatened, or controlled by a current or former intimate partner	☐ Yes ☐ No ☐ Don’t know	
D7	If yes, how many experienced psychological/emotional violence?		
D8	Did any affected woman or girl seek help or support?	☐ Yes ☐ No ☐ Don’t know	
D9	If yes, where did they seek help? (Tick all that apply)	☐ Family members ☐ Community leader / LC ☐ Religious leader ☐ Health facility ☐ Police ☐ CSO/NGO/CBO ☐ Counsellor / Social worker ☐ Other (specify): 6-Other (specify)	

	SDG 5.2.2 (Proportion of women and girls aged 15+ subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence)		
D10	In the past 12 months, has any girl/women aged 15 years and above in this household experienced sexual violence by persons other than an intimate partner?	☐ Yes ☐ No	
D11	If yes, where did this incident occur?	☐ Home ☐ School ☐ Community ☐ Workplace ☐ Road ☐ Other	
D12	Did they seek help or any support after the incident?	☐ Yes ☐ No	
D13	If yes, where did you seek help/ support?	☐ Family ☐ Community leaders ☐ health facility ☐police ☐CBO ☐counsellor ☐ Others	
	SDG 5.3.1 (proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18.)		
D14	Does this household have any women aged 20-24 years?	☐ Yes ☐ No	
D15	If yes, among the women aged 20–24 in this household, did any one of them get married or start living with a partner before age 18?	☐ Yes ☐ No ☐ Don't know	
D16	If yes, how many were married or in a union	Before age 15: ________ Before age 18: ________	
D17	What are the main reasons for getting married or starting living with a partner before age 18?	☐ Poverty ☐ Culture ☐ Pregnancy ☐ Lack of schooling ☐ Family pressure ☐ Other	

	SDG 5.3.2 (Proportion of girls and women aged 15–49 years who have undergone FGM, by age.)		
D18	Are you aware of any girl aged 0–14 in this household who has undergone FGM?	☐ Yes ☐ No ☐ Don't know	
D19	If yes, How many		
D20	Are you aware of any woman or girl aged 15–49 in this household who has been circumcised/cut (FGM)?	☐ Yes ☐ No ☐ Don't know	
	SDG 5.6.1 (proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care.)		
D21	Who mainly makes decisions about a woman's personal health care?	☐ Woman herself ☐ Woman + partner jointly ☐ Partner alone ☐ Other family member ☐ Other	
D22	Who usually decides on family planning use for women in this household	☐ Woman herself ☐ Woman + partner jointly ☐ Partner alone ☐ Other family member ☐ Other	
D23	Who decides whether a woman can visit a health facility?	☐ Woman herself ☐ Woman + partner jointly ☐ Partner alone ☐ Other family member ☐ Other	
D24	Are women in this household able to access reproductive health services when needed?	☐ Yes, freely ☐ With difficulty ☐ Not able	
D25	Have women in this household received information about family planning in the past 12 months?	☐ Yes ☐ No	
D26	What barriers do women face accessing SRHR services? (Multiple choice)	☐ Cost ☐ Distance ☐ Partner restriction ☐ Cultural or religious barriers ☐ Lack of information ☐ Fear or stigma ☐ Other	

	Section E: Violence Against Children SDG 16.2.1: (Proportion of Children Aged 1–17 Years Who Experienced Any Physical Punishment And/or Psychological Aggression by Caregivers In the Past Month.) School-related violence and bullying (in some reporting frameworks)		
E1	In the past one month, what forms of discipline have you or any adult used on children aged 1–17? (Tick all that apply)	☐ Physical punishment (beating, slapping, spanking, hitting with object) ☐ Shouting, yelling, or verbal insults ☐ Threatening to harm the child ☐ Denying food or basic needs ☐ Sending the child away from home ☐ Assigning excessive chores as punishment ☐ Positive discipline (counselling, guidance, time-outs) ☐ None of the above	
E2	In the past month, has any child experienced physical punishment by: (Tick all that apply)	☐ Parent/guardian in the household ☐ Other adult living in the household ☐ Sibling or another child in the household ☐ Teacher ☐ Community member ☐ Other ☐ None	
E3	What types of physical violence have children experienced in the past month? (Multiple choice)	☐ Slapping or pulling ear ☐ Hitting with hand ☐ Hitting with stick, belt, or other object ☐ Kicking or pushing ☐ Burning or scalding ☐ Locked out or confined ☐ None	
E4	What forms of psychological or emotional violence have children experienced in the past month? (Multiple choice)	☐ Shouting or screaming ☐ Calling offensive names ☐ Humiliating the child in public ☐ Threatening to beat or harm ☐ Threatening abandonment ☐ None	
E5	Who in the household or community is most likely to discipline children using violent methods?	☐ Mother ☐ Father ☐ Stepparent ☐ Grandparent ☐ Sibling ☐ Teacher ☐ Neighbor / community member ☐ No one uses violent discipline	
E6	What reasons usually lead to violence or harsh discipline against children? (Multiple choice)	☐ Disobedience ☐ Poor school performance ☐ Household chores not done ☐ Cultural norms supporting physical punishment ☐ Stress or economic pressure	

		☐ Alcohol or substance use by caregiver ☐ Other ☐ None	
E7	What support or services do children in this household need to reduce violence? (Multiple choice)	☐ Parenting support or guidance ☐ Counseling / psychosocial support ☐ Access to child protection services ☐ School-based support ☐ Community awareness programs ☐ Reporting channels / helplines ☐ Other	
E8	Are you aware of any safe reporting mechanisms for child violence in your community?	☐ Yes ☐ No	
E9	If yes, which reporting mechanisms exist?	☐ Community child protection committee ☐ Police / child desk ☐ Local council (LC1) ☐ School reporting system ☐ Helpline / toll-free line ☐ Other	

Annex A2. Community Service Satisfaction Scorecard

Purpose: To assess the quality and responsiveness of key community services related to SRHR, GBV, and VAC.

Target respondents: Community members, survivors, care givers at Household level

Scoring: 1 = Very Poor, 2 = Poor, 3 = Fair, 4 = Good, 5 = Excellent

Service Area	Indicator	Score (1–5)
Health Facilities (SRHR)	Availability of family planning and maternal care	
	Accessibility of youth-friendly services	
GBV Response Services	Timeliness of response for survivors	
	Availability of counselling and psychosocial support	
	Police handling of GBV cases (sensitivity and confidentiality)	
Education & Child Protection (VAC)	Safe learning environment	
	Active child protection or guidance mechanisms	
	Support for pregnant girls or survivors of abuse	
Community Leadership & Coordination	Responsiveness of local leaders to GBV/VAC cases	
	Availability of community awareness programs	
	Inclusiveness of women, youth, and PWDs in decision-making	

Annex A3. Focus Group Discussion (FGD) Guide

Purpose:
To explore community experiences and perceptions, regarding sexual and reproductive health and Rights (SRHR), Gender-Based Violence (GBV), and Violence Against Children (VAC).

Key respondents:
Adolescent girls 10-19 years, adolescent boys 10-19 years, female youth 20 -29 years, male youth 20 -29 years, Women 30-49 years, men 30-49 years, Elderly Women 50+, Elderly men 50+

1. **Access and Use of Services**

What services under each are available in your community

a. SRHR b. GBV c. VAC

2. **Community Awareness and Engagement**

How informed are people in your community about their rights and available services related to

a. SRHR b. GBV c. VAC

(Probe to find out who provides this information)

3. **Barriers and Gaps: What challenges prevent people from reporting or seeking help for;**
   SRHR b. GBV c. VAC

4. **Recommendations and Solutions**

What should be done by government institutions, CSOs, or communities themselves to make SRHR, GBV, and VAC services more accessible, confidential, and effective?

a. SRHR b. GBV c. VAC

Annex A4. Community Impact story guide on SRHR, GBV, and VAC outcomes

Purpose: To capture real stories of change, empowerment, or improved access to SRHR, GBV, and VAC services as experienced by community members.

Target Respondents: Community members, survivors, parents, youth leaders, caregivers, or groups who have directly benefited from or participated in SRHR, GBV, or VAC programs.

Questions

Background

1. Can you tell us a bit about yourself or your community, which issue relates to you and how you were/are involved?

Situation Before

2. What challenges did you face before the intervention or support was introduced?

Change

3. What positive change or difference has occurred as a result of the intervention, program, or service?

What Made It Work

4. What factors contributed to this change?

Lessons

5. What lessons have you learnt along the way as a result of the intervention, program, or service?

Future hopes

6. What further actions would you like to see to improve outcomes in your community/ at personal level?

Annex A5. KIIs for District, Subcounty, Parish and village leaders

Health KII – DHOs/VHTs/CSO

1. As a DHO/VHT/CSOs, what role do you play in the provision of family planning services in this district/community? (Probe for role in uptake of modern FP services by women 15-49)
2. What are the common barriers to women accessing family planning services in this district/community?
3. As a DHO/VHT/CSOs, how would you wish to be supported in order to improve the delivery of family planning services in this district/community?
4. How are adolescent pregnancies tracked in this district/community? (Probe for cases of adolescent pregnancies 10-19 years + those recorded in last 12 months, community preferred reporting mechanisms, case referral pathways)
5. What SRHR services are accessible to adolescents and young people in this district/community? (Probe for modes of access, preferred SRHR services)
6. As DHO/VHT/CSOs, what strategies are you employing to reduce adolescent pregnancies in this district/community? (Probe for prevention activities and challenges faced)
7. What recommendations do you suggest towards the prevention of adolescent pregnancies in this district/community?

Education KII – DEO/Head teacher/CSOs

1. As DEO/Head teacher/CSO, what is your role in the generation and management of data on education in this district/ community? (Probe for capacity and challenges)
2. How do you utilise data on education in your role as DEO/Head teacher?
3. What are the major causes of school drop outs for girls and boys in this district/ community?
4. As DEO/Headteacher/CSO, what is your role in reducing school drop-out rates in this district/community? (Probe for support extended to learners from low-income households & children with disabilities, re-entry and retention of pregnant learners and young mothers)
5. As DEO/Head teacher/CSO, what efforts do you have in place to promote equal education for girls, boys and marginalised learners (e.g., refugees, indigenous groups, conflict-affected, orphans) in this district/community?
6. As DEO/head teacher/CSO, what additional resources or capacity do you require to strengthen gender and inclusion monitoring in the provision of education services in this district/community?

CDO/CSOs/Police/Probation & Social welfare officer/Parish chiefs/LC/Judiciary

1. What is your role in the advocacy/enforcement for Sexual Reproductive Health and Rights in this community/district? (Probe for capacity and challenges)

2. What is your opinion about the availability, accessibility and usability of data on the following forms of violence in this district/community?
   a) Intimate partner violence
   b) Sexual violence by persons other than intimate partner
   c) Sexual violence involving minors
   d) Early or forced marriages
   e) Female Genital Mutilation
   f) Physical violence
   g) Psychological violence
   h) Violence against children

3. What capacity does your institution have to collect data on the following forms of violence? (Probe for type of data and the extent to which it is disaggregated)
   a. Intimate partner violence
   b. Sexual violence by persons other than intimate partner
   c. Sexual violence involving minors
   d. Early or forced marriages
   e. Female Genital Mutilation (FGM)
   f. Physical violence
   g. Psychological violence
   h. Violence against children

4. What form of support is your institution able to provide to survivors of the following forms of violence?
   a. Intimate partner violence
   b. Sexual violence by persons other than intimate partner
   c. Early or forced marriages
   d. Female Genital Mutilation (FGM)
   e. Physical violence
   f. Psychological violence
   g. Violence against children

5. How can you be empowered to handle cases of the following forms of violence? (Probe for ideal support and source)
   a. Intimate partner violence
   b. Sexual violence by persons other than intimate partner
   c. Early or forced marriages
   d. Female Genital Mutilation (FGM)
   e. Physical violence
   f. Psychological violence
   g. Violence against children (VAC)

Annex A6: Data collection team

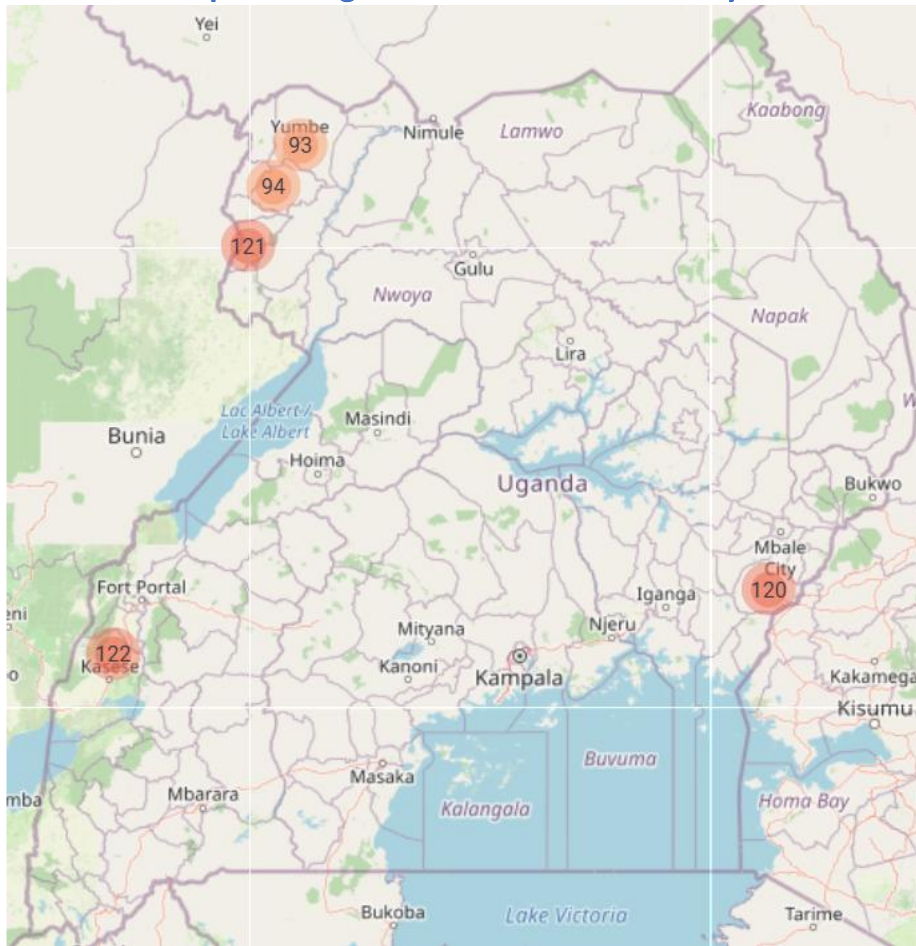
Kasese District		
SN	**Names**	**Contacts**
1	Mbirwa Rhonah	704750571
2	Kule Amon	788932812
3	Baseme Evalyne	784592888
4	Masika Sikahwa Harriet	774802751
5	Ndaireho Nyangoma	756096274
6	Muhindo Dan Tabu	782025591
7	Kule Sajon	762760004
8	Mbusa Tadeo	781554424
9	Masereka David	778973021
10	Wilson Kabebe Baluku	782284677
Tororo District		
SN	**Names**	**Contacts**
1	Saba Joseph Aluka	776401577
2	Oloka Nelson	779352175
3	Awora Lydia Patience	763229088
4	Adongo Gift Scovia	778161788
5	Okongo Benard	787898999
6	Okadapau Isaac	746110885
7	Okello Robert	776390801
8	Asiyo Florence	788892899
9	Otwani Shadrack	774631941
10	Anyokin Ezra	779915960
Terego District		
SN	**Names**	**Contacts**
1	Ozitiru Juspine	0782379707
2	Anduru Jilda	0780542559
3	Amaniyo Joyce	0786440598
4	Aziyo Francis	0781867021
5	Acema Denish	0780345180
6	Pariyo Alfred	0774481471
7	Oyeru Hellen	0779780246
8	Andema Allan	0762539070
9	Dramani Willy	0786513524
10	Draniku Samson	0782497703
Yumbe District		
SN	**Names**	**Contacts**
1	Alichi Toah Sebbi	0782577902
2	Akuma Hamim	0781477663

3	Fatima Bint Abdullah	0786212983
4	Tabuga Majid	0786637920
5	Arike Ismail David	0773165992
6	Atiku Akibaru	0785723281
7	Orodriyo Gloria	0778841056
8	Tiko Faima	0786623545
9	Aliga Akbaru	0782541595
10	Maida Zubeda	0769247995
Arua District		
SN	**Names**	**Contacts**
1	Drateru Sharon	0783984510
2	Yikii Innocent	0767318115
3	Orodriyo Florence	0775190180
4	Draru Kevin	0755336983
5	Eyotaru Margret	0785905806
6	Akuma Eliakim	0773514240
7	Erima Symeon Amanzu	0773343273
8	Tiyo Lawrence	0779998399
9	Atanze Gilbert	0773146877
10	Okuonzi Nobert	0782433923

Annex A7: List of Facilitators

S/N	NAME	TEL NUMBER	INSTITUTIONS	DISTRICT SUPPORTED
1	Michael Lyavala	0774131338	Consultant	Terego, Arua, Yumbe
2	Anne Gidudu	0773253828	AGDHI	
3	Robert Bogere	0702173174	AGDHI	
4	Adrian Ssessanga	0772369812	Co- Consultant	Kasese, Tororo
5	Victoria Nairuba	0773537200	AGDHI	
6	Joash Kaweesa	0778912520	AGDHI	

Annex A8: Map showing Household Distribution by district.



Annex A9: Pictorials