Children and Women in Uganda

unicef

A Situation Analysis

United Nations Children's Fund
Kampala, Uganda 1989

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Table of Contents

Preface

The future of Uganda lies in the hands of its children.

That being the case, there are pertinent questions we should be asking ourselves concerning the situation of our children. What are the forces which presently shape the future of these children? How are they going to grow and develop? Will they be able to shoulder the burden of the future, physically, mentally and morally? What opportunities exist which we can use to give them the best beginning possible, and prepare them to carry that burden successfully?

Women are the first and most important care providers of children. Even before birth, their nurturing role begins and is continued throughout childhood, adolescence and maturity. They are not only involved in their children's lives as mothers, but also as homemakers, food-producers, educators, health care providers and moral guardians.

Women are also important in their own right, constituting more than half of the adult population and providing 80% of agricultural labour and about 50% of the social service providers.

We who are planners and policy-makers need to know as much as possible about the present situation of women and children in Uganda, so that we will be able to plan for their future, and the future of our country.

In the present scarcity of readily available scientifically assembled data, the information contained in this Situation Analysis goes a long way in enabling us to respond to the very difficult challenges of our times. It is welcome as a useful tool for all those who hope to work to improve the well-being of children and women in Uganda. I commend it to policy-makers, planners, programme implementors and researchers as a document providing a background of relevant information for solving the problems faced by Uganda's children and women.

The National Resistance Movement Government sees the increasing of children's chances of survival and the promotion of the development of their fullest potential as a central element of the Ten Point Programme, and, as such, accords high priority to concrete achievements in this area. The Government has also made it a premium concern to uplift the status of women and empower them to cope with the multiplicity of the roles they play in our society, not only through the Resistance Committee System but also by strengthening their contribution in all sectors of our community.

I wish to acknowledge with gratitude the efficiency and relevance of the joint cooperation between UNICEF and the various governmental and non-governmental institutions working to improve the situation of women and children in Uganda. I am confident that their combined efforts will ensure that the goals and targets set to reduce the mortality and morbidity rate of our children and to uplift the quality of life of our people will be achieved before the turn of the century.

"The world was not left to us by our parents.....It was lent to us by our children." (African Proverb)

Dr. S.B.M. Kisekka
Prime Minister
Republic of Uganda

Acknowledgements

The Analysis of the Situation of Women and Children in Uganda is part of the UNICEF Country programming process. It provides the basis for identifying priority problems and presents the context in which the new Country Programme is to be developed.

Many people have been involved in the preparation of this report, including Government officials, University and UNICEF staff, and concerned Ugandan citizens. While several individuals, especially Ms. Josephine Harmsworth, made major contributions, others helped ensure that the presentation is as comprehensive and accurate as possible.

To provide a sense of the actual conditions in which women and children live in Uganda we have included in the report individual profiles based on interviews with rural women and men. Special thanks goes to these individuals and their children whose lives make up the real story behind the facts and analysis presented in this report.

It is likely that the report is missing some important sources of information, and omitted areas of relevance to the well-being of women and children. However, the programming process is a dynamic one, and work has already started on the next Situation Analysis. As new studies are completed and new data are available, they will be incorporated into the next edition. We would appreciate any contributions of information or analysis that you feel should be included.

We gratefully acknowledge the contributions of the following individuals who helped in the preparation of the report:

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Overview

A typical Ugandan child starts life in a large family in a rural area. Like most of her relatives, she is delivered at home by an older neighbour. No public transport reaches her village, and it was too far for her mother to walk to a health unit once labour had begun. Most of her mother's prenatal care came from local grandmothers who told her what foods to avoid and how to behave herself during the pregnancy, although a nurse did talk to her once when she visited the clinic for another problem. The local women advised her to stop breast-feeding her one-year old son when she knew she was pregnant, because they believe that her milk would now harm him.

The baby is surrounded by a large extended family, but some adults are missing because they died during the many years of war, of malaria, or from an infection during child birth. Some adult males have temporarily migrated to find work, or spend part of their time with another wife and family in a different village. One sister died in infancy from measles complicated by diarrhoea.

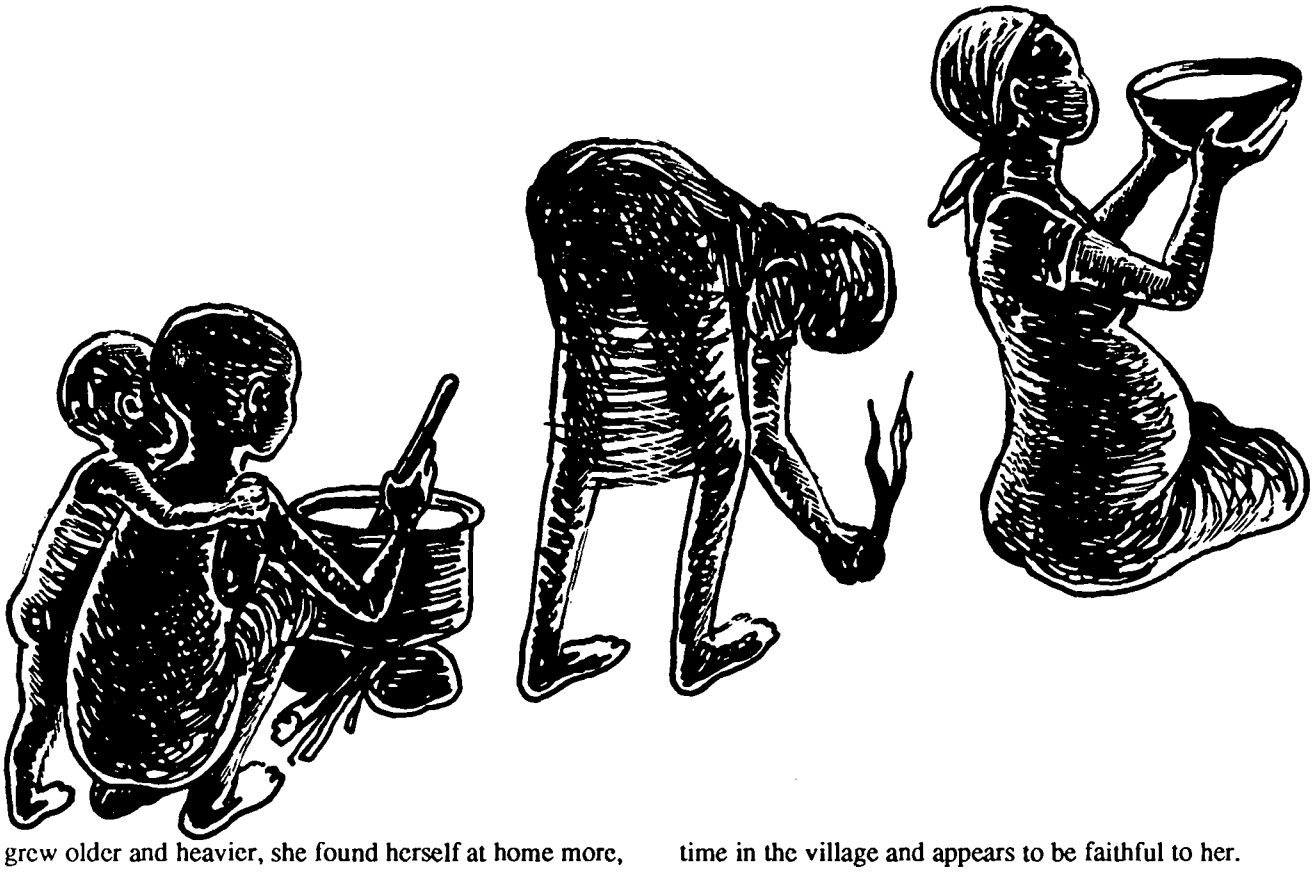
As a small baby, the child is likely to be healthy and grow well, as long as she has her mother to care for her and breast-feed her. After six months however, the protection she obtains from breast milk will wane, and the child will begin to suffer from repeated bouts of infectious diseases, especially diarrhoea, because her mother does not have the time to carry enough water from two kilometers away to keep the house, kitchen, and utensils as clean as she would like. The child also picks up infection as she plays around the yard, because not all the villagers use latrines.

Each episode of diarrhoea or other illness leaves the child a little thinner and weaker, because she cannot regain the weight lost when she was ill. Her undernutrition is not due to of a lack of food in the village, but is because her mother does not have the time or firewood to cook frequent small meals or to coax her to eat when she does not feel well. The family may have abandoned more nutritious traditional weaning foods in favour of what they consider "modern" or easier-to-prepare staples.

The child has little contact with formal health services, except perhaps an immunisation clinic, although as she grows her mother finds it more and more difficult to carry her the long distance to complete her vaccinations. The nearest dispensary is two or three kilometers away, and her mother prefers to treat fevers with herbs from the garden, or to go to the traditional healer in the next village, who does not make her wait a long time. If she went to the Government health unit, she might have to search for a health worker willing to

help her, and then travel an even longer distance to buy a drug that the facility does not have.

When she was tiny, the baby went everywhere with her mother, tied securely on her back. As the child grew older and heavier, she found herself at home more, under the loose supervision of a sibling or grandmother while her mother worked on the farm. She gradually learned to do the same chores they did - peeling bananas, mashing groundnuts, weaving mats, and when she could walk long distances, helping collect water and firewood.



There is a primary school nearby which almost all the village children attend for at least a year or two. The school was built by the community, and the parents support it through the Parent-Teacher Association. The teacher studied through Senior 1, and although she has no formal training for the job and very few teaching materials, she likes to teach and is there most days. The child starts school and learns to read and write in her own language, and she even learns a little English. However, the school committee starts a collection for a building fund at the same time that her mother has another baby. Home finances are strained, and there are more chores to do, so she leaves school after Primary 3. Her older brother continues, as her parents believe that boys need education more than girls do.

As she grows, she turns out to be good at gardening, and she is able to feed her family well. She makes a little cash by selling the mats she makes at the trading centre market. However, many other women in the area also weave mats, and the price she can sell them for is very low, so it is hardly worth her time to produce them. She knows no other way to gain a cash income except brewing *waragi* but she has seen what happens to the families of the men who drink it.

When she reaches 16 years of age, her parents encourage her to marry a local man they like, whose parents can pay a reasonable brideprice. As a new bride she moves into her husband's home. Although she does most of the work in the house and fields, she feels fortunate because her husband spends a lot of his time in the village and appears to be faithful to her. Her neighbour's husband travels a lot and must have visited a prostitute or had many other wives, because he is weak and thin and probably has AIDS. The neighbour is pregnant, and worries that she and her child might be infected.

The young married woman has more voice in the community than her mother did, because the Resistance Committee members encourage women to speak out. However, she is afraid to express herself in public even though some of her friends are becoming more vocal. She would like to improve herself, but with her limited education it is hard to find information suited to her reading ability, and the few extension workers that make brief visits to her village seem to speak another language. She knows more about immunisation and treating diarrhoeal disease than the older women in the community, but she is also confused because she hears conflicting information on health issues from health workers, from the Resistance Committee, and from the traditional healer.

As a grown woman, she has essentially taken up the same position in society as her mother did twenty years ago. This traditional role is comfortable for her, and the community accepts her. In any case, she is usually too tired from her long working day to think about how she could change her life. As long as she has her health, and her husband and children are reasonably well, she is happy. She would like to have many more children to help her and her husband in their old age, but she often worries about how they will pay school fees for even the children they already have.

Situation Analysis

And so the story of the majority of Uganda's women and children is likely to go on unless the circumstances described in this Situation Analysis are changed. The children in Uganda currently face a series of obstacles to their survival, growth, and development.

The most **direct** threats to a child's well-being are the communicable diseases, including measles, diarrhoea, malaria and respiratory infections, which are the most common causes of morbidity and mortality. However, the reasons why these diseases continue to kill so many children are much more complex. There are many factors which **indirectly** contribute to the present situation, and unless they are also taken into consideration, no significant improvement in the national health status will be possible.

Indirect Causes of Death Among Children

- OVER-BURDENED AND ISOLATED MOTHERS

  Ugandan women work long hours each day, bear many children, have little formal education, and lack channels for obtaining clear and appropriate health education. Thus, they may have the desire and will to adequately care for themselves and their children, but many lack the time, knowledge, and skills to do so.

- POVERTY

  As in every society, there are many families in Uganda who permanently live on the edge of survival. These families barely manage to survive in normal times and any small misfortune, such as illness or poor harvest, pushes them over the edge. Society's capacity to provide a safety net for these vulnerable groups has been severely eroded by the economic decline of the past 15 years. Infant deaths appear to be clustered among the poorest sector of the population.

- MALNUTRITION

  Malnourished children are more likely to die of communicable diseases which they are too weak to resist. While protein-energy malnutrition is not widespread in Uganda, weaning practices make children especially vulnerable to growth faltering from about six months of age.

- REPEATED INFECTION

  An otherwise healthy child easily survives one episode of fever or diarrhoea. However, the unsanitary environment in which many Ugandan children live leads them to be repeatedly exposed to pathogenic agents that wear down their resistance, resulting in increased infant and child mortality.

- INACCESSIBILITY OF ADEQUATE HEALTH CARE

  Preventive and curative services are essentially limited to the country's 975 health units, and many families live too far from these units to freely use them when needed. Outreach services are available only for immunisation and from the few NGOs who support primary health care workers.

  For those who live within reasonable proximity of a health unit, unmotivated health workers, limited supplies, and lack of understanding of the importance of prevention, impede the full utilisation of the limited health services that are available.

- ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

  Relatively few child deaths are directly attributable to AIDS to date, although higher mortality can be expected in the future. The illness will also be an increasingly prevalent cause of suffering for children due to the death of adult relatives and the subsequent breakdown of the extended family support network.

Underlying Factors

Fundamental to the direct and indirect causes of morbidity and mortality are the underlying factors which have led to the breakdown of the economy and social services. Foremost has been the violence and turmoil of the past two decades which has led to the weakness of central Government and the collapse of the economy.

To change the Situation of Women and Children in Uganda, Government, the international community, and the people, must work together to find new ways to revive the economy and redevelop the social and physical infrastructure.

The conditions for this new beginning are in place.

- Security is no longer a paramount concern in Uganda, and most of the country is now peaceful.
- The National Resistance Movement Government is committed to improving the conditions of women and children.
- The Resistance Committee structure provides a real opportunity for communities to be fully involved in the planning and implementation of their own social and economic programmes.
- The Government has embarked on an ambitious Economic Recovery Programme, and donor support is encouraging.

However, the challenges to be faced should not be underestimated, particularly in the economic sphere.

Short-term Action

In the short run, all parties must work together to ensure that the children of Uganda grow up as healthy and well educated as possible. There is much that can be done to make more effective use of the existing resources, and low-cost interventions can be introduced that will have an immediate impact on the direct causes of morbidity and mortality.

The strengthening of sustainable control programmes and increased involvement of communities in their implementation can reduce morbidity and mortality due to malaria, measles, diarrhoea and acute respiratory infections.

Uganda's women need special help to develop their potential through reducing their workload and providing opportunities for them to increase their cash incomes and further their education. They must also be more fully involved in local decision making, and have access to the information they need to be able to protect their families.

Long-term Action

In the longer-term, interventions are required to address the indirect causes of child deaths, including inadequate social services and communications, under-utilisation of health care, low standards of female education, and the inefficient use of women's time. The interventions could include:

- Sensitisation of policy makers toward a redefinition of "productive" sectors of the economy and the development of sensible ways to finance needed social services.
- Improved informal public education and increased quality and relevance of the education system to ensure that women have the knowledge and skills to improve their home environments, and to care for themselves and their children.
- Increased opportunities for women to generate income to supplement subsistence farming.

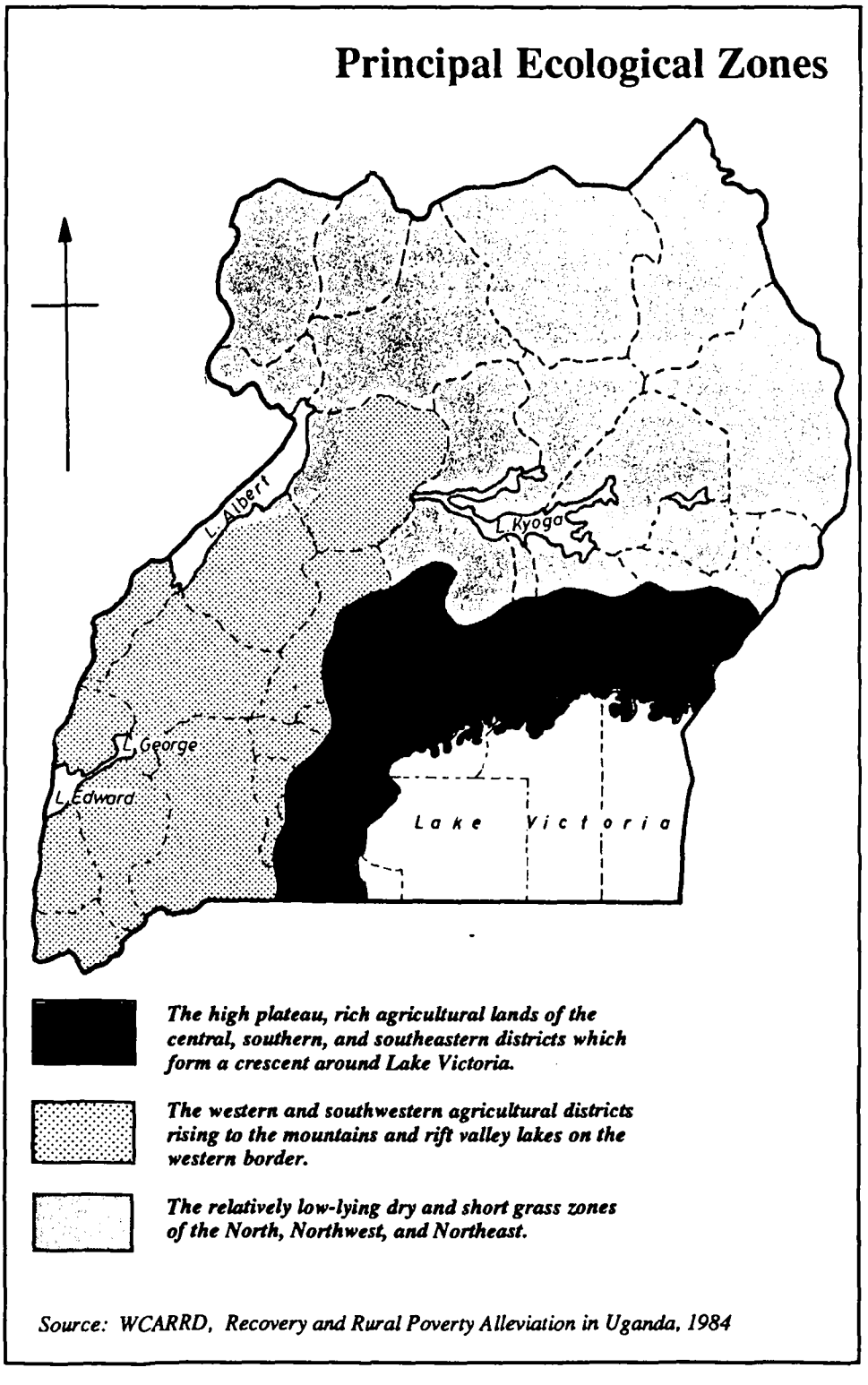
These measures would provide mothers with improved opportunities to participate in community affairs and see that favourable local and national policies evolve for the nurturing and development of the next generation of Ugandans.

General Background

Geography

Uganda is set in the heart of Africa in the Western Rift Valley. It has a total land area of 241,139 sq. km, of which 41,440 sq. km (17%) are swamps and water, and 29,709 sq. km (12%) are forest reserves and national parks.

Of the remaining 169,990 sq. km only about 5% is under cultivation according to Government figures, compared with 13% in 1958. In 1987, about one-half the cultivated area was officially stated to be planted with cash crops, whereas observation suggests that such crops occupy only a small percentage of most farmland.



Uganda's rural and urban populations are concentrated in the Lake Victoria crescent, which produces much of the country's coffee and sugar, some tea and livestock products, fish and staple food crops.

The country's rural and urban populations are concentrated in the Lake Victoria crescent, which produces much of the country's coffee and sugar, some tea and livestock products, fish, and staple food crops.

The western and southwestern districts, with some exceptions, also have rich agricultural lands and receive heavy and evenly distributed rainfall at most times of the year. These areas are suitable for the production of tea, coffee, and cotton, as well as bananas, grain crops, and vegetables. Heavy concentrations of livestock are found in the larger districts. Most of the country's minerals, such as copper, iron ore, cobalt, gold, tin, wolfram, beryl, and salt, are located in the western and southwestern highlands. However, the soil is light and thin, and in some places the dry seasons are often prolonged.

In the North, Northwest and Northeast, rainfall is not reliable but can support cotton, tobacco, grain, and root crops. Large permanent swamps suitable for rice cultivation are present. This zone has a heavy concentration of livestock and supports large pastoral societies. The 23,906 sq. km of Moroto and Kotido Districts are almost exclusively pastoral (MOA, 1962). Most of this zone is sparsely populated.

Uganda has access to five major lakes whose resources are not yet fully exploited. Fishing is an important activity. However, in 1987 the recorded catch from lakes was only 149,700 tonnes, compared to 212,300 tonnes in 1984 and 167,800 tonnes in 1981 (MPED, 1988a, Table 34).

There are two distinct rainy seasons in the southern half of the country, with peak levels in April-May and November, while in the North there is one peak around August. Most of Uganda can depend on 1,000 mm of rainfall or more in an average year with a minimum annual mean of about 500 mm in the Northeast to over 2,000 mm in the Sesse Islands.

Temperature ranges do not vary greatly apart from the mountainous districts in the West and around Mt. Elgon in the East. Variation depends largely on differences in altitude, although the proximity of Lake Victoria affects some areas.

The lowest minimum temperatures are found in July or August, while the highest temperatures generally occur in February. In the West the temperature ranges between a low of 5° C in the Kigezi hills to a high of up to 32° - 35° C in the Lake George flats. Temperatures in the North reach a maximum of 28° C. In Karamoja, temperatures of 32° - 35° C occur during the dry season and about 26° C during the wet months.

Demography

As in most former British colonies, the census history in Uganda dates from 1911, when the first headcount was taken for tax purposes. Uganda is one of the few African countries to have held all four decennial censuses as called for by the United Nations. The results of these censuses, linked with other headcounts, show that the population rose more than five-fold from 2.5 million in 1911 to 12.6 million in 1980.

All recent population statistics must be treated with caution. The 1980 census was flawed by general under-counting and under-representation of some areas of the country. In addition, much of the data was lost before the results were calculated. As a consequence, most national population statistics are derived from the 1969 census, and do not reflect the many population movements and other events which have affected the country since then.

The population is presently calculated to be about 16 million, based on the 1969-80 annual growth rate of 2.8%. The annual growth rate of the 1969-80 intercensal period falls below the 3.8% growth rate realised between 1959 and 1969 and the 3.4%

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Population of Uganda, 1911 - 89

Year	Population	Annual Growth Rate (%)
1911	2,463,469	--
1921	2,847,735	1.5%
1931	3,525,014	2.1%
1948	4,917,555	2.0%
1959	6,449,558	2.5%
1969	9,456,466	3.7%
1980	12,636,179	2.8%
1989*	16,201,441	-

*Estimate based on growth rate from 1980 census

Source: WCARRD, Recovery and Rural Poverty Alleviation in Uganda, 1984, p.4

previously projected for the 1970s. A higher growth rate in line with those of neighbouring countries (Kenya 3.8%, Rwanda 3.4%, and Tanzania 3.3%) might be more realistic, and the actual 1989 population could be nearer 17 million.

Current official United Nations estimates based on projections from old data place the crude death rate at 16/1000, the crude birth rate at 50/1000, the infant mortality rate (IMR) at 104/1000, and the cumulative under-five mortality rate at 172/1000. Total fertility is 6.9.

According to the 1969 census, Uganda has a young population, displaying the pyramid structure typical of most developing countries. Forty-six percent of the population was under 15 years at that time, and 19.2% below five years. Only 10.7% of the population was over the age of 50. The trend was towards an increase in the younger age groups, while the proportion over 60 had remained constant since 1948 (MPED, 1971).

The 1980 sex ratio was 98.2 males per 100 females, compared to 101.9 males in 1969, implying a considerable depletion of the male population during the 1970s.

The overall demographic impact of AIDS in Uganda has not yet been studied. However, evidence from projections in other countries suggests that the epidemic may dramatically reduce population growth rates, increase the already high dependency ratio, and create burdens on the productive minority.

Settlement Pattern

At 64 per sq. km in 1980, Uganda's population density ranked fifth among the most crowded in Africa. However, this figure masks strong regional differences. District densities range from the relatively low levels of 12 to 85 per sq. km in Karamoja and Nebbi to 197 to 223 in Kabale and Mbale. Even this disaggregation understates the real situation as habitation tends to be clustered, with wide stretches of uninhabited land.

Uganda is one of the least urbanised countries on the continent and ranks eighth in the world. Ninety-one per cent of the population lives in rural areas. Towns are small, with only 8.7% of the population in centres of 2,000 or more inhabitants. The largest, Kampala, had a population of 458,500 in 1980, and the population of the next largest, Jinja, was little more than 50,000. Elsewhere one can easily walk from one end of a town to the other in 30 minutes.

Urban growth between 1969 and 1980 was highly variable. Some towns declined by as much as 3.6% while others grew by up to 24% (MPED, 1982, p. 244). Little is known about the dynamics of urban growth and how much is due to migration. However, trends indicate a pattern of movement toward the Lake Victoria crescent of Masaka, Kampala, Jinja, and Tororo Districts. This area is attractive not only because of its high land fertility and relatively higher level of agricultural development, but also because it includes major towns (WCARRD, 1984, p.10).

Average household size is between five and six persons. A study of four contrasting ethnic areas found that more than 30% of homes had nine or more residents (The Experiment in International Living, 1984, p.48). Extended households of 20 or more are not unusual.

Social Organisation

While general statements may be made about Uganda as a whole, they often mask major regional differences related to cultural and ecological characteristics. There are four main language groups with several subdivisions: Bantu, Nilotic, Nilo-Hamitic and Sudanic. The Bantu inhabit the more fertile and earlier-developed southern half of the country, while the other groups are found in the drier North.

These distinctions are broadly co-terminous with differences in traditional social and political organisation and economic activity. While the original political institutions that divided these groups no longer exist, many of the attitudes and some forms of organisation inherent in these traditions impinge on modern life.

Culturally, a broad distinction may be made between the Bantu monarchic societies and the Nilotic, Nilo-Hamitic, and Sudanic, which were loose federations or alliances of villages based on territorial or kinship groupings. These cultural divisions have been reinforced by ecological factors and economic developments before and after independence.

Regional Distinctions

By most development parameters, the North compares less favourably with the South. Access to schools and health units, utility services, employment, and industry are all lower in the North, and the general deterioration of the past decades has had a more devastating effect there.

The ethnic divisions in the country have underlaid much recent strife. Southerners see Northerners as responsible for the violent depredations of the last one and one-half decades, even though many Southerners also participated in violent crimes. Northerners, on the other hand, are often jealous of the development achieved in the South, and the continuing concentration of commercial activity near the capital.

The present Government is committed to eliminating such communal conflicts and introduced the Anti-Sectarian Act in 1988 which is directed toward discouraging inter-community tensions.

The Karamojong of Moroto and Kotido Districts have never been integrated into the mainstream of national economic life. Traditional cattle raiding continues to be commonplace and has been exacerbated by the use of modern weapons. Since 1985, the range of the cattle raiders has expanded beyond traditional boundaries in conjunction with rebel activities and is responsible for destabilising neighbouring northern districts. Karamoja lags behind not only because of natural disasters, but also because it has a less developed infrastructure. Indicators such as communications, health care, and education have usually ranked Moroto and Kotido at the bottom of the country's districts (MPED, 1970).

Uganda is divided for administrative purposes into ten regions and 34 districts. The districts are further divided into counties, sub-counties, parishes and villages.

Political History

Uganda has been independent since 1962. The Independence Constitution provided for four kingdoms Ankole, Buganda, Bunyoro, and Toro with a federal relationship to the central Government, and fourteen districts with a unitary relationship. The most powerful kingdom, Buganda, was also the site of the national capital.

Independent Uganda inherited a divided nation of at least 17 major ethnic groups and a number of minor ones, with a disparity in development between the relatively impoverished North and the more affluent South. The new nation was also divided by religious sectarianism which permeated political life.

The first elected Government was overthrown in 1966 in an internal coup led by Prime Minister Milton Obote against Mutesa, the President and Kabaka (King) of Buganda. A new Constitution which made Obote an executive president was passed by Parliament in 1967. The Obote regime was overthrown by Idi Amin in 1971 and replaced by a military Government.

The excesses of Amin are well known. It is estimated that tens of thousands of people "disappeared" or were killed during his regime. Non-citizen Asians were expelled in 1972, and nearly all citizens of Asian origin and of mixed blood also chose to leave at that time.

In the same year all foreign businesses were nationalised or simply expropriated and handed over to Amin's supporters. As a result of these practices and growing insecurity, most bilateral aid was withdrawn and multilateral aid reduced.

As the Asians dominated many sectors of the economy, their sudden exodus had devastating results. The marketing system was particularly disrupted, and the effects of their departure are still felt today.

From 1979 to 1980 national leadership changed

several times until Obote regained power in the 1980 elections. The election results were widely disputed, and several prominent political leaders retreated into rebel activities to press for a change of national leadership. The resulting insecurity of the early 1980s caused particular suffering in the Luwero Triangle north of Kampala, where Government forces committed excesses trying to suppress the rebellion. In 1985 a coup by the military supporters of Tito Okello overthrew Obote. Okello was in his turn ousted in January 1986 by Yoweri Museveni, who had been fighting a guerrilla war since 1981.

Since 1986, President Museveni and his National Resistance Movement have been engaged in an effort to bring peace and security to the country. Pacification efforts have already paid dividends, with most parts of the North now accessible and delivery of social services resumed in Gulu, Kitgum, Soroti, and Kumi Districts where peace negotiations have been concluded with the rebels. Only a few pockets of armed bandits with no obvious political motivation remain active, principally in Gulu and in the eastern districts above Lake Kyoga.

The present Government has demonstrated its commitment to human rights and national reconciliation. The top echelons of power include members of major national political and regionally-based groups. A Human Rights Commission was set up in 1987, and its investigations are laying bare a catalogue of violent and inhuman crimes. At the same time, Government has rigorously enforced discipline in the armed forces. A series of national elections were held in February 1989, the first free and fair polls in over 20 years.

Government Structure

Administrative Divisions

Uganda is divided for administrative purposes into ten regions and 34 districts. The districts are further divided into counties, sub-counties, parishes and villages. In 1989 the estimated district populations ranged from 85,000 to over one million, with the number of subdivisions per district dependent mainly on population density. The regions are largely artificial entities as far as the day-to-day operation of Government is concerned. Amin initiated administrative boundary revisions which were modified by subsequent Governments. These new borders have not been adequately mapped, and many people still refer to the old districts, which roughly coincide with ethnic divisions. There is also uncertainty about the present boundaries of parishes and sub-counties, and even local administrators are not completely clear about the present delineations.

Uganda has a highly centralised system of Government, although in theory responsibility for many activities is divided between central and local administrations. To a large extent, the policy of local responsibility is a carry-over from the post-Independence political concern with decentralisation through the traditional kingdoms and the strengthening of grass-roots democracy. After the 1966 coup this policy ceased to be very meaningful, and the Government became increasingly centralised.

The division of responsibility between central and local Government impacts especially on two crucial areas, health and education. With the exception of Mulago, the national referral hospital which is essentially independent, hospitals are administered directly by the central Government through the Ministry of Health. All other health units and public health programmes are the responsibility of the 34 District Administrations, which are under the Ministry of Local Government. This division underlies some of the difficulties of administering and managing the Government health care system.

As an example of this dual administration, District Medical Officers are employed by the Ministry of Health but work for a local District Administration. They are responsible for all primary health care activities in their respective districts, but not for any hospitals established there.

While salaries and expenses are in theory paid by local authorities, central Government actually pays most health staff. The financial resources of District Administrations are severely limited as they are financed through tax collection which has been lax or non-existent in recent years.

The education sector is similarly divided. Secondary and post-secondary schools and institutions are the responsibility of central Government, while primary schools are administered by local authorities. All teachers' salaries, however, are paid by central Government and curriculum and general education policy emanate from the Ministry of Education.

Theoretically, many line ministries have extension staff operating in the rural areas; however, many of these posts are vacant. Some ministries have staff at sub-county and others only at county level. Parish and village staff are rare.

There are also Chiefs at each administrative level from county to parish. In the post-Independence kingdoms, these posts were hereditary. However, the incumbents were removed in 1966, and new Chiefs were selected as appointees of the Ministry of Local Government, where they continue to serve as civil servants.

Resistance Committee System

The National Resistance Movement Government has introduced a new dynamic element, empowering local communities through a hierarchy of Resistance Committees.

The apex of the system is the National Resistance Council, which has taken the place held by Parliament under the original Constitution. Within the National

Resistance Council is the smaller National Executive Council which is the political organ. This Executive Council is comprised of the "historical" members of the National Resistance Council (who derive their positions from their experience in the Resistance War), one representative from each district elected by the Council from among its district representatives, and ten members nominated by the President.

The Resistance Council is the law making body and final arbiter of national policy. Cabinet Ministers are appointed by the President from within the National Resistance Council but are not necessarily members of the National Executive Council. There are 37 ministries, including a Ministry of State for Women in Development.

The Independence Constitution provided for elected councils at district level and for Kampala city and other major municipalities and towns. After the overthrow of the first Obote Government, however, these councils ceased to be elected assemblies. Popular election of officials has returned to Uganda through the Resistance Committee system.

The system is based on universal participation of all citizens over age 18, who are *de facto* members of Village Resistance Councils. The Councils are empowered to "identify local problems and find solutions ...[and] formulate and review development plans." To implement the decisions of the Councils, the members elect Village Executive Committees from among themselves.

The Committees form the day-to-day administrative structure of the system and the Chairman is considered the village leader. The Committee members stand and are elected for specific responsibilities by serving as secretaries for Youth, Women, Information, Mass Mobilisation and Education, Security, and Finance (GOU, 1987).

The Resistance Committees are mandated to:

- Assist the police and chiefs in mantainance of law and order.
- Mantain security.
- Encourage, support, and participate in self-help projects and mobilise people, material, and technical assistance.
- Vet and recommend persons who should be recruited into the armed forces, police force, and prisons service.
- Serve as the communication channel between the Government and the people.
- Oversee the implementation of Government policy.
- Where necessary, elect *ad hoc* and other sub-committees to assist the Committee in its functions.

Resistance Committees and Councils at higher administrative levels are elected from members of the Committees directly reporting to them, with the Committees forming electoral colleges for each successive level in the hierarchy. In this pyramid fashion, village level Councils are responsible for the election of representatives within the district system and to the National Resistance Council.

Each Committee at every level is mandated to have at least one female representative who is responsible for women's affairs. Some Committees have more than one woman member, and one Committee in Kampala was composed entirely of women in 1988. This initiative is a major step in the recognition of the equality of women and the need to assist them to fulfill their potential in national affairs.

The first General Elections for the Resistance Committee system were held on succeeding weekends in February 1989, beginning at village level and ending with the election of national positions. The expanded National Resistance Council now has 278 members, the majority of whom have been elected through the Resistance Committee system, including one women's representative from each district. At present, 40 members of the National Council are women.

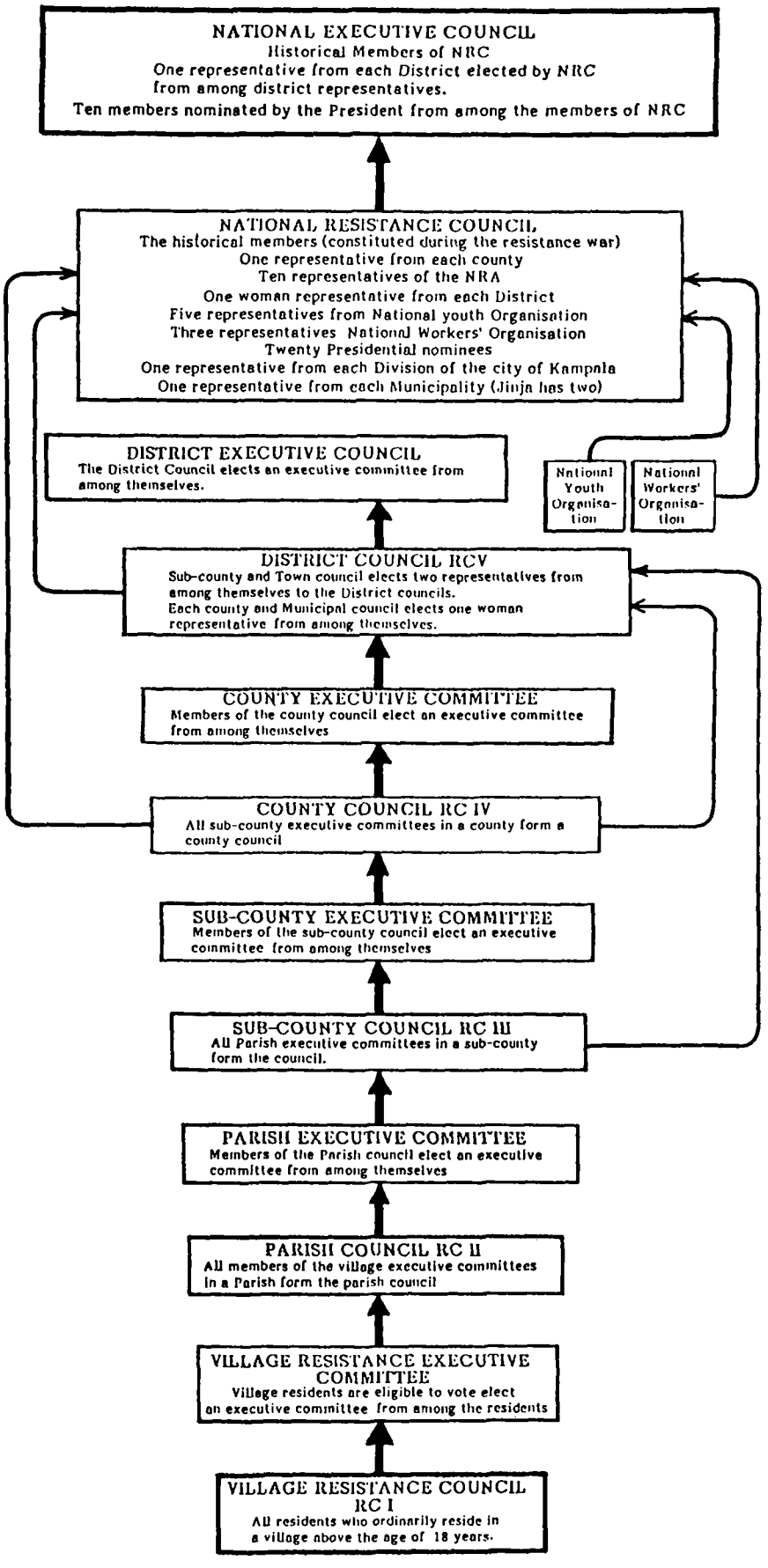
The Resistance Committee system is the cornerstone of present Government policy and represents a real opportunity for community-based development. However, there are significant bottlenecks to the full realisation of the potential for this system. The Resistance Committees have many responsibilities but few real powers, as the executive arm of central Government is controlled by parent ministries and the local executives are responsible to the Ministry of Local Government.

Summary Analysis

Uganda's recent turbulent political history has been largely a result of its geographic and ethnic divisions. The form of government and the leaders that emerged at Independence were not capable of over-coming these historical divisions. Thus, two decades of violence ensued with relative peace coming only in the last few years.

While maintaining the existing centralised structure, the NRM Government is also developing an alternative system intended to give individuals and local communities a greater voice in policy-making. Women may find it easier to express their concerns through the Resistance Committee system than through more traditional structures. However, many issues of power and reponsibility between the two systems remain to be resolved. The future effectiveness of the Resistance Committees will depend on the continued responsiveness of the Government executive and political apparatus to their representations.

Structure of National Resistance Councils and Committees



Source: Directorate of Information & Mass Mobilisation, NRM Secretariat Kampala

Profile

A Woman Leader: Problems of Women in Public Life

It is often difficult for women to participate in group activities, especially political or economic ones. Many husbands do not like to see their wives involved in such activities; they often suspect that there may be ulterior motives or that their wives will become easy prey for other men. Husbands also resent the time women might take away from domestic or farm work. Joyce, a widow in her 60s, describes her experience.

"From the time I was 30 years old, I was very interested in doing something about the welfare of women. In 1948, I joined a women's group started by Busoga Council, and in 1960 I was awarded a medal for my achievements.

"Up to the 1970s women in Uganda stayed in the background, because they lacked confidence in themselves. This was largely because they had never handled any money. Until that time the menfolk made the money and dictated how it should be spent.

"But in the past five years, very many changes have occurred, and women in Busoga are playing a much more active role in all that concerns them.

"In 1986, I was elected to my village RCI as Secretary for Women's Affairs. I had the support of the women and the confidence of the whole community. I now represent women's interests at the district level in the RCV. In this position, I am able to play a leading role in developing programmes for the improvement of the situation of women. I always stress the need for women to work humbly and in unity with their husbands, because progress cannot be achieved by women alone.

"Although I enjoy my work, it requires a lot of patience, time, and dedication. Not all people are grateful for the effort I put in. Some are jealous of me, and some misunderstand my good deeds and think I am just exploiting them. On the whole, however, I believe that the majority of women appreciate me as their leader".

If Joyce continues to keep their confidence, she hopes to help in building a future Uganda where women and men will be equal partners.

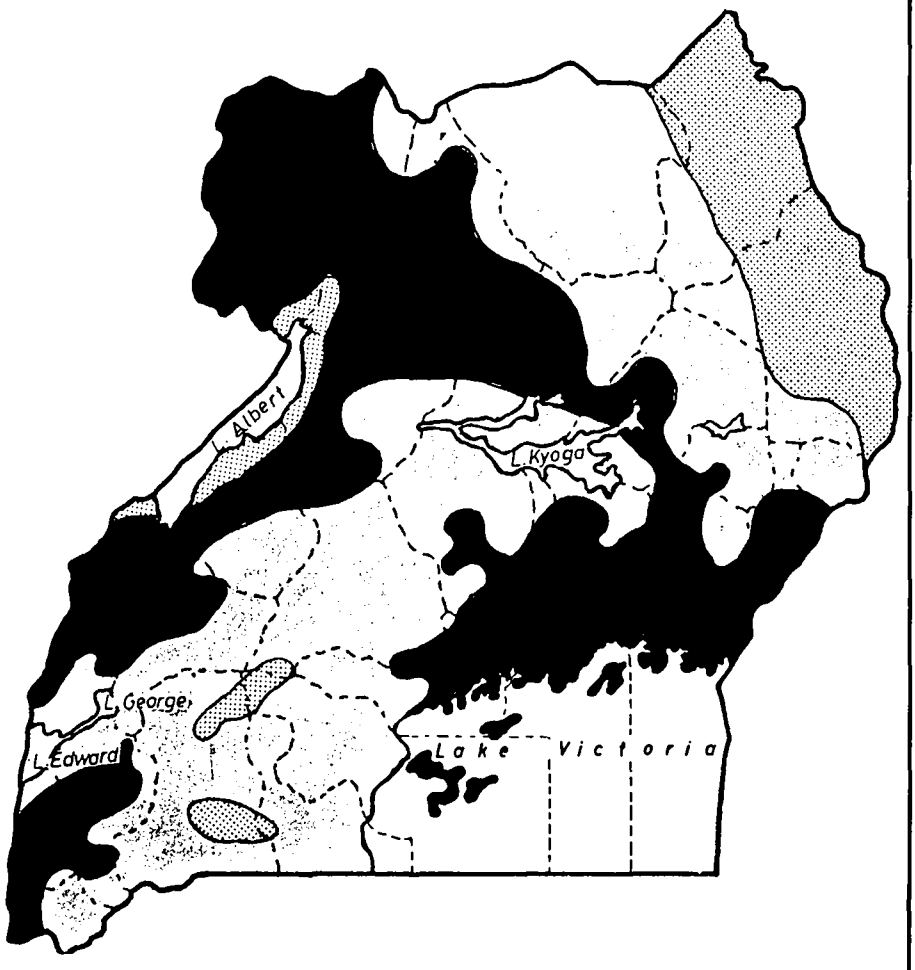
The Living Environment

The Physical Setting

Uganda has a wide range of soils, rainfall patterns, and altitudes, which gives it considerable diversity and distinct agro-ecological zones. These zones are roughly demarcated by the Nile River from Lake Victoria to Lake Kyoga.

Due to favourable climatic conditions, Uganda rarely experiences famine, except in the arid Northeast. However, food shortages in other areas also developed in 1979 and 1980 due to the Liberation War, subsequent security problems, and coincident drought. Occasional

Annual Rainfall Pattern



Mean Annual Rainfall in Millimetres

400-800

800-1200

1200-1600

Above 1600

Source: Uganda Secondary School Atlas, Macmillan Publishers Ltd. 1989

There is a wide range of soils, rainfall patterns and altitudes.

disruptions in food supply still occur but only during extreme conditions in isolated locations.

Subsistence farming is the daily experience of the great majority of women and children, and town dwellers remain close to rural roots. Urban and rural communities are interlinked by a network of family and economic ties. Urban households often get food from rural landholdings, while urban residents remit cash and goods to rural relatives.

Most families live on their own farms in a dispersed pattern of settlement. There are few plantations or even large farms or ranches. In most cases there are no landlords, although there are reports of conflicts between customary farmers and new leaseholders who have formal title to land under the Land Reform Decree of 1975. This law converted traditional forms of ownership to rights of cultivation through leases granted by Government for up to 99 years (Kasfir, 1987; New Vision, March 28, 1989).

In 1987, fifty-five percent of the rural population depended on crop cultivation as their primary source of income, while 19% depended on mixed farming, 3% on animal husbandry, 2% on fishing, and 22% on other work or enterprises (Ministry of Animal Industry, 1987). Pastoralism is usually accompanied by limited crop cultivation in Karamoja. Most fishermen also practice agriculture. Nearly all those who are employed in rural areas and many urban families also farm.

Environment

The national environment has experienced considerable degradation in recent years; it is estimated that the percent of the national landmass covered in natural forests has been reduced from 12% in the late 1970s to 3%-4% in 1989. It is thought that this reduction is essentially due to population pressure as farmers move into national forests to clear land for cultivation.

National programmes to address environmental issues are being coordinated by the Ministry of Environment and Forestry with support from EEC, NORIDA, USAID, and several NGOs.

The Social Setting

Most of Uganda's children grow up in villages which are an aggregate of many individual homesteads, each on its own land. Larger villages have a few shops, a school, and perhaps a dispensary, church, and local Government office. The accessibility of community institutions is limited by this spacial dispersal. However, nearly all communities have several facilities within easy walking distance.

Rural families are linked in a network of extended kinship relationships, although these may not necessarily be supportive. They are also members of a neighbourhood of sometimes unrelated family groups. The extent to which kinship permeates a local community is culturally determined and varies by ethnic group. It is, however, the primary basis for local organisation.

In general, the more densely populated districts in the South, Southwest, Southeast, and Northwest have a larger number of community institutions.

Village Level Community Institutions Four Areas of Uganda, 1984

Facility	Jinja/ Iganga	Kigezi	Masaka	Teso
Health Unit	1	1	0	0
School	2	6	5	3
Church	2	7	5	3
Market/Auction	1	1	2	1
Shop	1	7	20	0
Bar	NA	20	NA	0
Co-operative Store	1	1	3	1
Club*	1	5	1	0

*Mainly women's groups

Source: The Experiment in International Living, The Uganda Social and Institutional Profile, 1984, pp. 42-45

Profile
The Wife of a Fisherman

Nearly everyone in Uganda has access to a plot of land and cultivates for personal consumption or for sale. Even herdsmen and fishermen have farms. Most agricultural work is carried out by women. Rose, aged 24, is married to a fisherman. They have two children, aged three and one and one-half years old.

"In the morning, my husband and I wake up early together. I go to dig in our gardens, and Joel goes to the lake to get his fish. After working in the gardens, I prepare breakfast for the family. Joel has his later on at home or by the lakeside with his fellow fishermen.

"Joel comes home toward lunch time after selling his fish and mending his nets. He usually comes home with some fish for lunch. If a lot is left over, we have it for supper too, as sauce with some food from our garden, like *matooke* and sweet potatoes.

"I am quite lucky to be a fisherman's wife. We always have fish to eat, which many of the neighbours who are farmers simply cannot afford. I have the best of both worlds.

"During the dry season, many of the families who depend on greens from their gardens for sauce often go without, because the greens do not grow then. I always have some fish whatever the season, and our children are quite healthy all the time. Fish is also easy to prepare.

"But being a fisherman's wife is not always enjoyable. You can get tired of eating fish every day. Fishing can also be dangerous. Joel uses canoes which capsize easily, and many of his friends have died out on the lake. I do not have a settled mind until my husband is safe at home each night, especially during the rainy and stormy seasons."

Religious affiliation is fundamental to social groupings in Uganda, and regular attendance at weekly religious services is thought to be as high as 80%.

Religious Affiliation By Area, 1980s

District	% of Respondents				
	Catholic	Protestant	Muslim	Other	None
Kampala	37%	32%	19%	1%	0%
Arua	51%	37%	15%	1%	4%
North Teso	31%	27%	0%	1%	40%
Central Tororo	52%	43%	1%	0%	4%
Toro (West)	63%	22%	4%	1%	10%
Mbarara	38%	54%	7%	0%	1%
NATIONAL	49%	33%	7%	0%	10%

Source: UNICEF, Report on the Main Findings of IYC Child Study, 1980; MOH et al., Baseline Survey for SWIP Mbarara, 1989

Religious Institutions

There are no national figures on religious affiliation, but area studies have shown that about 49% of the population is Catholic, 33% Protestant, 7% Muslim, and 10% belong to no group. Religious affiliation is fundamental to social groupings in Uganda, and regular attendance at weekly religious services is thought to be as high as 80%. In some parts of the country entire villages may belong to a single religion while neighbouring villages belong to another. Older citizens still recall physical fights between members of different churches (Senteza-Kajubi, "The Historical Background to the Uganda Crisis 1986-88").

In the past, religious divisions between Protestants and Catholics provided the basis for political party affiliation and recruitment into administration. Generally, Protestants dominated senior offices and chieftainships. This situation alienated many Catholics who believed that they were systematically excluded from appointed office. The recruitment bias in the 1960s is illustrated by data from the former Ankole district, where the proportion of Catholics and Protestants in the population was roughly equal during this period, but the King of Ankole was Protestant.

In many places, the Democratic Party is still the party of Catholics, while the Uganda Peoples' Congress is associated with Protestants. The National Resistance Movement is non-sectarian and represents all community groups. Continuing internal conflict on the basis of religion or ethnicity resulted in the promulgation in 1988 of a statute making sectarianism a punishable offence.

In addition to the three main religious groups, there are many small sub-groups. Some of these sub-groups have their roots overseas, while others are locally-based evangelical sects. The main ones include Baptists, Seventh Day Adventists, Jehovah's Witnesses, Pentecostals, and the Unification Church. In Rakai, a new focus of worship has arisen around a vision of the Madonna that seems to be a direct outcome of the depredations of AIDS in that district. In the North followers of extreme religious movements still fight skirmishes with the army, spurred on by the belief that their religion will protect them against injury.

Religious institutions are some of the principal channels for the delivery of social services. The major churches all operate hospitals and other health units which provide a large proportion of all health care. (For more information see chapter on the Health Care System.) Many have special development projects for child survival, including immunisation and other primary health care activities. Religious groups have also been active in providing assistance to displaced persons in all parts of the country. The main religions also support orphanages and schools for the disabled.

Other Community Organisations

Little is known about the participation of community members in organised meetings and membership in associations other than religious services. There are, however, several nation-wide institutions found in many communities, including the Resistance Councils, Parent-Teacher Associations, and women's clubs. (For more information see the chapter on the Situation of Women.)

The following institutions and organisations have significant influence. Many are examined in detail in

Ankole Higher Chiefs & Senior Officers By Religion, 1960s

	1961		1963		1966	
	Higher Chiefs	Senior Officers	Higher Chiefs	Senior Officers	Higher Chiefs	Senior Officers
Protestants	50	27	52	27	34	27
Catholics	12	4	14	4	9	2

Source: Young et al., Uganda District Government and Politics, 1977, pp. 67, 68

Recruitment bias by Religion in the 1960's is illustrated by data from the former Ankole district.

other chapters but are briefly noted here to provide information on the dominant community organisations to be found in rural areas.

Resistance Committees

The Resistance Committees provide a foundation and impetus for community-based activities of all kinds and a forum for the formulation and expression of community needs and responses to Government policies. They are also the chief medium for arbitrating local disputes including marital, domestic, and land issues.

A Secretary for Women's Affairs has been established within the Resistance Committees at every level to ensure effective mobilisation and participation of women in the development of their communities. If creatively used, the position offers an excellent opportunity for women to influence community affairs.

Primary Schools

The network of 8,000 primary schools reaches almost all parishes throughout the country. Parents have demonstrated strong support for the school system, and the Parent-Teacher Associations have been responsible for almost all school construction and improvements in the last decade. Teachers are among the best educated members of the community and are often looked to as leaders.

Health Units

Another rural institution which cares for women and children is the local health centre or dispensary. Access to health facilities is poorer than to schools. Whereas a primary school is likely to be not more than 2-3 km from a child's home, the local health unit is more often 10 km or more away. Area studies for the International Year of the Child found that 68% of homes were 2 km or less from the nearest primary school, while a 1984 report on access to health facilities indicated that 73% of the population was more than 5 km from a health unit (UNICEF, 1980; Alnwick et al., 1985b).

Agents of Central Government

At one time, Chiefs were important agents of Government in rural areas, wielding considerable influence and power. In many districts, they were also a key part of the traditional system of Government. However, the appointment of Chiefs for political reasons by past Governments eroded their credibility. While the Chiefs must still be involved in the initiation and implementation of activities in their areas, the Resistance Committees have assumed a dominant role in many locations.

Ministry field staff do not reach down to village level but are concentrated at county or sub-county headquarters. Extension workers for agriculture, community development, and health inspection exist, but many years without pay, supervision, or support have led to a high attrition rate, and most remaining staff are inactive. As an example, a 1988 meeting of the Health Inspectorate in Hoima District opened with the comment that the meeting was the first time the district team had assembled in 14 years.

These problems have led to a serious fall in the number of outposted staff. Most districts are underserved by all categories of extension workers, yet training programmes for new staff are very limited; the School for Hygiene in Mbale graduated only 30 students in 1988. Due to the low salaries, recent graduates are most often posted back to their home areas, where they can rejoin their family survival network. Because of this problem, staffing of underserved areas is not the primary consideration when assigning duty locations.

The extension staff are not reaching households. (For more information see the chapter on the Situation

Profile
A Woman Who Works with the Church

The churches in Uganda have many welfare programmes and were the pioneers in establishing health and education facilities at the beginning of the century. From early times women have been important as church workers in every field. Joy, aged 31, joined the Protestant Busoga Diocese in 1982 to work with grass-roots women's programmes.

"I trained women in leadership skills, handicraft making, and better farming methods because I am interested in seeing women play a more active role in improving their welfare.

"In 1984, I started working with an income-generating project for women in poultry keeping. This was given up after two years because the women had not assumed management but continued to be dependent on central planning and support. I then joined the family life and education project which I am still working in. I go out to rural areas with a team and try to educate women in improving their welfare, including child spacing.

"To develop, Uganda's women need better access to clean water, health services, family planning, farming facilities, and education. With these, the women would have better-spaced, healthier families, and then have time for development projects like the poultry one. When funds are given to women's programmes, many fail because the women simply do not have the time to attend meetings and compare results. They are busy with their large families and housework."

of Women.) A 1987 survey of 1,600 families in six districts found that less than 3% had been visited by a health worker of any kind in the preceeding month. In four of the six districts there had been no visits during the month, and only 4% of families reported ever being visited at any time within memory (UNICEF, 1988a).

Agriculture and Community Development extension workers are also inactive. In the three months preceding a 1988 survey in Mbarara, only 7% of families had been in contact with a non-health Government official (MOH et al., 1989).

Housing

Household Basics

Most people still cultivate with hand tools, cook with firewood in a temporary fireplace, and walk to work. A rural consumption survey in 1968 found that nearly 100% of rural households used firewood for cooking. This situation has not changed in twenty years; recent studies in Mbarara District and the Northeast found that between 96% and 100% of households still cook with wood, and only 16% to 28% use even the most rudimentary kerosene lamp for lighting (MOH et al., 1989; GOU et al., 1985).

The majority of families carry water for domestic purposes from the nearest well, borehole, pond, or

Household Construction in Six Districts, 1988

	% of Houses			
	Type of Roof		Type of Walls	
District	Tin	Grass	Mud	Brick/Cement
Kabale	50%	39%	96%	4%
Masaka	51%	45%	76%	21%
Mbale	72%	5%	88%	12%
Iganga	41%	59%	87%	12%
Hoima	51%	48%	86%	11%
Arua	7%	93%	92%	8%

Source: UNICEF, CDD KAP Survey, 1988

Most houses in Uganda are made of semi-permanent materials and thatched with grass. There is substantial regional variation in standards of housing between the North and South.

Household Drinking Water Sources, 1988

	% of Respondents						
REGION	Piped in Residence or Yard	Public Tap	Borehole	Well	River/ Spring	Protected Spring	Tanker/ Rain
West Nile	0%	0%	26%	25%	44%	5%	1%
East	3%	3%	3%	52%	36%	3%	0%
Central	2%	5%	9%	42%	35%	5%	3%
West	0%	0%	6%	57%	29%	7%	1%
South West	1%	4%	0%	37%	38%	19%	1%
Kampala	27%	32%	2%	15%	7%	14%	3%
AVERAGE	3%	5%	5%	43%	34%	9%	1%

Source: MOH and DHS, Uganda Demographic and Health Survey, 1989

Profile

The Life of a Health Inspector

The civil service has suffered greatly since the economic collapse of the 1970s. Field staff have been essentially cut off from the central level; they are unsupervised, and often go months without payment of their salary. One of the longest serving Health Inspectors relates his work experience.

"In 1966, I became one of the youngest District Health Inspectors in the country. At that time the Health Inspectors used to put on khaki uniforms with helmets, with a coat of arms on the buttons. Offices were well-furnished and equipped with all the necessary staff and stationery.

"My daily work was to supervise my staff who worked on rural household improvements and mosquito control. We also investigated and controlled outbreaks of infectious diseases.

"In my first years in the service, the salary was good and consumer goods were available. With my monthly salary I could afford to feed, clothe, and house my family, and put aside some savings.

"Government programmes lent money for buying bicycles and vehicles. I bought a vehicle for the first time with such a loan. The payment was 90/- a month for 48 months, and my salary was 1,430/-.

"In 1971, the overthrow of Government by a military coup was a surprise to many Ugandans. Nobody had ever experienced a military Government. I was in charge of Lango District where the then-President of Uganda came from, and I had to ask for a transfer to somewhere I could hide my face. I was totally broken down when my colleague who took over from me was murdered in 1972.

"All goods became expensive and were sold at *magendo* prices. Government loans stopped, rents went up, allowances disappeared, and promotions were considered through nepotism. Personnel files disappeared, and salaries stopped coming from headquarters to districts. We ended up being stagnant and doing no work.

"Now life is very difficult for me. I cannot sustain my family on my salary, and they have had to return to the village to live. Even though I am a Principal Health Inspector at the top rank of my Ministry, I have no accommodation. I cannot afford even a single-roomed house, which rents from 20,000/- to 30,000/- a month, on my salary of only 4,730/-."

Ownership of Household and Farm Goods 1984 and 1988

District	% of Respondents				
	Radio	Bicycle	Hoes Only	3-6 types of tools	7 or more types of tools
Busoga	18%	22%	49%	47%	3%
Kigezi	25%	20%	4%	95%	1%
Masaka	36%	25%	26%	67%	4%
Teso	13%	26%	26%	61%	8%
Mbarara	NA	32%	NA	NA	NA
Arua	13%	44%	45%	55%	NA

Source: The Experiment in International Living, The Uganda Social and Institutional Profile, 1984; MOH et al., Baseline Survey for SWIP Mbarara, 1989; Harmsworth, Tobacco Economic Impact Study, 1988

In many homes there are not enough agricultural tools for each adult to have a hoe, especially in areas where the population was displaced or subject to raiding or looting. In as many as 4% of rural households, there may be no agricultural tools at all.

swamp. Only 13% of these sources are protected. (For more information see the chapter on Water and Environmental Sanitation.)

In 1984 only 23% of families owned a bicycle or radio and most lacked mattresses or blankets. A 1988 study in Arua found that 77% of households had no beds and 82% had no mattresses (Harmsworth, 1988).

Land Tenure

Most families subsist on very small farms. In some districts it is difficult or impossible to obtain more land nearby. This restriction is more common in mountainous areas and parts of the South, where population pressure is becoming acute. Land cannot be

Main Person Responsible for Household and Farm Work, Four Areas, 1984

Task	% of Households	
	Children Only	Children with Mother
Cultivating	0%	28%
Cooking	8%	17%
Sweeping	5%	23%
Washing Clothes	5%	27%
Fetching Water	16%	31%
Collecting Firewood	12%	27%
Looking after Infants	3%	17%

Source: The Experiment in International Living, The Uganda Social and Institutional Profile, 1984, p. 56

In many families children are responsible for a wide range of household duties.

purchased, but must be obtained through traditional means or borrowed in small plots for the short term. An alternative is to lease tracts of unused public land from Government. This procedure is expensive, time consuming and administratively difficult. The people who resort to it are mostly elites. In areas such as Kabale, this situation has resulted in the enclosure of common lands used for grazing or dry season cultivation.

Even where land is available, few can take full advantage of it because of labour and capital constraints. Most families use hand tools and few routinely employ extra labour.

Summary Analysis

For most Ugandans, the living environment is still a rustic home on a small plot of land in a rural area. While a variety of facilities may be available, the most important institution is probably the church or other religious group. All but the most basic consumer goods and hand tools remain a luxury available only to the minority. Daily life is little touched by Government services or ideas. In the absence of other strong unifying forces at the local level, the Resistance Committees may serve as an effective channel for communications and community integration.

Economy

Background

Uganda is endowed with abundant physical and human resources. However, the management of these resources has varied greatly over the decades since Independence. Consistent and competent economic management in the 1960s led the economy to a healthy 4.8% annual growth rate in real Gross Domestic Product (GDP), and output outpaced population growth by 2.2% per annum. The country was able to feed its population, supply the domestic economy with a range of basic inputs and consumer goods, and at the same time generate a surplus of agricultural products, textiles, and copper for export.

Export earnings were more than adequate to cover import needs, and a current account surplus was maintained in most years. Central Government finances were also in a relatively healthy state; revenue increased faster than recurrent expenditure and helped finance significant development efforts, including transport infrastructure and hydro-electric power.

Economic growth ceased after the military coup in 1971. Gross mismanagement combined with political violence to undermine the productive base of the economy, and GDP declined at an annual rate of 0.2% between 1970 and 1978. As most of the best trained personnel left the country, the parastatal sector became saddled with abandoned or confiscated industries, and professional standards and morale were seriously eroded.

The economy was also shaken by external shocks, particularly the increases in petroleum prices after 1973 and the collapse of the East African Community in 1977.

These developments resulted in a severely weakened economy and rising inflation. Critical shortages developed, and both urban and rural families adjusted their consumption patterns to survival levels. A large share of economic activity was diverted into the black market, further reducing Government's revenues and its ability to provide services. It has been suggested that by 1980 the black market was the dominant sector of the economy and accounted for 51% of GDP (Green, 1981, p. 5).

GDP declined at an annual rate of 0.2% between 1970 and 1978. But it has shown positive growth in recent years.

Annual Real GDP Growth by Sector Selected Periods, 1963-87

	1963-70	1970-78	1978-80	1987
Total GDP Growth	4.8%	(0.2)%	(9.7)%	4.5%
Monetary Economy	5.2%	(2.0)%	(6.8)%	4.0%
Agriculture	4.6%	(1.6)%	(10.2)%	5.5%
Industry	6.5%	(5.9)%	(17.0)%	20.0%
Other Sectors	5.3%	(1.4)%	(3.2)%	1.9%
Subsistence Economy	3.9%	3.4 %	(14.3)%	5.6%
Agriculture	4.0%	3.4 %	(16.3)%	6.8%
Other Sectors	3.7%	3.4 %	(1.3)%	2.4%

Figures in brackets are negative

Source: MPED, Background to the Budget, various years

Economic Perfomance 1981-1985

In 1981, the Government launched economic reforms to stabilise the economy and revive investment and production by restoring confidence in the currency, eliminating price distortions, and improving fiscal and monetary discipline. It reached agreement with the International Monetary Fund on a comprehensive financial programme supported by a US$ 135 million stand-by arrangement. The key component of this programme was a 90% devaluation of the Shilling and related price adjustments which led to a substantial

reduction in black market transactions and smuggling.

The economy reacted positively to these initiatives and performed well for three years. GDP grew at an average of almost 6% annually from 1981 to 1983, and by 1983 it had reached 96% of the 1972 peak level. Growth was strongest in the non-monetary sectors, particularly agriculture. GDP per capita, however, remained one-third below that of 1972.

The balance of payments improved substantially, due largely to an increase in the country's coffee quota. Cotton, tobacco, and maize exports also picked up sharply in 1983 and 1984. Favourable import prices and strong export performance resulted in a fairly steady reduction in the trade deficit during this period.

However, the progress of the early 1980s was fragile and fell easily from mid-1984, due to a marked deterioration in fiscal performance and a resulting increase in inflation.

In March 1985, the Government announced expenditure control measures. However, Obote was overthrown in July before any policy initiatives could be applied. The following period of unrest led to heavy additional recurrent budget expenditures for defense, and enlarged development budget requirements through resulting rehabilitation needs. Cash crop marketing was constrained by isolation from Kampala and decreased availability of transport.

Economy 1986 - Present

Following the short-lived Okello Government, the National Resistance Movement assumed control in January 1986. The new Government came to power with the responsibility to restore peace, security, and stability, and to resettle a large number of displaced persons. These demands required heavy recurrent and development outlays at a time when the economy continued to experience difficulties. State demands for finance and continued insecurity led to a 2.7% decline in GDP in 1986.

The new Government's initial economic initiatives were a series of *ad hoc* experiments, including appreciation of the exchange rate, increased producer prices, higher Government salaries, the reimposition of price controls, and the establishment of monopolies for key external and domestic trade items. Ultimately these measures led to further economic imbalances. However, the new Government used this experience to refine its development strategy, which led to the formulation of a

The total trade deficit grew by nearly three-fold between 1983-84 and 1984-85, financed largely from bank borrowing.

Government Budget and Finance 1983/84 - 1986/87 (U. Sh. billions)

	1983-84	1984-85	1985-86	1986-87
RECURRENT BUDGET				
Revenue	90.3	162.1	284.4	500.5
Expenditure	79.0	178.1	413.3	802.7
Deficit/Surplus	11.3	(16.0)	(128.9)	(302.2)
DEVELOPMENT BUDGET				
Revenue	4.5	7.8	38.4	85.3
Expenditure	16.0	35.6	70.9	223.7
Deficit/Surplus	(11.5)	(27.8)	(32.5)	(138.4)
Unallocated Expenditure	(21.9)	(19.2)	(2.4)	(115.1)
TOTAL DEFICIT	(22.1)	(63.1)	(163.8)	(555.7)
FINANCING				
External (net)	3.0	13.5	47.4	136.2
Domestic	19.1	49.6	116.4	419.5
--Bank	(6.9)	53.9	77.5	218.2
--Non-Bank	26.1	(4.3)	38.9	201.3
TOTAL FINANCING	22.1	63.1	163.8	555.7

Figures in brackets are negative

Source: *MPED, Background to the Budget, 1988-89, Table 13*

three-year Economic Recovery Programme that was launched in May 1987. The key objectives of this programme were to:

- Restore price stability and bring about a sustainable balance of payments position.
- Stimulate economic growth through improved producer incentives and marketing in agriculture and increased capacity utilisation in agro processing and industry.
- Improve public sector resource use through increased revenue mobilisation, improved resource allocation, and greater discipline, accountability, and efficiency.

The first year of the programme aimed at restoring GDP growth to 5% and reducing annual inflation to around 90%. To restore the competitiveness of Uganda's exports, the exchange rate was depreciated by 329%. At the same time, producer prices were raised substantially, including a 182% increase in the price of coffee. Petroleum prices were adjusted in line with the exchange rate and designed to yield revenue rather than be subsidised as in previous years.

However, the key to the reforms was fiscal adjustment aimed at producing positive public savings and substantially reducing Government's domestic bank borrowing. This goal was complicated by the need to accommodate an increase in civil service salaries and to finance a 400% increase in development expenditures to stimulate infrastructure rehabilitation. To repay the banking system while substantially raising expenditures, the programme relied on a major increase in income from increases in Shilling revenue from coffee through the devaluation, and also partly from higher taxes and improved tax collection. A substantial increase in aid and debt rescheduling was anticipated, while structural policies in tax administration, budget formulation, expenditure control, and parastatal reforms were to increase revenues.

For a few months the reforms appeared to have an impact on inflation. However, pressures to spend were severe, and Government was unable to limit expenditure to planned targets. Prices soon began to rise sharply. The situation was exacerbated by constraints in the provision of consumer goods due, in part, to slow donor response to the Recovery Programme. Inflation was also fuelled by Government's intensification of the war against rebels in the North and Northeast. At the same time, the unit value of coffee fell sharply so that despite the increase in export volume, foreign exchange earnings fell nearly 24% from 1986 to 1987.

Lower world prices, combined with aggressive Coffee Marketing Board purchases at higher producer prices, improved transportation, more efficient operations of the Board and local cooperatives, and the reopening to cultivation of areas previously affected by the war, resulted in an unplanned build-up in coffee stocks. The inflationary impact of the credit expansion for coffee was compounded by the new producer prices which led immediately to higher incomes for growers; yet because of quotas and border closures, there were substantial delays in collecting foreign exchange earnings. Moreover, whatever foreign exchange was earned went largely into debt service and petroleum imports. What was left was used for intermediate goods rather than for direct consumer good imports. The unsatisfied demand for consumer goods led to pressure on the parallel market exchange rate which then fed back into inflation.

A second key element in the credit expansion was the slippage in fiscal performance due largely to unplanned outlays on defense, the Preferential Trade Agreement summit held in Kampala, and relief for displaced persons.

The 1988-89 Programme

Following the mixed performance of the first year of the Recovery Programme, Government launched a revised strategy for 1988-89 that seeks to fine-tune the recovery policy. The strategy continues to emphasize the long-term objectives of diversifying the economy away from over-reliance on coffee production and developing a vertically-integrated industrial base of crop processing enterprises.

The present programme differs from the 1987-88 effort in several ways:

- More flexible exchange rate policy.
- Avoidance of over-stimulation of coffee sales to the Coffee Marketing Board.
- More active monetary policy.
- Establishment of a programme monitoring committee to follow developments on a monthly basis and to initiate corrective action in a timely fashion.
- Increased efforts to explain the programme to the public.

While the impact of the 1988-89 phase of the Recovery Programme has not been evaluated, inflation is slowing down. After the July budget announcement and the initial, irrational leap in prices historically associated with the event, many prices came down; the rate of inflation from August to December 1988 was less than 3% per month. If this trend continues, the target of 60% annual inflation set for the 1988-89 financial year will be achieved.

While the budget seems to have had positive effects toward stabilisation, there are indications of adverse impact due to the tight monetary and fiscal policies. As the poorest urban residents had already established subsistence survival strategies, it is not clear what the total effect of the structural adjustment policies has been. At the request of Government, a Task Force comprised of ministries and key donor agencies (including UNICEF and the US Agency for International Development) is attempting to identify target groups

While it is hoped that the Recovery Programme will lead to substantial annual increases in economic output, per capita performance will probably remain well below the 1972 peak levels for some years.

GDP 1984-87 Compared to Peak Years (1966 U. Sh. millions)

	Peak	Year	% Change 1985-84	% Change 1986-85	% Change 1987-86	1987 as % of Peak
GDP	7,542	1972	(1.1)%	(2.7)%	4.5%	91%
GDP per Capita	775	1971	(3.8)%	(5.3)%	1.6%	57%

Source: MPED, Background to the Budget, 1988-89, Table 1.1

adversely affected by adjustment measures, and design appropriate interventions to cushion the impact where possible.

Exchange Rate Policy

The official exchange rate of the Bank of Uganda in mid-1989 was U. Sh. 200/US$ 1. Another rate, U. Sh. 400/US$ 1, existed for some commercial transactions. At the same time, parallel market exchange traders were offering U. Sh. 550-600/US$ 1. The difference between the official and parallel rates is a result of the limited hard currency available through the banking system and the demand for imported consumer goods. The street price of consumer goods reflects the lower real market value of the Shilling.

External Debt Assistance

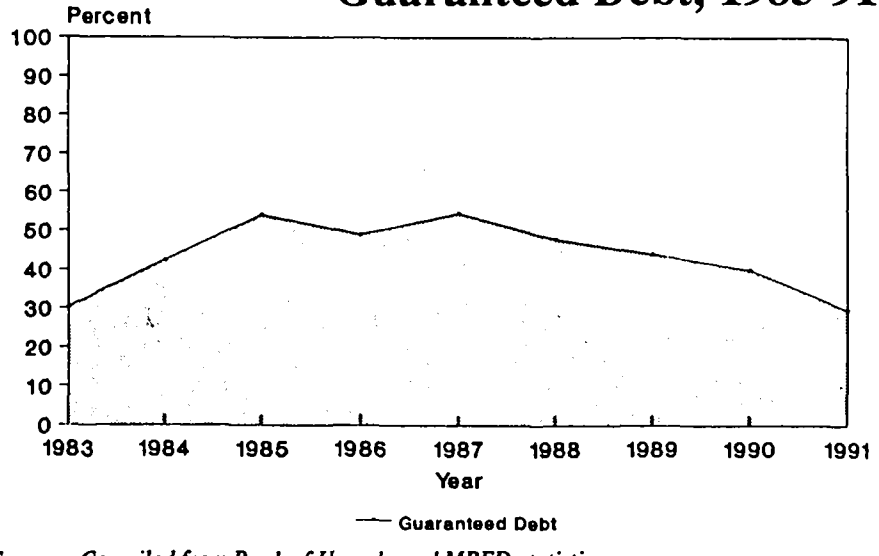
The repayment of debts incurred by previous Governments places a major burden on available resources. In 1988, repayments comprised 65% of the total value of exports of goods and services. However debt repayment is expected to decline sharply in 1990-91 as the debt obligation is in the process of being renegotiated. New loans to Uganda are being made on much more concessional terms, with a higher proportion of grants and soft loans.

At the end of 1987, external debt was US$ 1,239.2 million compared to approximately US$ 461.8 million at the end of 1980. This represented over 50% of the country's GDP and was nearly three times the year's level of export earnings (MPED, 1988a). Bilateral creditors accounted for 25% of the total debt.

Uganda is the recipient of increasing amounts of external aid. The total rose from US$ 298.2 million in 1986-87 to US$ 454.2 million in 1987-88, when it constituted 99% of the value of the national development budget.

Debt repayment is expected to decline sharply in 1990-91 as the debt obligation is in the process of being renegotiated.

External Debt Service Ratio Government and Government - Guaranteed Debt, 1983-91



Source: Compiled from Bank of Uganda and MPED statistics

Government Revenue

Government revenue is strongly dependent on the coffee export duty, and the annual collection is based on production, coffee quota levels, the world price, and the official producer price. In July 1989 the international coffee cartel and coffee quotas were suspended for two years. The collapse initially caused a sharp drop in world coffee prices, but the long-term implications for the world market and the national economy remain unclear.

Other revenue sources include income tax, sales and excise taxes, and import duties. Government has made strong efforts to strengthen the tax base since 1987. Collection of graduated income taxes from the rural areas is to be reintroduced following many years of lax enforcement. This action should have a significant impact on district level Government financing, which is strongly based on locally-generated income.

While overall revenue collection is on the rise, the real value of generated funds in 1988 was only 50% of the level reached in 1984. The per capita level was even lower.

Main Sources of Recurrent Revenue 1982-87

Source	1982	1983	1984	1985	1986	1987
Income tax	4.8%	6.7%	6.1%	5.5%	11.4%	9.1%
Export tax	30.7%	44.4%	58.8%	67.3%	39.9%	32.3%
Customs duty	12.2%	10.0%	8.9%	6.2%	11.9%	10.3%
Sales tax	20.2%	19.0%	19.9%	14.9%	25.3%	34.6%
Other	32.1%	19.9%	6.3%	6.1%	11.5%	13.7%

Source: MPED, Background to the Budget, 1988-89, Table 8

Goverment Financing of Social Services

Government support for social services, principally health and education, has declined radically from the early 1970s. Public sector support for improved services cannot be matched by adequate budgetary allocations while Government is financing the strengthening of the economic base. During the 1980s the budget allocation to health steadily declined in real terms until 1988-89, when there was a marked increase. The allocation to education has remained fairly constant over this period.

Health

Real financing of the Ministry of Health recurrent budget in 1988-89 was 16.9% of the 1970-71 level, and the actual allocation may be significantly less than that. After dropping to 1.7% of the 1970-71 level in 1985-86, the development budget has increased substantially, although this was mostly due to donor support. The figure for 1988-89 may be misleading; it is unclear whether it represents an increase in total investment or an improvement in accounting methods, as observation suggests that there has not been such a large real increase.

The Ministry of Local Government also supports the health sector through the central ministry and district authorities who are responsible for meeting the salaries and allowances of health staff below hospital level, and for maintenance and upkeep of health facilities. Funds for the local authorities are generated locally from income taxes, licences and fees, etc. These funds are supplemented by block grants from the central ministry based on a sliding scale of need in each district; the grants usually account for about 5% of the district total budgets.

Data on local health service expenditures are very limited. In 1988-89 the share of three district budgets devoted to health ranged from 11% to 17%. This proportion is thought to hold for other districts as well and is similar to the estimate made in a recent study (Lee et al., 1987; MLG, Unpublished Data, 1989).

Real financing of the Ministry of Health recurrent budget in 1988-89 is 16.9% of the 1970-71 level. The development budget has increased substantially after dropping to 1.7% of the 1970-71 level in 1985-86.

MOH Recurrent and Development Budget Selected Years, 1970-88 (U. Sh. millions)

Fiscal Year Total	70-71	82-83	84-85	86-87	88-89
Recurrent	1	21	66	180	2,629
Development	1	5	14	59	3,436
Total	2	26	80	239	6,065
% National Budget					
Recurrent	5.8%	4.0%	3.1%	2.1%	3.0%
Development	2.9%	0.9%	0.7%	0.7%	4.0%
Real Expenditure % 1970 Level					
Recurrent	100%	17.6%	22.0%	7.3%	16.9%
Development	100%	8.2%	9.4%	4.7%	44.3%
Total	100%	14.5%	17.8%	6.4%	26.0%

Source: MPED, Unpublished Data, 1989

In the 1980s, the real value of the recurrent and development budget allocations to the Ministry of Education has varied greatly from year to year. In 1988-89 the total allocation was 21.1% of the value allocated in 1970-71.

MOE Recurrent and Development Budget Selected Years, 1970-88 (U. Sh. millions)

Fiscal Year Total	70-71	82-83	84-85	86-87	88-89
Recurrent	3	68	279	877	9,370
Development	1	5	14	206	759
Total	4	73	293	1,082	10,129
% National Budget					
Recurrent	14.6%	12.9%	13.0%	10.2%	1 0.8%
Development	3.1%	0.9%	0.7%	2.4%	0.9%
Real Expenditure % 1970 Level					
Recurrent	100%	22.1%	36.6%	13.9%	23.6%
Development	100%	7.1%	8.8%	15.3%	9.0%
Total	100%	19.5%	31.7%	14.1%	21.1%

Source: MPED, Unpublished Data, 1989

The real value of the funds allocated to health and education in 1988-89 together represent only 32% of the total allocated in 1970-71. When corrected to reflect population expansion over this period, the picture is worse.

Even with the significant increase in 1988-89, the recurrent budget per capita for health and education is just over 10% of the 1970-71 level.

Real Changes in Health and Education Budgets 1970-71 Compared to 1988-89

	Total 1988-89 as % of 1970-71	Per Capita 1988-89 as % of 1970-71
HEALTH		
Recurrent	16.9%	10.5%
Deveopment	44.3%	27.5%
Total Health	26.0%	16.1%
EDUCATION		
Recurrent	23.6%	14.6%
Development	9.0%	5.6%
Total Education	21.1%	13.0%

Source: Derived from MPED Statistics

Income, Wages and Salaries

A recurring problem in all sectors is the continuing inadequacy of Government salaries. In early 1989, Ministers earned a maximum of U.Shs. 9,000 per month which was only 4% of an unofficial United Nations estimate of the monthly income needed to sustain a middle-income family of five in Kampala. In mid-1989 Government salaries increased by 40%, with even larger rises for key officials, including judges and physicians. The impact of this move has yet to be felt.

Government salaries have been below subsistence level for over ten years, and no public servant, however frugal, could survive on his salary alone. The more fortunate Government staff augment their official salaries with allowances, housing, and other fringe benefits. Many with Government housing rent out space in their homes to others, realising a much greater income from this activity than from their salaries. The less well-connected and more typical employees supplement their income through work in the private sector or on their plots of land.

According to the 1988 Census of Civil Servants, all respondents had some additional form of income and 58% engaged in agriculture to supplement their wages. Others were in family businesses and part-time jobs.

Government is the single largest employer, with 271,000 employees in 1989. There is, however, a significant number of "ghost workers" in this figure; it is estimated that 11% of individuals on the payroll are fictitious or no longer work in the ministry that pays them (New Vision, April 12, 1989).

There is no information on private sector salaries, but they are known to be much higher than in Government and provide a living wage. Private wages are not controlled, but Government plays a leading role in establishing their level through the civil servant salary scales.

Income Distribution

No detailed information on income distribution exists. The data available suggest that there is a very large group of urban and rural poor, a rather broad, not very rich class of civil servants, traders and farmers, and a very small, very wealthy, elite who have accumulated wealth from trade and speculation rather than from land ownership or industrial production.

Rural Income

The great majority of families rely on agriculture for their livelihood. Possibly 15% of rural households supplement farm earnings with receipts from urban-based relatives, while about 20% are mainly dependent on wage or profit earning occupations. A large percentage of the agricultural sector survives at least in part on subsistence farming. The share of agriculture devoted to non-cash farming is unknown, but is estimated to be 57% of the total agricultural share of GDP (MPED, 1988a). There are few families who do

Government salaries have been below subsistence level for over ten years, and no public servant, however frugal, could survive on his salary alone.

Uganda Government Salary Scales by Grade, 1988

Grade	Estimated Number	Average Salary (U.Sh.)	% of UN Middle Income Estimate	Category of Staff
A	NA	7,963/-	3.0%	Principal Judges
UI	NA	4,208/-	1.6%	Directors, Heads of Departments
U2	NA	4,000/-	1.6%	Doctors, Deputy Heads, Engineers, Town Clerks
U3	1,000	3,763/-	1.5%	Academic Staff, Senior Executives
U4	3,500	3,035/-	1.3%	Graduate Teachers, Senior Administrators
U5	9,100	2,551/-	1.0%	Higher Executive Staff, County Chiefs
U6	15,500	2,172/-	0.8%	Registered Nurses, Grade V Teachers
U7	49,000	1,917/-	0.7%	Teachers, Chiefs, Enrolled Nurses
U8	161,500	1,765/-	0.7%	Group Employees, Casual Workers

Source: *New Vision, August 1988; Department of Information-Jinja, Personal Communication, 1988; MPED, Census of Civil Servants, 1988*

not participate in the monetary economy to some degree, and virtually all families have at least some manufactured consumer goods and purchased essentials such as plastic mugs and salt (UNICEF, 1988a).

Women undertake limited income-generating activities, such as making baskets, brewing beer, selling garden produce, etc., but the extent of the contribution to overall household income from these sources has not been studied in detail. (For more information see the chapter on the Situation of Women.)

The rural environment in Uganda contains a heterogeneous mix of economic and social classes. A recent survey in Mbarara found that about 34% of the population were subsistence farmers who owned a few acres of land, sometimes worked on other people's farms, had a very low level of education, did not own a radio, and had been resident in their village for many years. On the other end of the scale (about 10% of the population) both husband and wife were well-educated, the husband was typically a Government officer or teacher who hired labour to work on the family farm, and the family usually had a radio (MOH et al., 1989). Researchers did not determine variation in real income levels between the groups. Whether such distinct groups occur in other parts of Uganda, and whether the same factors distinguish them, is unknown.

Very little data exist on individual household income, and how macro-economic policies affect living conditions. This lack of data is a recognised long-term problem that will require the attention of Government, probably with external assistance, to link macro policies to their household level impact.

Profile

A Working Woman's Problems

Women are handicapped by a tradition of male exemption from domestic chores and a general lack of understanding by men of what managing a home, family, and job entails. Jane, a woman who has to work outside her home because of deteriorating economic conditions, is aged 34 and has three children.

"I married my husband soon after graduating from Makerere University in economics. At that time my husband, a businessman, earned enough to support the two of us. We decided that I should stay at home and look after the family instead of getting a job. We thought this was better than hiring a house servant.

"After our third child was born, my husband's business no longer made enough money to keep us going. I had to get a job, and I now work as a trading officer in a leading parastatal company. We then had to employ a housegirl.

"My husband is a man who is very strict and demands perfection in the home. No house servant seems to satisfy his high standards, and most have left after a short time. With so many changes, I often worry about what is happening at home while I am at work.

"Often I have no help at home, and I have to wake up at 5:30 a.m., clean the house, prepare breakfast and lunch, get two children ready for school and the youngest one ready to go to my neighbour's who helps look after him. I then eat breakfast and rush to work.

"Often I get to work late. If the children are sick, I have to take time off from work to look after them.

"I'm often sick myself. I keep on getting malaria. Even when I am ill I still have to see that the housework is done before I can rest. Sometimes I postpone taking the medicine because it makes me feel dizzy. Each time I become sick these days I find I get better slower and I keep away from work longer.

"As a result of lateness, absenteeism, and absent-mindedness as well as my inability to work overtime when requested, I have lost any chance of promotion. I feel lucky to keep my job at all when I am unable to do the work expected of me."

Summary Analysis

Government's attempts to improve the economy will likely bring long-range benefits to the country. In the short-run, however, the concentration on stimulating the income-producing sector, and consequent low budgets for social services, produces suffering for many individuals. Low Government salaries tend to lead to corruption and inefficiency.

Not all of the limited funds budgeted for services that would most directly benefit women and children are actually released. At the same time, the allocation of funds available within a given sector may be determined by technicians who may not have a full understanding of the social effects of their disbursement preferences. Thus, the budget allocation for hospitals is more substantial than the budgets for primary health care activities. Funds might be better utilised if policy-makers had more orientation on the relationship between economic productivity and health and educational status, as well as on the economic benefits of preventive compared to curative health services.

The Health Situation of Children and Women

Health Situation of Children

Definitional and diagnostic problems make it difficult to interpret and compare national morbidity and mortality statistics and an absolute ranking of the importance of various diseases may not be warranted. However, the existing data indicate that respiratory tract infections, malaria, measles, and diarrhoea are the most frequent causes of morbidity and mortality in children under five years of age. Some regional differences exist in the relative importance of each disease.

Infant and Under Five Mortality

In 1987, the official figure for the infant mortality rate for Uganda was 104/1000, and the cumulative under-five mortality rate was 172/1000. The 1988-89 Demographic and Health Survey provided the first semi-national infant and child mortality rates since the 1969 census. Based on interviews of 4,730 mothers in 25 districts, the survey identified a shifting pattern of mortality rates that closely follows the changes in the economy. The Infant Mortality Rate (IMR) for 1983-88 is 101.2/1000, which is lower than the period 1978-82 but not as low as the rate recorded for 1973-77.

Several surveys conducted in recent years have yielded similar estimates of IMR while the annual death rate of children 0-4 years of age recorded in these surveys is also high. The DHS provides the only information available on the 1-4 year age group mortality rate or the cumulative under five mortality rate. It is estimated that more than one-half of all deaths in Uganda each year are among children below five years of age. A 1988 household survey found that one-quarter of all deaths occurred in children below one year of age (MOH et al., 1989).

Infant Mortality and Under Five Death Rates (/1000/year) from Selected Districts 1984-88 Surveys

Area	Year	0-11 Months	0-4 Years*
Mbarara	1988	98	57
North East	1985	125	48
Lira	1984	112	58
Mbale	1984	95	40
Bushenyi	1984	108	46
Kasangati	1984	98	NA

*Calculated as Deaths ≤5 years/Population ≤5 years

Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989; GOU et al., Baseline Survey Northeast Uganda, 1985; various internal project documents

It is estimated that more than one-half of all deaths in Uganda each year are among children below five years of age.

The Infant Mortality Rate for 1983-88 is 101.2/1000, which is lower than the period 1978-82 but not as low as the rate recorded for 1973-77.

Infant and Childhood Mortality Five-Year Calendar Periods, 1988-89

Period	Infant Mortality Rate	Childhood Mortality Rate	Under 5 Mortality Rate
1983-1988*	101.2	88.1	180.4
1978-1983	113.9	97.0	199.9
1973-1977	91.9	96.5	179.6

* Includes calendar year 1988 up to the month preceding date of interview

Source: MOH and DHS, Uganda Demographic and Health Survey, 1989

Immediate Causes of Death

Mortality data for young children in Mbarara District represent a picture found in many parts of the country. Among infants below one year of age, respiratory infections contributed to 18% of all deaths followed by diarrhoea (15%) malaria (12%) and measles (10%). Between the second and fourth years, measles was responsible for 30% of all deaths followed by malaria (18%), diarrhoea (18%) and respiratory infections (11%). All deaths from malnutrition were concentrated in the second and third year of life, accounting for 6% of deaths in that age group.

The principal causes of death among young children are preventable communicable diseases and, to a lesser extent, malnutrition.

Causes of Hospital Mortality, All Ages 1981 and 1987

1981			1987		
Cause	% of All Deaths	Rank	Cause	% of All Deaths	Rank
Measles	25%	1	Malaria	10%	1
Resp. Infections	16%	2	Diarrhoea	9%	2
Diarrhoea	9%	3	Tetanus	8%	3
Malaria	7%	4	Anaemia	8%	4
Trauma	6%	5	Measles	7%	5
Anaemia	5%	6	Resp. Infection	6%	6
Tetanus	5%	7	Malnutrition	5%	7
Tuberculosis	3%	9	Pneumonia	5%	8
Malnutrition	2%	8	Fractures	4%	9
Whooping Cough	1%	10	Hernias	4%	10
Other	21%			35%	

Source: BSF et al., Report of the General Identification Mission, 1984, p. 37; MOH Health Planning Unit, unpublished data, 1988

Causes of Death, Mbarara District, 1988

	% of All Deaths	
	Total Population	< Five Years
Diarrhoea	17%	16%
Malaria	16%	15%
Respiratory Infections	14%	14%
Measles	13%	21%
Accidents	4%	1%
Vomiting	4%	4%
Malnutrition	2%	3%
Tetanus	1%	2%
Other	29%	24%

Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989

Infant and Under Five Morbidity

Reasons for hospital admission follow the disease profile found in the community surveys. The two primary causes of admissions for all ages in 1970 were respiratory tract infections and injuries; in 1987 they were malaria and diarrhoea.

Morbidity in Children Under 5 Years Selected Rural Areas 1985-88

	% of Children with Illness Previous Two Weeks		
	Northeast	Arua	Mbarara
Disease	**1985**	**1987**	**1988**
Malaria	44%	31%	18%
Respiratory Infections	12%	12%	38%
Diarrhoea	19%	26%	21%
Measles	6%	4%	4%
Skin Diseases	NA	11%	5%

Source: GOU et al., Baseline Survey Northeast Uganda, 1985; CUAMM, Arua Baseline Survey, 1987; MOH et al., Baseline Survey for SWIP Mbarara, 1989

Survey data on morbidity of young children shows a similar pattern of causes to that for mortality. However, skin diseases appear to be a common, non-fatal illness.

Specific Causes of Morbidity and Mortality

Insufficient data exist to describe the incidence of disease by season or geographic area. Many of the figures quoted below were drawn from limited samples that may not be completely representative of the national disease profile.

Malaria

Malaria appears to be a leading cause of morbidity and mortality among children, particularly in those under five years of age. The disease is endemic in all districts with the exception of the mountainous areas of the Southwest and extreme East, with the incidence varying by location and season. Available statistics indicate that malaria as a cause of ill health is increasing as are mortality and case fatality rates.

Two species of anopheles mosquito act as vectors in Uganda, *A. Gambiae* and *A. Funestus* (Hall and Langlands, 1975, p. 75). The most common form of malaria is *plasmodium falciparum* which, in its cerebral form, can be fatal or permanently damaging to young children unless treated promptly.

Malaria is also a contributing factor to other illnesses; in pregnant women it leads to anaemia and causes low birthweight and thus contributes to infant

Leading Causes of Admission, All Ages Government and NGO Hospitals 1970-87

Disease	% of All Admissions				
	1970	1977	1981	1986	1987
Respiratory Tract Infections	10%	11%	10%	9%	9%
Diarrhoea/Gastroenteritis	6%	6%	7%	7%	11%
Malaria	6%	9%	10%	13%	16%
Measles	4%	8%	12%	13%	5%
Genito-Urinary Problems	4%	4%	NA	NA	5%
Hernias	2%	2%	NA	NA	4%
Injuries	10%	17%	NA	NA	5%

Source: MOH, Medical Services Statistical Records, Various Years; Alnwick et al., Morbidity and Mortality in Selected Ugandan Hospitals, 1985; MOH Planning Unit, Unpublished Data, 1988

mortality. In one survey, wasting was found to be significantly higher among children who had suffered from malaria in the previous two weeks than in other children (GOU et al., 1985).

Malaria incidence is highest between nine months and two years of age, between the time neonatal immunity has lapsed and partial immunity is acquired. Thereafter, incidence declines with age.

The control of malaria is now limited to individual prophylaxis and treatment. The vector control section of the Ministry of Health is inactive.

The national supply of chloroquine is theoretically adequate to provide curative treatment for all projected cases of malaria. However, many health units do not have sufficient chloroquine, mainly because of inadequate distribution and overprescription of the drug in some areas (UEDMP, 1986). Considerable chloroquine resistance exists in at least part of the country, which may in the future complicate control efforts.

Malaria appears to be a leading cause of morbidity and mortality among children, particularly in those under five years of age.

Malaria Morbidity and Mortality By Age As Percentage of All Patients/Deaths in Hospitals and Health Units, 1987

Age Group	Inpatient		Outpatient
	Morbidity	Mortality	Morbidity
<1 year	21%	13%	32%
1-4 years	21%	13%	27%
5-15 years	19%	12%	19%
≥ 16 years	19%	9%	19%

Source: MOH Planning Unit, Unpublished Data, 1988

Diarrhoeal Diseases

Diarrhoea is another leading cause of death, and its relative importance has increased over time. In 1982 diarrhoea was sixth in incidence and third in mortality, but by 1987 it ranked second as a cause of both inpatient and outpatient consultations.

The pathogenic agents responsible for diarrhoeal diseases in Uganda have not been studied. However, as in other countries, the main danger of the disease is from dehydration. Available statistics do not indicate the proportion of diarrhoea cases that arrive at health facilities with dehydration.

Diarrhoea in children varies by age, with the highest rate among one and two-year-olds at the time of weaning and increased mobility. In Mbarara District the incidence of diarrhoea in the two weeks prior to the survey increased from 100/1000 in children less than one year of age to 190/1000 in the second year of life, declining in the third year to 80/1000 (MOH et al., 1989).

There is a tradition of increasing liquid intake and maintaining feeding for children with diarrhoea in many areas of the country (UNICEF, 1988a). In Mbarara almost all mothers continue feeding and breast-feeding; 44% give more liquids, 39% give liquids as

Diarrhoea Morbidity and Mortality by Age As Percentage of Admissions/Deaths Hospitals and Health Units, 1987

	Severe Diarrhoea		Intestinal Infections	
	Morbidity	Mortality	Morbidity	Mortality
<1 year	7%	4%	5%	5%
1-4 years	7%	6%	6%	8%
5-15 years	6%	8%	4%	4%
≥ 16 years	4%	6%	2%	1%

Source: MOH Planning Unit, unpublished data, 1988

In 1982 diarrhoea was sixth in incidence and third in mortality, but by 1987 it ranked second as a cause of both inpatient and outpatient consultations.

Reported Proportion of Children Under 5 Years of Age With Diarrhoea Household Level Surveys, 1989

	% With Diarrhoea	
Region	Past 24 Hours	Past 2 Weeks
West Nile	12.8%	20.7%
East	18.4%	29.4%
Central	9.0%	17.0%
West	11.6%	20.2%
Southwest	9.6%	18.0%
Kampala	10.2%	19.4%
TOTAL	12.3%	21.4%

Source: MOH and DHS, Uganda Demographic and Health Survey, 1989

Diarrhoea in children varies by age, with the highest rate among one and two-year-olds at the time of weaning and increased mobility.

usual, 13% give less and only 4% stop liquids (MOH et al., 1989). However, the treatments chosen by mothers also include inappropriate ones, such as antibiotics and injections.

In a 1989 survey, between 78% and 97% of mothers in different districts recognised Oral Rehydration Salts (ORS) sachets and between 63% and 92% had actually used ORS. The proportion of mothers who knew how to correctly mix ORS (31%-66%) was much higher than for sugar-salt solution (7%-20%) (MOH, 1989 b).

Few mothers link unclean water to diarrhoea, while 10% associate developmental stages such as teething or learning to sit as the cause. Many traditional beliefs relate to the illness, including those of spiritual or supernatural origins (Lwanga, 1989).

The choice of treatment was found to be related to the level of education in Mbarara, with a preference for injections increasing with education, and use of herbs more frequent among the uneducated.

Diarrhoeal Disease Treatment* For Children Under Five Years Selected Districts, 1988

District	Herbs	Tablets/ Injections	SSS/ORS	Other/None
Mbarara	39%	47%	43%	NA
Masaka	55%	21%	11%	13%
Hoima	56%	6%	9%	29%
Kabale	39%	38%	17%	6%
Iganga	32%	23%	17%	28%
Mbale	5%	40%	31%	24%
Arua	22%	50%	27%	1%
Luwero	14%	29%	28%	29%

SSS = Sugar-Salt Solution
ORS = Oral Rehydration Salts
* More than one response possible for each child

Source: GOU et al., Baseline Survey for SWIP Mbarara, 1989; UNICEF, CDD KAP Survey, 1988; UNICEF, Luwero Water and Sanitation Survey, 1988

The ownership of key materials for preparing Oral Rehydration Salts (ORS) and sugar-salt solution varies within the country, with almost all families having a plastic 0.5 litre *tumpeco* mug and salt, but few having sugar.

Percentage of Households with Materials for Preparing Rehydration Fluids Various Districts, 1988

District	ORS Sachet	Tumpeco Mug	Salt	Sugar
Mbarara	18%	98%	94%	22%
Masaka	5%	98%	97%	30%
Hoima	11%	97%	94%	35%
Kabale	13%	95%	99%	22%
Iganga	12%	98%	90%	17%
Mbale	11%	93%	88%	37%
Arua	6%	91%	95%	17%
MEDIAN OF SURVEYS	12%	97%	94%	22%

Source: GOU et al., Baseline Survey for SWIP Mbarara, 1989; UNICEF, CDD KAP Survey, 1988

Mothers' Belief of Cause of Diarrhoea Various Districts, 1988

District	% Stating Cause					
	Unsafe Food	Unsafe Water	Flies	Worms	Teething	Don't Know
Mbarara	32%	3%	NA	36%	NA	29%
Masaka	34%	4%	3%	12%	10%	12%
Hoima	38%	8%	3%	9%	18%	7%
Kabale	26%	2%	2%	41%	1%	10%
Iganga	31%	4%	9%	9%	5%	10%
Mbale	18%	5%	6%	5%	3%	33%
Arua	29%	3%	18%	9%	16%	4%
MEDIAN OF SURVEYS	29%	4%	3%-6%	9%	5%-10%	10%

Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989; UNICEF, CDD KAP Survey, 1988

Measles

Measles has probably been responsible for more infant and child deaths in Uganda than any other disease over the past ten years. However, evidence indicates that incidence and mortality is being reduced by immunisation, although the case fatality rate remains high. The proportion of hospital deaths attributed to measles dropped from 25% in 1981 to 7% in 1987. Health personnel observe that while a few years ago measles wards were crowded, they now register very few cases. Seasonal peaks in incidence and cyclical epidemics still occur, but they are less dramatic than in the recent past.

Measles strikes most often during and just after weaning, when children are also at the highest risk of both malnutrition and malaria. In a rural hospital in Rukungiri, 50% of measles cases occurred in children between nine months and five years of age, and 30% in children over the age of five. This high incidence of late measles may be lower in more densely populated areas (GOU, 1987).

Surveys show that the incidence of measles among children below five years of age in the preceding six months was 20/1000 in the Northeast, 10/1000 in Arua and 20/1000 in Mbarara. Measles accounted for 18% of deaths below five years in Arua and 21% in Mbarara.

Respiratory Tract Infections

Acute and chronic respiratory tract infections are one of the most common causes of childhood morbidity and mortality. In Mbarara they accounted for 16% of reported illnesses among children under five, while reaching more than 12% of the total national recorded health unit outpatient attendance in 1987.

While no national tuberculin surveys have been carried out since the early 1970s, the majority of adults have been exposed to the tubercle bacillus. The actual incidence and death rates of tuberculosis are not known, as the available statistics are incomplete and based on medical unit admissions. The extent of bovine tuberculosis is also unknown.

Measles Morbidity by Age Selected Hospitals, 1987

Age Group	Inpatient	Outpatient
< 1 year	4%	1%
1-4 years	9%	2%
5-15 years	6%	2%
≥ 16 years	0	0
Deaths	7+%	-
CFR	13%	-

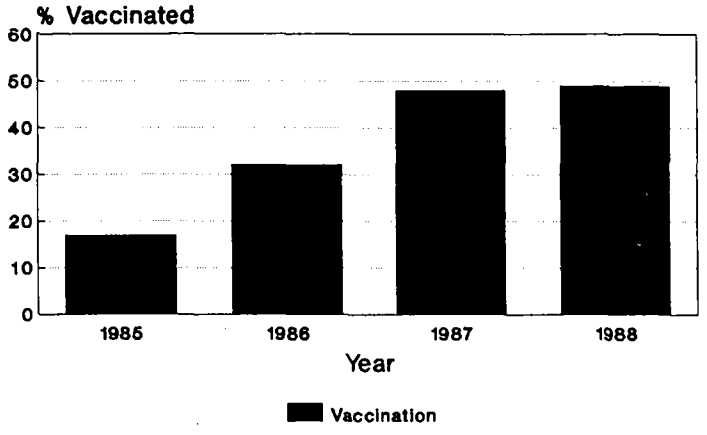
CFR = Case Fatality Rate

Source: MOH Planning Unit, Unpublished Data, 1988

Evidence indicates that incidence and mortality is being reduced by immunisation, although the case fatality rate remains high.

Vaccination coverage for measles increased considerably from 1985 to 1987, with a leveling off in 1988 due to a series of adverse factors.

National Measles Vaccine Coverage Children 0-11 Months of Age 1985-1988



Source: UNEPI, Annual Vaccination Reports, Years Cited

Neo-Natal Tetanus

In Mbale District in 1984, neo-natal tetanus accounted for 15 deaths per 1,000 live births (Malison et al, 1987). Extrapolating this figure to the national population, neo-natal tetanus may cause as many as 9,000 deaths per year. Low tetanus toxoid vaccine coverage (14% in 1988) and the high percentage of unhygienic deliveries contribute to this elevated number.

Poliomyelitis

According to information from eight hospitals, there were 358 reported polio cases among outpatients and ten among inpatients during the first six months of 1988 (MOH, 1989c), yielding an estimated incidence of 9-12 cases per 100,000 population. In 1988, reported Polio III vaccine coverage was only 41% among infants.

A polio serosurvey carried out in 1988 found that seropositivity among vaccinated children was 90% for Polio type 1, 98% for Polio type 2, and 60% for Polio type 3 (Lule, 1988). The lower percentage of seroconversion for Sabin type 3 is similar to results found in other developing countries.

Pertussis (Whooping Cough)

Whooping cough is common among children, especially in the colder parts of the country and during the rainy season. Most deaths occur in children under five years, but the mortality rate from the disease is not known.

Acquired Immunodeficiency Syndrome (AIDS)

AIDS is a new health risk which may emerge as the number one cause of death among Ugandan children under five years of age in the next decade. AIDS in children occurs almost exclusively due to transmission from mother to child during pregnancy. The actual influence on the child death rate depends on HIV prevalence among pregnant women. WHO models suggest that in countries where Human Immuno-deficiency Virus (HIV) prevalence in pregnant women is 10% and the cumulative under five child death rate from other causes is 100/1000, child mortality will increase by 20/1000; where HIV prevalence is 20%, child deaths will increase by 40/1000. The model for Uganda, where the cumulative under five mortality rate is over 150, may be different.

As the rate of HIV infection in child bearing age women increases, the number of paediatric cases of AIDS continues to rise. Virtually all cases are among children under five years of age.

Although some of the increase may represent an improvement in the recognition and reporting of paediatric cases over the past four years, it is clear that HIV infection will play a substantial role in infant and childhood morbidity and mortality in Uganda in the future, and may, if unchecked, set back some of the gains made by Child Survival activities. It is also likely that many children will be affected by the loss of one or both parents (for more information see the chapter on Children in Difficult Circumstances).

Profile

Treatment of Women in a Government Hospital

Women who live in town and are more educated are most likely to deliver in hospitals. Sylvia, a woman aged 32 with six children, is a housewife whose husband works as an assistant welfare officer.

"Money is hard to come by for us. When I am sick, whatever the disease, I go to the outpatients' department of the hospital. There, depending on what I'm suffering from, I join the appropriate line until it is my turn to be treated.

"There are several lines in the outpatients' department. One is for those with ear, nose, and throat problems, another is for men's general diseases, another is for women's general illnesses like malaria and typhoid. If there are any gynaecological cases, they are told to come back on a certain day, once a week, when a gynaecology doctor treats them.

"Once, I had a gynaecological problem. I had very painful periods, and was told to go back on a particular day to see a gynaecology doctor. When I went back, I saw a doctor who examined me and told me to go to the hospital pharmacy, where I was given the medicine prescribed. If it is out of stock then one has to look for the medicine at a private pharmacy and buy it. It is given free in a hospital pharmacy.

"The longest line in the outpatients' department is that for the antenatal care clinic. It is only open during office hours, from Monday to Friday. Friday is put aside for those attending antenatal clinics for the first time. The women are told to go with their own exercise books which they use as antenatal cards. There are also midwives and health assistants who brief the women on child and women's health care.

"I delivered all my children in the Government hospital. Sometimes you find friendly nurses, but most of the time they are rather hostile and overworked. The delivery room is rarely cleaned properly, so I dread the time of delivery."

Reported Paediatric AIDS Cases 1986-1989

Year	Paediatric Cases	% of Total Cases Reported
1986	3	2%
1987	323	9%
1988	429	12%
1989 (first half)	308	16%

Increasing numbers of orphans due to AIDS are expected to pose an exceptional social and economic problem. In heavily affected areas, children may lose not only their parents but other close adult relatives as well.

Other Infectious Diseases

Ugandan children and their caretakers are also exposed to other infectious tropical diseases, including trypanosomiasis, leprosy, and onchocerciasis, but no recent data describe their incidence and distribution. The prevalence of schistosomiasis reaches nearly 100% in some villages, and fishing communities around Lake Victoria are especially affected (Author Unknown, 1982; Doumenge et al., 1987). Guinea worm continues to be a problem in the North, despite borehole drilling and health education. In 1984, nineteen percent of the population in Kitgum District reported the emergence of at least one worm in the previous year (Henderson et al., 1988).

Although meningitis is a problem in neighbouring countries, no recent epidemics have occurred in Uganda. Sporadic cases appear in isolated populations, such as orphanages and military camps.

Malnutrition

Although a national nutrition survey has never been carried out, localised surveys during the past decade provide a picture of the nutrition situation, which is generally better than in many countries in the region. The main problems are protein-energy malnutrition and anaemia. Vitamin A and iodine deficiency probably occur in limited areas.

Under normal circumstances in Uganda, about 2% of children are acutely malnourished. However, regional disparities exist, and urban children have a higher risk of both acute and moderate malnutrition. In general, nutritional status is satisfactory during the first six months of life and deteriorates somewhat during the weaning period between six and 18 months. The situation improves in the following years, but many children never return to the level of early life. The prevalence of stunting--short height-for-age, which represents a scar of past nutritional problems--increases with age and is highest in the fourth and fifth years.

Information collected from 4,200 children in Mbarara District in 1988 graphically illustrates this pattern of growth. During the first four months of life, mean weight-for-age follows the median of the international standard. Between the fifth and 13th months, mean weight for age declines to the third percentile, representing a marked failure to thrive during the weaning period. Between the 14th and 60th months, the mean weight oscillates between the median and the third percentile of the standard but never returns to the median.

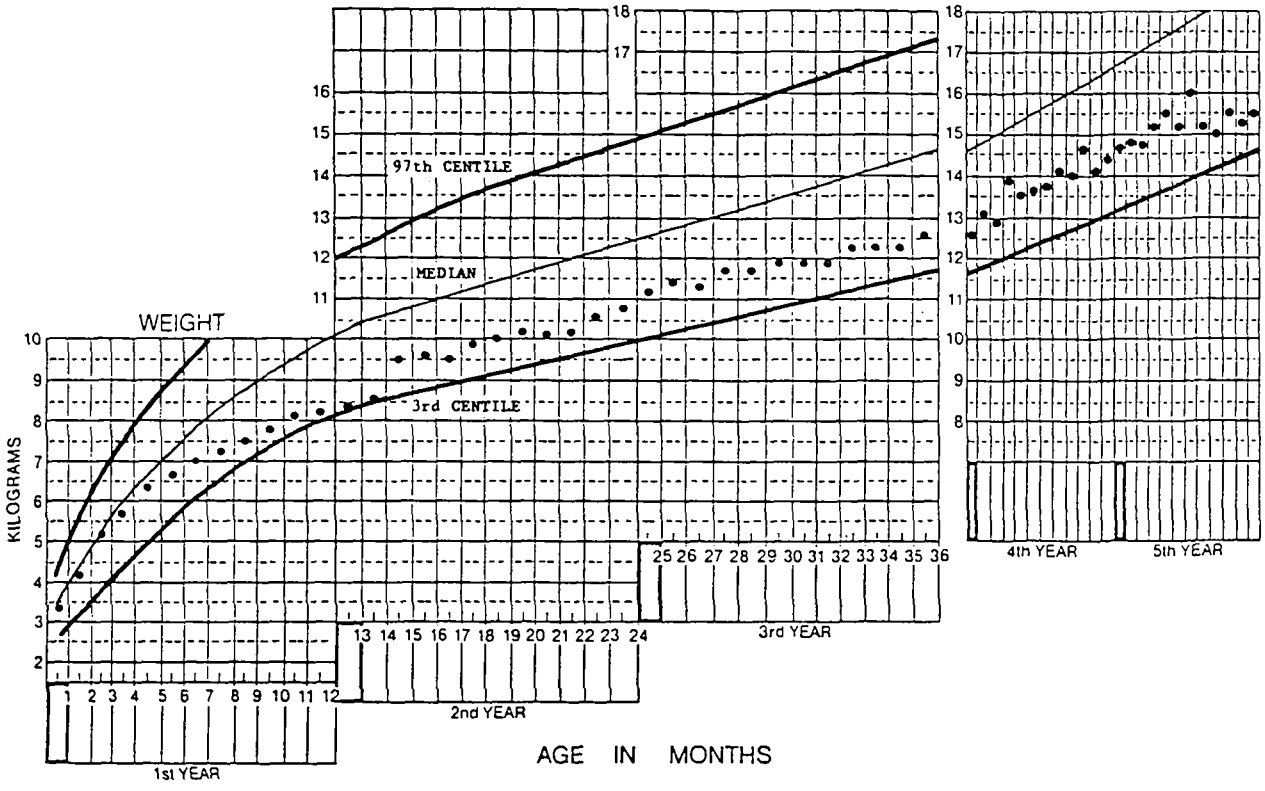
Breast-feeding and Weaning

Several studies have found that nearly all women breast-feed their children for at least one year. Uganda's economic problems may have helped maintain this practice, as the price of breastmilk substitutes is far beyond the reach of most mothers. In Mbarara, one-half of all children were still breast-feeding during the second year of life, and 6% in the third year. Recent data on the prevalence of exclusive breast-feeding in Uganda do not exist, but in Mbarara 10% of children were introduced to foods other than breastmilk by four months of age and nearly 90% by six months.

Surveys in the Northeast and Mbarara found that males were significantly more stunted than females. Researchers also reported that the number of underweight and stunted children was significantly higher among parents who lacked formal education or were not able to read (MOH et al., 1989).

No relationship was found between a mother's education and the age of her child at weaning. Urban

Mean Weight for Age in Months, Mbarara, 1988



Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989.

Nutrition Status of Children <5 Years by Area, Year and Season Selected Districts, 1981-88

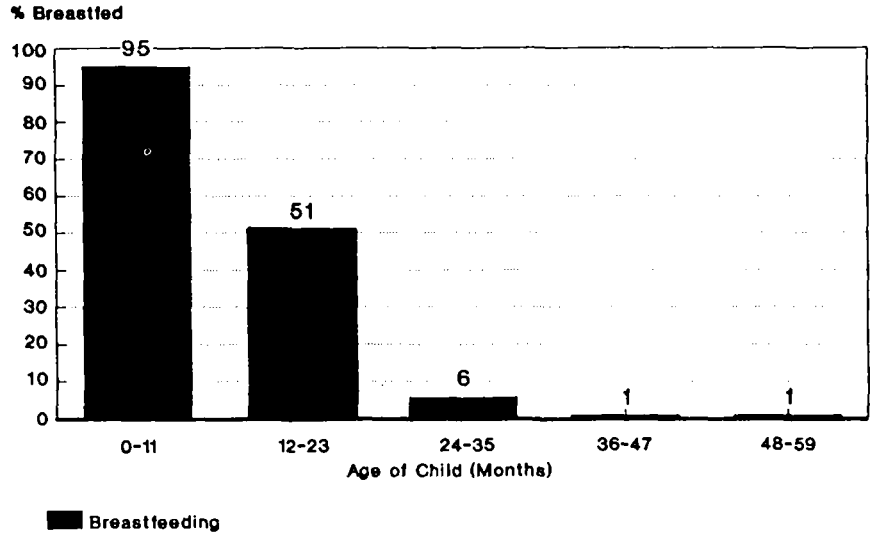
Area	Year	Special Conditions	Weight-for-Height Moderate & Severe <80%	Weight-for-Age Moderate & Severe <80%	Height-for-Age Moderate & Severe <90%
Northeast	1985	pre-harvest	2%	13%	23%
Arua	1987	pre-harvest	2%	28%	27%
Mbarara	1988	pre-harvest	3%	25%	21%
Luwero	1986	harvest	2%	-	-
Kampala	1987	urban	2%	-	-
Kampala	1981	urban slum	12%	29%	-
Mbale	1982	urban	4%	-	29%
Mpigi	1988	NA	2%	-	-

Sources: GOU et al., Baseline Survey Northeast Uganda, 1985; CUAMM, Arua Baseline Survey, 1987; MOH et al., Baseline Survey for SWIP Mbarara, 1989; Nash and Riley, Nutritional Survey of Luwero District, 1986; Riley, Nutrition and Health Survey of Kawempe Sub-District, 1987; Kampala City Council and Alnwick, Nutritional Status of Young Children, 1981; Bogan and Wangwe, A Nutrition Survey in Mbale Area, 1982; Riley, Nutrition and Health Survey Mpigi District, 1988

mothers in general do not continue to breast-feed as long as rural mothers; the median stopping point for urban mothers is nine months while it is 16 months for rural mothers (Karamagi, 1985, p. 229).

A 1988 study in four districts found that the majority of infants were started on supplementary feeding between four and six months of age. Common weaning foods include cow's milk, vegetable stews and porridges of millet, sorghum, maize, and cassava. Sorghum and cassava were also found to be traditionally processed by germination and fermentation into products suitable for infant feeding (Serunjogi, 1988).

Breast-Feeding by Age of Child Mbarara, 1987



Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989

Health Situation of Women

Maternal Mortality

The registration of deaths and births is grossly deficient, and it is impossible to accurately estimate the national maternal mortality rate (MMR). Based on Kampala hospital statistics, the MMR is 2.65 per 1,000 deliveries (excluding abortions). However, 74% of mothers deliver at home and it is not known what proportion of these mothers die. Many deaths probably occur far from medical care in the rural areas and slums where over 91% of the population lives.

The major causes of death in pregnancy are haemorrhage, infections, pre-eclampsia and eclampsia, obstructed labour, and abortion. These causes are generally related to poor hygiene and inadequate care rather than physical complications of birth. Malaria and anaemia threaten pregnant women and multiple births and pregnancy at the extreme ends of the reproductive age range also contribute to maternal deaths.

An increase in fatal birth complications has been recorded in Kampala hospitals (where the best care in the country is provided), with the rate doubling between 1970 and the early 1980s.

Abortions

Hospital reports show that more than one in five pregnancies in Kampala ends with self-induced or spontaneous abortion (Kampikaho, 1988); the figure would probably be higher if unhospitalised cases were included. Induced abortion is illegal, although health workers report that the practice is quite common. The maternal death rate from abortions increased between 1972 and 1986.

Child Delivery

Approximately 26% of women deliver in health institutions with the assistance of trained personnel, but there is wide variability between districts. While low, this figure does not differ very much from that prevailing in 1967, when 32% of deliveries took place in health facilities.

In 1988 in Mbarara, more than 75% of interviewed women received antenatal care. The age of the women and distance from a health unit did not greatly influence their decision to seek antenatal care, but those with higher levels of education were more likely to attend.

On average, 31% of those who do not deliver in health units are assisted by traditional birth attendants, while a high number of women deliver in their homes without specialised assistance.

Causes of Maternal Death in Kampala Hospitals 1970 and 1980-85

The major causes of death in pregnancy are haemorrhage, infections, pre-eclampsia and eclampsia, obstructed labour, and abortion.

	Number of Cases	
Cause	Mulago 1970	Five Hospitals 1980-85
Sepsis	1	147
Postpartum Haemorrhage	3	45
Other Haemorrhage	6	22
Ruptured Uterus	1	19
Anaesthetic Factor	-	19
Other Direct Causes	6	26
Anaemia	4	17
Pneumonia	1	16
Tetanus	-	8
Other Indirect Causes	4	37
TOTAL	26	356

Source: Makerere Medical School, Clinical Report 1970-72; Kampikaho, Maternal Mortality in 5 Kampala Hospitals, 1988

Adult/Female Morbidity

There appears to be no significant difference in morbidity between males and females over five years of age except for gynaecological problems. In household surveys, reported illness among individuals over five years of age in the previous two weeks ranged from 3% in Arua to 11% in Mbarara Districts.

Maternal Mortality Rates per 1,000 Deliveries in Five Kampala Hospitals 1972-86

The maternal death rate from abortions increased between 1972 and 1986.

	Non - Abortions			Abortions		
	Deliveries	Deaths	Rate	Abortions	Deaths	Rate
1972*	20,531	26	1.14	1,884	5	0.30
1980	22,615	48	2.12	4,680	12	2.65
1981	22,158	48	2.17	4,700	13	2.77
1982	22,623	54	2.39	3,951	14	3.54
1983	27,128	51	1.88	4,300	13	3.02
1984	30,751	87	2.83	4,900	22	4.49
1985	24,144	91	3.77	4,675	23	4,92
1986	21,504	84	3.91	5,522	20	3.62

*Mulago Hospital only

Source: Makerere Medical School, Clinical Report 1970-72; Kampikaho, Maternal Mortality in 5 Kampala Hospitals, 1988

On average, 31% of those who do not deliver in health units are assisted by traditional birth attendants, while a high number of women deliver in their homes without specialised assistance.

Place of Delivery and Birth Attendant Selected Areas, 1985-88

Area	Year	Health Unit	TBA	Relative/Self
Mbarara	1988	20%	34%	46%
Busoga Region	1988	43%	3%	54%
Northeast	1985	33%	40%	26%
Arua	1987	7%	55%	38%
Kitgum	1987	25%	56%	19%
South	1987	29%	11%	53%

TBA = Traditional Birth Attendant

Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989; Harmsworth, Personal Communication, 1988; GOU et al., Northeast Uganda Baseline Survey Northeast Uganda, 1985; CUAMM, Arua Baseline Survey, 1987; Rizzo, The Organisation of Maternal Services in Kitgum District. 1987

As in the under-five age group, the principal causes of morbidity among adults are malaria, diarrhoea, and acute respiratory infections.

Diagnosis Among Those Ill in Previous Two Weeks 5 Years of Age and Older, 1985-88

	Northeast 1985	Arua 1987	Mbarara 1988
Malaria	27%	12%	31%
Diarrhoea	11%	15%	15%
Respiratory Infections	10%	16%	27%
Worms	8%	13%	3%
Skin Infections	NA	6%	5%
Other	44%	38%	19%

Source: GOU et al., Baseline Survey Northeast Uganda, 1985; CUAMM, Arua Baseline Survey, 1987; MOH et al., Baseline Survey for SWIP Mbarara, 1988

AIDS

It is estimated that more than 500,000 individuals may currently be HIV-positive, and that by 1991 one million Ugandans in the most productive age group will be infected unless patterns of sexual behaviour change. On the basis of these projections, it seems likely that AIDS will be the number one health problem for women in Uganda for the next decade and a complicating factor for other diseases.

While there is considerable geographic variation in the spread of AIDS, it is estimated that as many as 10% of women in the 20-30 year age group may be HIV-positive. AIDS is more prevalent in some districts and especially in some urban areas, including Kampala. About 70% of all reported cases come from Masaka, Kampala, Rakai, Gulu, and Mpigi Districts. This concentration is changing with time and the share of cases reported in these five districts is falling as AIDS spreads to other areas. In northern rural areas there are fewer cases and the positivity rate may be lower.

Reported AIDS cases totalled 7,573 to the end of March 1989. The reported rate of increase was doubling every six months in 1987, while in 1988 the doubling period increased to over 12 months. This change may be related to a decrease in interest among health workers in reporting cases, or to the saturation of health facilities with a capacity to treat AIDS patients. Other cases may return home or be admitted to clinics and hospitals which do not report (ACP, 1989).

Profile

A Woman Goes to a Traditional Birth Attendant

Many people in Uganda have become discouraged by the poor treatment they receive at health units, although they still believe in modern medicine. Grace, whose home is in a village about 15 kms from a main road, uses both traditional and modern health care.

"The only available transport from the main road to my home is by bicycle, and the nearest hospital is 10 km along the main road. It takes about three hours to travel there from my home.

"When I am pregnant, I wait for four months, then I leave my home and go to stay with my mother who lives 6 km from Jinja. Living with my mother is advantageous because one can get to hospital within one hour during the day, although at night it is almost impossible to move from the village to town. So I attend antenatal clinics in Jinja hospital, just in case I get problems at childbirth and I need to be operated upon. I also go to the traditional birth attendant of the village, who lives nearby.

"From about four months pregnancy, the traditional birth attendant prescribes certain herbs to be squeezed in my bathing water about twice a week to keep me healthy. The traditional birth attendant also prescribes special herbs to be used when one has fever, headaches, or is feeling generally weak. Then there are certain soils that the traditional birth attendant mixes which she gives to her patients so that they have the extra iron and other nutrients that a pregnant woman needs.

"At about eight months, the traditional birth attendant prescribes another type of herb squeezed in water, and the expecting woman is supposed to sit in it for at least one-half hour everyday until she delivers. This is supposed to help widen the birth canal so that she does not get torn while delivering.

"When I started getting labour pains at around 2:00 a.m. I called for the traditional birth attendant, because it was impossible to get to town at that time of night. I delivered normally after two hours. I was then told to drink a bitter solution which contracted my tummy immediately and forced the placenta out.

"The traditional birth attendant just looked around for a rag, tore a strip of cloth off, and used it to tie up the cord. She used a new razor blade to cut the cord, and she advised me to dress it with ash everyday until it came off.

"I will stay with my mother until the baby is about one month old, then I will go back to my home and get a birth certificate."

There are very few cases of AIDS in the 5-15 age group and among the elderly and sexually inactive. Nearly all cases of AIDS in Uganda are a result of heterosexual transmission, and only 7% have had a history of blood transfusion.

Summary Analysis

The lack of reliable data seriously inhibits the analysis of the present health situation and limits the validity of any predictions for the future. The existing information only indicates the magnitude and relative importance of a few key diseases. However, from the available statistics and surveys, one can conclude that women and children in Uganda are at high risk of premature death.

The health problems which constitute the immediate causes of death in children in Uganda are mainly preventable communicable diseases, most of which are being addressed by major programmes (for more information see chapter on Health Policy, Plan, and Programmes). Most child deaths occur in infancy. Combined with high maternal mortality, this illustrates the pattern of vulnerability for women and children that develops during pregnancy and continues especially during delivery and the first few months of life.

Among the many factors influencing infant and child deaths is poor nutritional status. However, existing data indicates that malnutrition may be more likely a result of repeated episodes of infectious diseases than a direct cause of morbidity and mortality because of inadequate food intake. The root of many child deaths lies in lack of access to appropriate, timely treatment, and the inability to take advantage of preventive services. (For more information see chapters on the Situation of Women and the Health Care System).

Many maternal deaths would also be preventable if women had better access to ante-natal and post-natal care, and were delivered in hygienic conditions, whether at home with trained birth attendants or in health units.

It is anticipated that AIDS will have dramatic effect on the health of women and children in the years to come, even if transmission is controlled in the near future.

The Health Care System

Background

Mothers and children have been a special concern of Uganda's health services since *Mwana Mugimu* (well child) clinics were established near Kampala in the 1950s, and Maternal and Child Health services are now a major component of the national health care system. These programmes are principally implemented through Government health services, although missions and private charitable organisations play a major role.

By 1971, Uganda had developed one of the best health care systems in the region, both in the number and distribution of health units, and in the content of health programmes. The network of Government hospitals and health units was supplemented by mission hospitals and largely urban-based private practitioners. Doctors were trained locally at one of the first and finest medical schools in Africa at that time. Government devoted at least 4% of each year's national recurrent budget to health care, reaching a peak of 9% in 1962 (Scheyer and Dunlop, 1981), and several endemic and potentially epidemic diseases including trypanosomiasis and onchocerciasis had been controlled.

Although seriously neglected in the recent past, the physical infrastructure still exists, and a large cadre of trained staff could provide better health care if given refresher training, equipment, supervision, and most importantly, adequate salaries.

Health Facilities

Government has a well-developed infrastructure of 792 health facilities which in theory provide free medical care to all. However, most health units are in a poor state of repair; many hospital patients must bring their own mattresses and linen on admission (MOH, 1987). There are also 145 non-government hospitals and health units, most of which are attached to religious missions. These facilities usually charge at least a small fee.

The services offered in health units, especially those run by Government, are often inadequate but the majority of Ugandans still turn to them for curative services, even though they may have sought treatment outside the formal health system first.

Government and NGO Health Units, 1987

Unit	Government	Non-Government
Hospitals	46	33
Health Centres	102	5
Dispensary/Maternity Units	66	23
Maternity Units	30	10
Sub-Dispensaries	350	22
Leprosy Centres	1	10
Aid Posts	145	12
Dispensaries	52	30
TOTAL	792	145

Source: Lee et al., The Cost and Financing of Health Services in Uganda, 1987

Not all of the smaller units, especially those run by non-governmental organisations (NGOs), appear in Government statistics. In Busoga Diocese, for example, official figures list only 18 non-government aid posts, while there are at least 31 operated by communities under the Church of Uganda and additional units run by other church groups.

As Government units are usually poorly supplied and staffed, many patients prefer to use NGO units where they exist. Several recent surveys found that between 20% and 44% of the population attended NGO facilities when ill, compared to 17%-35% at Government units.

When ill almost 80% of the population surveyed in some parts of the country attended a government or NGO health facility.

Utilisation of Health Services Selected Areas, 1985-88

	Mbarara	Northeast	Arua
Government Unit	17%	35%	25%
NGO Unit	44%	20%	32%
Private Clinic	3%	10%	21%
Traditional Healer	2%	6%	3%
Relative/Friend/Self	18%	29%	9%
More Than One Source	12%	NA	NA
Shop/Market	4%	NA	13%

Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989; GOU et al., Baseline Survey Northeast Uganda, 1985; CUAMM, Arua Baseline Survey, 1987

Access to Health Facilities

Access to health units is reasonable throughout the country, although minor regional differences exist. Nationally, 27% of the population lives within five km of a health unit, while 43% live more than 10 km away from any facility. In the North, however, only 18% of the inhabitants have a health unit within 5 km of their homes and 43% within 10 km.

When ill or seeking preventive services the great majority of individuals must walk to a health unit, since public transportation in rural (and some urban) areas is limited. It takes a healthy adult approximately two hours to walk 10 km; a sick person or a mother carrying a child may take twice as long. This factor may influence the decision of some mothers to seek health care, especially preventive services.

In theory, the hierarchy of health units is designed to provide increasingly specialised treatment at each level. In practice, the lack of supplies at higher levels often means that there is little difference in the treatment provided. However, more qualified personnel, particularly physicians, are posted to hospitals. Mulago was designed to serve as a teaching and referral hospital, but for many years it has been functioning primarily as a health centre and district hospital for Kampala (MOH, 1987).

Due to low salaries some health staff reportedly

Distance to a health unit is generally shortest in the more mountanous areas and in the most populous districts.

Distance to Nearest Health Unit by Region, 1984

Region	% of Population Within 5 km	10 km
Eastern	28%	66%
Northern	18%	43%
South/Central	32%	60%
Western	27%	56%
NATIONAL	27%	57%

Source: Alnwick et al., Population Access to Hospitals, Health Centres and Dispensary/ Maternity Units in Uganda, 1985, p. 6

Profile

Health Care in the Village

Many people seek treatment by traditional healers. Even urban residents may return to their villages when they are sick, because they have more confidence in the old ways of doing things. Teopista, who lives in a rural area 15 km from Jinja, still practices traditional methods.

"I have six children. When they become ill I do not think of taking them to hospital straight away, but rather as a last resort.

"Around my house and in my gardens there are so many kinds of herbs which can be used for treating almost any disease. These include herbs for malaria, fever, coughs, burns, tonsilitis, and diarrhoea. I find it much easier to administer these herbal cures to my children because I do not have to move very far to get them and they cost nothing. Besides, they cure almost instantly. I learned about the use of herbs from my parents and neighbours. Most of the herbs require only a single application either by bath or chewing. The following day you are well again. This is true for even major burns.

"Some diseases, however, are stubborn and require further treatment by a native doctor who administers drugs in a special way. This is because some diseases are brought by the ancestors and only the native doctors know the cure. These native doctors, however, are quite expensive.

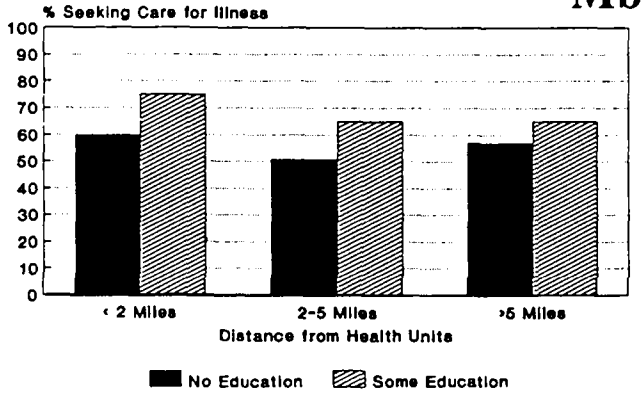
"The native doctors are powerful. They can even treat a patient with a broken leg. What they do is chant a few songs while mixing a strong-smelling solution of herbal juice which they give their patients to rub on the sprained or broken limb. In many cases, the patient gets better.

"If the traditional healer fails, I think of going to hospital. It is far, about two hours travelling. You need money to go there, even to the Government hospital which is supposed to be free. There is almost always a shortage of drugs so you have to buy them from a private pharmacy."

demand payment for services which should be free in Governmment units. This unregulated practice may cause poor patients to avoid seeking health care, while those who are able to pay may go to NGO units and private practitioners.

In Mbarara District, better-educated mothers are more likely to use health facilities, whatever the distance.

Attendance at Health Units When Ill by Distance and Education of Mother Mbarara, 1988



Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989

Health Staff

Qualified Government personnel are concentrated in hospitals, while there are relatively few staff manning other units.

Due to poor record keeping and difficulties in communications, exact personnel figures are unavailable. Almost all health facility personnel are trained in Ugandan institutions, but there has been considerable wastage due to poor salaries and insecurity. Over the past 15 years perhaps 1,500 Ugandan doctors have moved to other countries. Graduates of medical school and other institutions often refuse to accept a posting to a rural area or an insecure district.

While 91% of the population live in rural areas, only 10% of the hospital beds and 24% of the country's physicians are located there.

Government Health Manpower Distribution By Unit Type and Location, 1988

Category	UNIT		LOCATION	
	Hospital	Other	Urban	Rural
Medical Officer	82%	13%	76%	24%
Medical Assistant	62%	38%	64%	36%
Enrolled Nurse/Midwife	80%	20%	72%	28%
Dispenser	91%	9%	NA	NA
Health Visitor	28%	72%	NA	NA
Assistant Health Visitor	46%	54%	NA	NA
ALL STAFF	76%	24%	74%	26%

Source: Lee et al., The Cost and Financing of Health Services in Uganda, 1987; MOH, Description of the Demand for Health Manpower, 1989

Low salaries are not the only problem facing health workers. In the past, neglect and insecurity led to considerable damage and loss of property in health units. The problem continues today due to the lack of maintenance and the pilferage of equipment and drugs. Limited transport and funds for running and maintaining vehicles also undermine the quality of health care.

Curative services are also provided by private practitioners. An estimated 350 physicians practice privately in the country, and most hospital doctors (as well as some nurses) supplement their Government income with private consultations. Traditional practitioners and other non-formally trained individuals also offer medical treatment.

Many families rely on self-treatment and traditional healers. In one study, 35% of those surveyed obtained medicine from non-professional sources during their last illness (GOU et al., 1985), and a high percentage of mothers deliver at home, many without the assistance of even a trained attendant.

Traditional healers are found in every district. In many areas they are quite numerous, and may total 6,000 or more nation-wide. Most healers rely on herbal (43%) or spiritual (41%) treatments (Anokbonggo, 1988).

Community health workers (CHWs) and traditional birth attendants also provide care in Uganda. The total number of CHWs appears to be small, considering the many organisations operating primary health care programmes and the Government's commitment to the concept. Evidence indicates that, where CHWs exist, the utilisation of preventive services is better (UNICEF, 1987). However, it may be that the CHWs were trained in those areas where services were already better.

Little data exist on traditional birth attendants and few training programmes have been carried out. Many mothers utilise their services, but knowledge of their practices is limited.

MOH Approved and Filled Posts December, 1988

Many established posts in the Ministry of Health are unfilled and an overall shortage exists, especially for enrolled nurses and midwives.

Job Title	Approved Posts	Number Filled	Number Vacant
Medical Officers/Consultants	492	466	26
Dental Surgeons	10	13	(3)
Pharmacists	12	6	6
Dispensers	148	187	(39)
Health Assistants	1,030	460	570
Health Inspectors	507	223	284
Lab Assistants/Technicians	389	312	77
Medical Assistants	948	739	209
Assistant Health Visitors	543	139	404
Enrolled Nurses (all types)	3,346	2,959	395
Enrolled Nurses/Midwives	896	84	812
Health Visitors	125	50	75
Nursing Officers *	1,846	1,352	494
Others	2,476	1,339	1,266
TOTAL	12,768	8,329	4,618

*Nursing Officer covers all registered nursing personnel

Source: Katongole, Manpower Update, 1989

Training Institutions

Health worker training takes place at Government and NGO institutions. The number of workers and the quality of training have suffered due to the same factors that have affected health services in general, such as low salaries and limited supplies.

It will take 20 years to train enough midwives to meet the personnel shortage.

Health Training Institutions* Uganda, 1987

Category of Staff	No. of Training Institutions	Annual No. in Training	Annual Potential Output
Medical Doctor	1	75	NA
Medical Assistant	3	304	90
Registered Nurse	4	180	110
Registered Midwife	3	135	85
Enrolled Nurse	12	452	162
Enrolled Midwife	12	448	192
Health Inspector	1	30	30
Health Assistant	2	54	40
Dispenser	1	38	15
Health Visitor	1	4	4

*Some specialised institutions not included

Source: MOH, Annual Report, 1987

Health Service Financing

Government Support

Government support for health services is divided between budgetary allocations to the Ministry of Health, Mulago Hospital, and to rural health units through the Ministry of Local Government and local authorities. Donor support makes up a substantial share of the health sector budget, particularly for hard currency imports.

Actual expenditures are difficult to measure, especially for the share provided by Local Government. An estimate of Ministry of Health and Mulago financing for the recurrent and development budgets in 1987 was U.Shs.5,366 million, which in real terms was only 8% of the 1970 level.

Planning and Budgeting

Planning and budgeting in the Ministry of Health is hampered by Government's financial constraints, and

Budget allocations and donor contributions to the health sector at the official exchange rate present a pattern of falling Government support matched by equivalent increases in donor contributions. The major increase in Government's allocation to the sector in 1988-89 may reverse this trend.

Source of Funds for Government Health Services, 1983-87 (US$ millions at Official Exchange Rate)

Source	1983	1984	1985	1986	1987
Ministry of Health	19.4	22.2	13.9	15.1	9.9
Mulago Hospital	--	--	--	4.8	3.9
Donors	5.2	13.8	22.0	17.8	21.6
TOTAL	24.6	36.0	35.9	37.7	35.4
Donors as % of Total	21%	38%	61%	47%	61%

Source: MPED, Background to the Budget, 1988-89; UNDP, Report on Development Cooperation in Uganda, various years

approved budgets often bear little resemblance to funds actually disbursed. In the 1987-88 fiscal year, the approved budget allocated 1,147 million U. Sh. to the Ministry of Health, but only 49% of this figure was released (GOU, 1988; MPED, 1988a). While detailed figures are not available, it is likely that the principal cuts were in foreign currency items such as drugs.

Estimated donor support to the Ministry of Health has been growing since 1982, and in 1987 it constituted 61% of the health budget. Financial constraints within the Ministry have compelled donors to support some recurrent budget items, including fuel and field allowances, as well as most imported supplies and equipment.

Budget allocations and donor contributions to the health sector at the official exchange rate present a pattern of falling Government support matched by equivalent increases in donor contributions. The major increase in Government's allocation to the sector in 1988-89 may reverse this trend.

Primary Health Care Emphasis

Only a limited portion of the budgets of the ministries responsible for health care goes to support primary health care activities. The Mulago Hospital budget is exclusively for hospital services, and Local Government expenditures are for broadly defined PHC activities. The actual Ministry of Health budget is mixed. Forty percent of the approved budget in 1987-88 was earmarked to support hospital-related expenses. However, as one-half of the total approved budget was not disbursed, the actual drug and supply component is thought to have been very small, and the share to hospital support could have been as high as 70%.

NGO Health Service Financing

NGOs have a strong tradition of providing health care. Protestant, Catholic, and Muslim organisations have established medical bureaux to coordinate the purchase and storage of drugs and supplies for affiliated hospitals and health units throughout the country.

As NGOs operate autonomous health services in over 140 locations, consolidated financial figures are unavailable. Most are financed through a combination of external support, church collections, and user fees. There is no set formula for fees, although all units assess a charge for their services. NGO hospitals surveyed in 1987 covered 70% to 91% of their annual operating budgets in this way (Lee et al., 1987).

Distribution of Ministry of Health/Mulago Budgets 1987-88 (U. Sh. millions)

Category	Budget	% of Total
Staff (Salaries/Transport)	100.8	6.7%
Drugs and Supplies	689.4	46.0%
Other (of which Patients Abroad=23%)	111.4	7.4%
Hospital (All Expenditures)	597.1	39.8%
	1,498.7	100.0%

Source: GOU, Approved Estimates of Recurrent Expenditure, 1987-88

Only a limited portion of the budgets of the ministries responsible for health care go to support primary health care activities.

Government Initiatives for Health Service Financing

The Government of Uganda has established a Task Force on Health Financing chaired by the Ministry of Planning and Economic Development and including representatives from the Ministries of Health, Local Government, Finance, and several donors.

Health service financing is also addressed in the World Bank-funded First Health Project, which will field a health services management expert to develop, implement, and study financing options to be introduced in selected target districts for possible replication nationwide.

Several studies and pilot projects are underway which will provide information and opportunities to test alternative systems of revenue generation.

Kasangati Health Centre

The Institute of Public Health, in cooperation with Minnesota International Health Volunteers and UNICEF, began a small user fee experiment at Kasangati Health Centre in 1988. The results are encouraging; there has been no long-term drop in attendance and preventive services are still in high demand. However, as the user fee established by the community is low, the generated funds are only sufficient to supplement the salaries of the health staff and purchase a few drugs above those supplied by the Uganda Essential Drugs Management Programme.

Uganda Community Based Health Care Association

NGOs train their CHWs to use and sell basic drugs in the community at a price sufficient to cover the cost of repurchasing the drugs and provide a small incentive to the CHWs. NGOs monitor this experience through the Uganda Community Based Health Care Association. UNICEF is providing an initial supply of drug kits free of charge, and is working with Central Medical Stores and the Uganda Essential Drugs Management Programme to expand the system.

The Southwest Integrated Health and Water Project

A community financed Handpump Maintenance System based on the Resistance Committees was developed in Luwero District in 1986. From this experience, Government and UNICEF are working together in five districts in the Southwest to develop community financing mechanisms for rural water supply maintenance and to use them as entry points for establishing community financed health care systems. Communities which have been successful in supporting their Pump Mechanic are offered the opportunity to finance a CHW through the sale of basic drugs.

Summary Analysis

Government health services are inadequate to meet the needs of the majority of Uganda's population. Health facilities are poorly distributed, personnel and financial resources are concentrated in urban hospitals, and transport, supplies, and equipment meet only a small share of the demand. As a result, most people prefer to treat themselves, consult traditional healers or neighbours, or pay for treatment at NGO clinics rather than attend Government units.

The increasing willingness of donors to contribute to recurrent costs appears to be preventing the short-term situation from deteriorating further. In the long-term, however, Government will have to address this problem and develop strategies to make sufficient finances available to maintain and expand the health services network, motivate staff to perform better in Government service, and provide incentives to work in rural areas. Lessons in management, staff satisfaction, and cost recovery initiatives may be learned from NGO experiences.

Health Policy, Plan and Programmes

Health Policy and Plan

In 1978, following the Alma Ata Declaration on Primary Health Care, the Government of Uganda prepared a draft plan to orient the health care system toward PHC, but it was never implemented. At the same time, many NGOs went ahead with individual strategies to introduce components of primary health care in various parts of the country. In the following years until 1986, there was little progress made toward establishing a national primary health care model.

The National Resistance Movement Government's basic philosophy promotes community participation, and it has shown great interest in developing primary health care. As a sign of this commitment, a Health Policy Review Commission was appointed in 1987.

The health policy document, currently being finalised, lays out the basic framework for the future development of the health care system, somewhat revising the division of responsibilities between the Ministries of Health and Local Government. Financially, the Ministry of Health would be responsible for paying the salaries and allowances of health staff at all levels, and the Ministry of Local Government would develop and maintain health facilities.

In the spirit of decentralisation, local authorities would become responsible for coordinating the planning and implementation of health activities in their areas. This emphasis on grass-roots support also gives strong responsibility to communities themselves. The health policy calls for the establishment of Village Health Committees in every community and the selection and training of CHWs. This community-based network would be supported by a greatly expanded referral system, from health units in every parish up through a hierarchy of health facilities and hospitals.

The National Health Plan outlines the strategy toward achieving the goals of the health policy over the next decade. The expressed goal is to make comprehensive and integrated health care accessible to all citizens, at a cost the country can afford, by the year 2000.

Under the new health plan, priority will be directed toward primary health care activities, emphasizing promotive and preventive health care. To support expanded and strengthened health services, the Government plans to introduce health financing systems through the Task Force on Health Financing, chaired by the Ministry of Planning and Economic Development.

The health plan is an ambitious outline for the universal establishment of many primary health care activities. The demand for manpower, training, community mobilisation, and construction in the health sector are all significant, and the success of the plan will require strong support from Government and greatly expanded managerial and training capacities within the concerned ministries.

Maternal and Child Health and Family Planning Activities

Within the Ministry of Health, Maternal and Child Health and Family Planning are united under an Assistant Director of Medical Services. This sector is responsible for antenatal care, delivery, post-natal care, family planning, growth monitoring of children under five years of age, maternal guidance in child care, immunisation, nutrition education, food supplementation, and early treatment of common diseases.

Primary health care, health education, and training are the responsibility of other departments within the ministry.

Separate programmes aimed at reducing infant and child morbidity and mortality have been established by Government with the assistance of various donors. The development of these programmes over different times initially led to vertically directed activities. Based on experience to date, the Ministry now emphasizes integration and coordination in the health units, as essentially the same workers implement all programmes.

Family Planning (Expanded Family Health Services)

Government activities for family planning are implemented through the MCH/FP division of the Ministry of Health with support from USAID and UNFPA. The programme is to increase the demand for family planning and to expand the services available in health units. The Ministry is also promoting retail sales of contraceptives through the private sector where appropriate.

At present, the Ministry of Health offers only limited family planning services and few clinics stock

contraceptives or provide more than token advice on family planning. The Family Planning Association of Uganda provides most of the family planning services throughout the country and currently operates in over 90 clinics.

Constraints to contraceptive use include the opposition of religious groups and the lack of appropriate education materials for motivation. The recently completed Demographic and Health Survey should provide information for the development of expanded family planning activities. (For more information on fertility control see chapter on the Situation of Women.)

Uganda National Expanded Programme on Immunisation (UNEPI)

UNEPI was officially launched in October 1983. At different times in the past there have been other vaccination campaigns, including poliomyelitis (1963), cholera (1967), and smallpox (1968). Vaccination was also routinely provided in selected health units and was an accepted part of Maternal and Child Health services up to the 1970s, when vaccine shortages and other problems limited access. This history of immunisation services probably contributes to the receptiveness of the population to the present programme.

UNEPI has proved to be, along with the Uganda Essential Drugs Management Programme, one of the strongest Maternal and Child Health initiatives, and the backbone of the rural health care system for the last five years. Its development has served as the basis for expanding and improving all health services at the district level and below. The provision of vehicles and recurrent cost support has strengthened implementation not only for immunisation but for other programmes as well.

There has been a steady increase in immunisation coverage since 1984, although the rate of increase in 1988 was not as high as expected. Immunisation coverage for infants is still very low in some northern districts due to prolonged instability and civil strife. Unfortunately, the health information system does not provide the data necessary to assess the impact of UNEPI on disease incidence and mortality.

In 1989, routine immunisation was available in about 750 static units which have been supplied with cold chain and vaccination equipment and supplies, Child Health Cards, and reporting forms. Staff from static units also provide outreach immunisation services at almost 1,500 different locations.

UNEPI is supported by UNICEF and Save the Children Fund, with funding from the Governments of Italy, Norway and Canada, Rotary International, and other donors.

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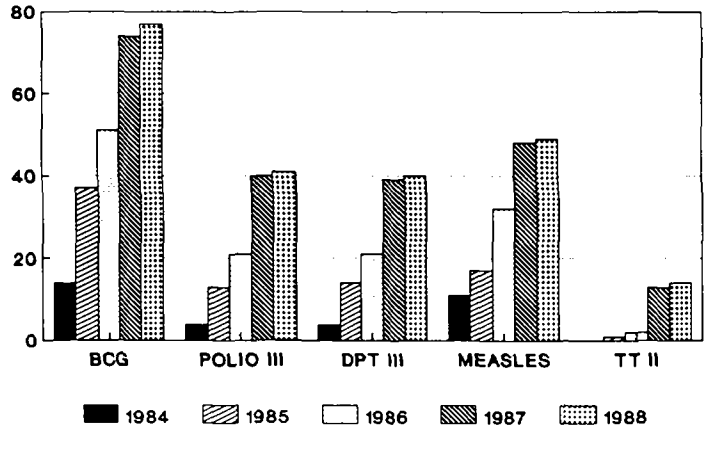
National Immunisation Coverage of Infants and Women (TT II Only), 1984-88



Source: UNEPI, Annual Reports, Years Cited

Control of Diarrhoeal Diseases (CDD)

The CDD programme was initiated in 1983 with support from USAID and UNICEF. The primary objective was to establish Oral Rehydration Therapy as the treatment of choice among health workers and mothers for dehydration due to diarrhoea. The programme emphasizes the education of health workers and the procurement and distribution of ORS.

Mid-level and operational-level staff training courses have led to near universal knowledge of ORT among health workers. Regular ORS supplies, however, were severely limited until 1988, and national

distribution of the available stocks was also weak. Over-reliance on static unit health workers led to a failure to disseminate knowledge adequately to mothers. This problem was addressed in 1988 with the introduction of extension worker training and support.

While ORT is now the treatment of choice among health workers and national supplies of ORS are regularised, it is often supplemented by unwarranted medications. In the Ministry's model health unit, Kasangati, 80% of diarrhoea cases are treated with ORS, but flagyl or antibiotics are also prescribed for 51% of patients (IPH and UNICEF, 1989). In a 1989 programme review, 35% of mothers surveyed used antibiotics, 30% herbs and 9% chloroquine when the child had diarrhoea (MOH, 1989b).

Uganda Essential Drugs Management Programme

The Uganda Essential Drugs Management Programme began in 1985 with assistance from the Danish International Development Agency through the Danish Red Cross to provide Government and NGO health units with essential drugs. The programme has made significant progress in providing regular stocks of basic pharmaceuticals to rural health facilities which had for the most part been without drugs for many years.

While distribution to the districts is greatly improved, the Central Medical Store of the Ministry continues to have problems with high pilferage. Poor vehicle service and maintenance has delayed quarterly drug kit deliveries. The root of these problems is low government salaries and limited resources allocated for vehicle support.

AIDS Control Programme

The National AIDS Prevention and Control Programme was inaugurated in October 1986, with financial support and technical assistance from the WHO Global Programme for AIDS. The National Committee for the Prevention of AIDS coordinates the programme, and an operational unit, the AIDS Control Programme, implements the Committee's directives.

The programme identifies seven major components in its Medium-Term Plan:

- mass public education and information
- screening of blood for transfusion
- protection of patients and health workers
- establishment of a national surveillance system
- provision of drugs for treatment of AIDS cases
- operational research
- training and orientation of health workers

A review in December 1988 commended the programme for the rapid establishment of activities despite many constraints. The review team recommended that AIDS Control staff should take a stronger role in the technical planning of a national strategy, coordination, and monitoring. It suggested that prevention should remain a primary objective, but that patient care and counselling should be addressed as well (WHO, 1988).

Other Health Programmes

The Italian Government plans to assist the Ministry of Health in an extensive national programme for the combined control of tuberculosis and leprosy.

A Health Education Network under the direction of the Health Education division of the Ministry of Health has been established to assist all Ministry of Health programmes with in-service training of health workers in specific content, and in how to train other workers and educate the public.

Other Maternal and Child Health programmes exist but operate at a low level because of small Government budget allocations.

Summary Analysis

The Government's present efforts to develop a national health policy and plan are a long overdue and welcome development. The draft national health policy emphasizes primary health care, and currently the strongest health programmes in the country are those with this orientation. Although, these programmes have strong donor support, a disproportionate share of Government funding still goes to hospitals. (For more information, see the chapter on the Health Care System.)

In the absence of strong Government policies in the early 1980s, donors provided the major impetus for most health initiatives. Vertical programmes tended to be established as a rapid, effective way to address priority problems. While nominally under the umbrella of the Maternal and Child Health Division, the separate programmes carried out the bulk of their own training, supervision, supply, research, and monitoring and evaluation activities independently. As a result, field level workers have been repeatedly pulled from their units for training or provided with supplies, educational materials, and forms by each programme, with little orientation on how to prioritise their work or integrate the components of the various programmes.

As the programmes have matured, the Ministry of Health and donors have begun to address the problem of integration. Much work remains to be done to provide a balanced package of Maternal and Child Health care at the local level, and the Ministry of Health should ensure that new initiatives are fully incorporated into existing health structures.

Profile

The Problem of AIDS from the Point of View of a Health Worker

Women in Uganda increasingly fear they may catch AIDS from their husbands or partners. Many husbands, especially polygamists, do not fully trust their wives either. Often people do not feel free to discuss their fears, especially if they suspect they already have the disease. Even health workers may not be well-informed, and feel very much at risk given the shortages of basic medical supplies. Mary is a nurse whose story reflects the fears of her profession, based partly on a knowledge of medical facts and partly on half-true rumours.

"AIDS is a very easily communicated disease through body fluids, especially to medical people. Many have fallen victim in the district in which I work because they are rarely provided with gloves, so they are forced to work on patients without them. As a result, very many medical workers, especially midwives, are dying in hospital from AIDS.

"The disease is also transmitted from one patient to another in hospital. Needles and syringes are, in most cases, not boiled properly. A nurse may use the same pair of gloves from one patient to another, and in so doing, spread the disease.

"The incubation period for AIDS is far too long - sometimes up to seven years! Meanwhile, the patients look very healthy, so it is difficult to tell who has it and who does not. Therefore it is a very difficult disease to control.

"AIDS has led partners to be very possessive and suspicious of each other. On the other hand, the fear of AIDS has led to a reduction in polygamy and cheating on one another. Fear of catching AIDS has caused me to keep a sharp eye on my husband's movements, and he also is more strict with me. This sometimes creates conflict between us, but it also reflects the concern we have for each other and in some ways brings us closer together.

"AIDS is a big problem for children because when one parent gets it, the other gets it too, and the children are left on their own. Because it is sexually transmitted, it affects mostly the productive youth, so development of the country at large will be arrested if the disease spreads as much as is feared."

Education

Introduction

The education system in Uganda is well developed. As with the health system there are a large number of institutions, and most children have access to a primary school within 2 km of their home (UNICEF, 1980, p. 46). However, the quality of education is declining and the proportion of children continuing beyond primary school is small. Only 12% of those entering Primary 1 are likely to enter Senior 1. Even fewer go on to technical or other post secondary institutions.

The School System

The school system is based on seven years of primary school, four years in lower secondary and two in upper secondary. At each stage there are qualifying examinations: Primary Leaving Examination, Uganda Certificate of Education or Ordinary Level Examination, and Uganda Advanced Certificate of Education Examination. At each level above primary, there are options for pursuing academic or technical and vocational careers. Some professional training colleges are associated with Government ministries such as agriculture, animal industry, and health.

Physical Infrastructure

No other social sector has had a greater rate of physical growth since 1980 than education. The number of primary schools has doubled in the past ten years from 3,969 in 1978 to 7,955 in 1987. The increase in secondary schools has been even greater, jumping from 120 to 515 over the same period (MPED, 1988a). This growth is wholly the result of community action and demonstrates the great priority given to education. All primary and most secondary school construction has been through self-help initiatives which have taken place in all parts of the country (IDA, 1987, p. 11).

Access to School

Enrollment statistics are available for 8,000 registered primary schools in Uganda. Many other community-run primary schools do not satisfy registration criteria and operate outside the official system. This may account for the disparity between Ministry of Education enrollment figures and those generated in area-specific studies. Non-registered schools are not examination centres, and their pupils do not qualify to sit the primary or secondary examinations unless they register at an approved school.

Gross Primary School Enrollment by Region, 1980

Region	Population in 6-12 Age Group	Primary School Enrollment	Gross Enrollment Ratio
Eastern	584,525	349,521	60%
Central	631,818	366,244	58%
Northern	506,672	275,233	54%
Western	692,350	365,799	53%
TOTAL	2,415,365	1,356,797	56%

Source: Cited in IDA, The Financial Feasibility of UPE, 1987

Although almost all children have physical access to primary schools, actual enrollment is limited by means and motivation. There are also regional differences.

All primary and most secondary school construction has been through self-help initiatives.

Existing Schools by Level, Selected Years

Institution	1981	1983	1985	1987
Primary	4,585	5,695	7,025	7,955
Secondary	178	285	500	515
Teacher Training Colleges	33	59	83	102

Source: MPED, Background to the Budget, 1988-89, Table 51

Primary school attendance has been growing steadily through the 1980s and has outpaced the estimated annual population increase. According to Ministry of Education statistics, 70% of primary age children now attend school nationally. Other studies indicate a higher rate of attendance and one Ministry report notes that data on schools and enrollment is incomplete (Balyamujura et al., 1985).

There are several reasons for non-attendance, but the principal constraint is money. In theory, fees are very low but parents and guardians are required to contribute to a number of obligatory expenses, including allowances for teachers and school building and maintenance funds. They may also have to buy school uniforms and scholastic materials.

Secondary day schools cost somewhat more than primary day schools, while secondary boarding schools demand similar fees to those for primary. Schools near Kampala charge the highest fees. In the second term of 1988, some private boarding schools were charging more per term than ten times the monthly salary of a graduate teacher or seven times the monthly salary of the highest paid Government official.

Secondary Education

Entry to secondary and post-secondary establishments is highly competitive, and only a small number of students go on to further education. Of those who sat the Primary Leaving Examination in 1986, only

Primary school attendance has been growing steadily through the 1980s and has outpaced the estimated annual population increase.

Enrollment in Government Primary Schools by Standard, Selected Years (Thousands of Students)

Standard	1981	1983	1985	1987
Primary 1	325	413	495	575
Primary 2	248	320	395	454
Primary 3	212	285	344	413
Primary 4	181	220	280	342
Primary 5	155	181	227	285
Primary 6	145	164	199	236
Primary 7	138	145	177	198
TOTAL	1,407	1,730	2,117	2,505

Source: MPED, Background to the Budget, 1988-89

43% secured secondary school places. There are not enough Government secondary schools to meet the demand, which means that not all students who pass their examination can go on for further studies unless they can afford private school fees.

Forty-two percent of those graduating from Senior 4 enter Senior 5 and 26% of those graduating from Senior 6 go on to other institutions of higher learning. Makerere, presently the only Ugandan University, had 6,318 undergraduate and postgraduate students in 1987. In the same year, technical and specialised institutions had 29,153 students.

There are no accurate statistics on drop-out rates, but the number of pupils in Primary 7 in 1984 was about 65% of the number who entered Primary 1 in 1978. Drop-out rates are confused by the number of pupils who repeat classes (IDA, 1987, p.6).

Total Education Enrollment by Level, 1987

Level	Students	% of Total
University	6,318	0.25%
Other Post-Secondary	29,153	1.14%
Secondary	226,875	8.90%
Primary	2,286,580	89.70%

Source: MPED, Background to the Budget, 1988-89, Table 51

Entry to secondary and post secondary establishments is highly competitive, places are limited and only a small number go on to further education.

Access to Education for Girls

Girls are less likely than boys to go to school, but overall the percentage difference at primary level is not very great and has changed little over time. Girls, however, drop out sooner, especially as they reach Primary 5-7. The proportion of girls to boys in secondary schools is only one-half that found at the

Drop-Out Rates Among Girls Primary School Cycle, 1977-83

Year	Class	Enrollment	%	Drop-Out	%
1977	P.1	105,141	100%	-	-
1978	P.2	90,382	86%	14,759	14.0%
1979	P.3	82,397	78%	8,985	9.9%
1980	P.4	74,617	71%	7,780	9.4%
1981	P.5	65,632	62%	9,025	12.0%
1982	P.6	63,107	60%	2,525	3.8%
1983	P.7	50,396	48%	12,711	20.0%
TOTAL				55.786	59.1

Source: Bitamazire, Statistical Information on Women's Education in Uganda, 1988

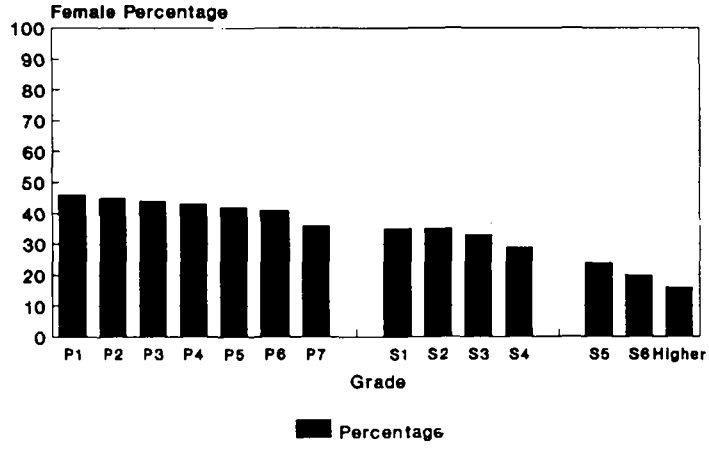
Girls are relatively less likely to go to or continue in school in some districts than in others, and they also tend to achieve poorer results than boys in all subjects.

primary level, although female enrollment rates increased slightly from 1971 to 1982.

In principle boys and girls have an equal right to schooling, but there is no special emphasis on education for girls. While girls are accepted into secondary schools with generally lower qualifying marks than boys, many secondary schools are all male. Overall, there are fewer places for girls than boys.

There is evidence that parents are less concerned to educate girls. When money is limited, fees for boys will be paid in preference to those of a girl.

Females as a Percent of Total Primary and Secondary Enrollment by Grade, 1983



Source: MOE Planning Unit, Unpublished Data, 1988

Quality of Education

Physical Condition

The quantitative increase in schools masks a qualitative deterioration. Schools are often little more than open rooms with mud floors and walls, lacking windows and permanent roofs. Only a few primary schools have a library or laboratory.

Secondary and post-secondary institutions also have poor physical and material infrastructure and, even more importantly, lack teaching aids, including laboratory chemicals and books. A 1985 study of resources available in primary and secondary teacher training colleges indicated that even at that level, institutions had on average only 3% to 16% of enumerated physical requirements, and no single institution had more than 70% of any category of requirements (Balyamujura et al., 1985, p. 112).

Teacher Training

Teacher-pupil ratios appear acceptable at 1:36 in primary schools and 1:22 at secondary level (1982 figures). However, the level of teacher qualification is very low. Forty-four percent of primary teachers and 39% of secondary teachers have not been trained in education (Balyamujura et al., 1985, p. 68). This situation means that a Senior 6 leaver with an Advanced Certificate may teach Senior 1-4 classes. At primary level, secondary school leavers teach primary classes. At times, even primary school leavers instruct first grade pupils.

A further 37% of teachers are underqualified. Less than one-half of secondary school teachers are Teacher Training College graduates. Some teachers who are qualified to teach primary classes are found in less well-endowed secondary schools. Official payrolls may be padded with non-existent staff and the actual pupil/teacher ratio may be a great deal higher than reported. Urban schools often have up to 90 students in a single classroom.

Teachers' salaries are often supplemented from Parent-Teacher Association funds. Not all teachers are housed in Government premises or other subsidised accommodation. As with health staff, the lack of housing is a major obstacle to the mobility of teachers, who are not prepared to be transferred to another school where they may have to establish new survival systems.

Profile

A Woman Who Dropped Out of School

Education for women is still thought of as unnecessary by many people, and even parents who send their girls to school often withdraw them after a few years. Alia, now 36 years old, left school early.

"There are 14 children in my family, six girls and eight boys. When I was young my father had a shop which just kept us going. My father believed that it was a waste of time to send a girl to school because traditionally, once a girl was 15 or 16 years old, she was ready to marry. He thought educating girls was a waste, because all we needed to know was how to cook and look after children. However, a girl with some education was normally easier to marry off than one who had none, so he sent me to school.

"I was only allowed to study up to Primary 4. Then my father decided that I had enough education to prepare me for an early marriage. The boys in the family continued up to Senior 4. My mother, who had not gone to school at all, supported this. I was very sad when I was pulled out of school. I had enjoyed my lessons very much and was doing quite well. However, my father never even bothered to look at my term report. He was only interested in those of the boys. I felt very frustrated and envied my brothers.

"After leaving school, I felt restricted at home with only household chores to do and was unhappy most of the time. I decided to go to stay with my aunt, who had a large family. Anything, I thought, was better than staying at home in that closed and stifling atmosphere.

"Since then, I've worked as my aunt's cook. I blame my parents, especially my father, very much for my present situation. I think that if I had been allowed to go to school, I would have been better educated, got a good job, and maybe be married by now.

"I have become resigned to remaining single and being a cook all my life."

Content and Quality

The current primary school curriculum was published in 1977, although there have been a few revisions since then, notably in the Social Science, and Science and Health syllabuses. The essential structure, however, remains unchanged, with little emphasis on technical and practical subjects.

While 91% of the population lives in rural areas and supports itself through agriculture, agriculture is not a part of the primary syllabus, and it is only an optional subject at secondary level. As fewer than 50% of students continue beyond primary level, young boys and girls often return to their villages without sufficient life and employment skills (Bitamazire, 1988). There are only six post-secondary agricultural colleges, including two for veterinary and one for forestry training, and only 6% of the students at Makerere University studied agriculture in 1988.

The secondary curriculum, on the other hand, was revised in 1982 and includes both practical and academic subjects. However, the teaching practises and examination system continue to support academic subjects and hinder the full implementation of relevant subjects.

The quality of education is reflected in the national examination results and the low marks necessary to achieve credits. In mathematics, for instance, only 40% is required to pass. In 1988, eighty-six percent of science students at Makerere University failed their final examinations. Similar percentages fail lower-level technical courses.

The high failure rate is an indicator of the poor performance of the education system. It is also a measure of the failure of the economy to reward academic achievement or excellence. At present, Makerere University, including the Medical School, operates with about 50% of the lecturers it needs. Science faculties are particularly badly staffed (Makerere University, Personal Communication from Office of Registrar, 1988).

Mulago is affiliated with Makerere and is the main teaching hospital. It suffers from the same shortcomings as other health institutions, some of which also provide medical training. Despite dedicated staff it is difficult for physicians or nurses to be well trained there. Shortages of essential surgical supplies prevent operations and make it difficult for students to obtain practical experience. The lack of up-to-date medical literature makes comprehensive training difficult. Since 1976, degrees in medicine from Makerere have not been internationally recognised.

Summary Analysis

Ugandans clearly value the education of their children, as demonstrated by their willingness to construct schools and contribute substantial resources to support the education system. However, while more children attend school each year, the quality and appropriateness of the education they receive appears to be declining. Government finance is insufficient, and donor interest to fill the gap between needs and means has been less than in the health sector. It is unlikely that Uganda will achieve Universal Primary Education in the near future. Those children who do complete some years of school may be frustrated because no formal employment is available to match the knowledge they have gained, while their education has left them unprepared to return to an agricultural life.

The under-enrollment of girls remains a critical problem, especially given the relationship between a mother's education and the health status of her children, as has been observed in other countries. Most of the vital health information a future mother requires is not introduced until Primary 6 level. The social and cultural determinants behind parents' reluctance to encourage girls to remain in school, apart from the obvious economic ones, need to be clarified. In the meantime, the introduction of appropriate health and child care topics at lower ages should be encouraged.

Profile

A Woman Teacher Speaks Out

People often complain that teachers do not work properly these days, but the conditions under which they work are very discouraging. Grace started teaching two years ago.

"As a woman teacher I find a number of problems. I teach in a boys' secondary school, and the boys behave in a more disciplined way with male teachers than with female teachers. Nevertheless, I think I manage my students well.

"I remember when each student had his own textbooks; now I pity my students because the school does not have enough books to lend one to each student, and they have to make do with the one or two copies in the school library. Some students never get a chance of seeing the books at all, because there are several streams of about 40 students in each class needing to study the same texts. Many rely solely on class notes.

"I try to get information from here and there to help me teach, but most of the books I use as references are those I used in my own school days, and they are quite outdated. To pass on information to my students I have to dictate to them for the greater part of the lessons.

"I am forced to give tuition to my students to pass on additional information as we do not always cover the whole syllabus in class. I rely on the fees from tuition to supplement my salary. If I have a good number of students to teach, I can make as much in one lesson as I do from my monthly salary.

"With my poor salary I do not feel guilty about dodging lessons to work at a small side job I have. I like to teach, but while I teach I also must live."

Children in Difficult Circumstances

Virtually all children in Uganda have been in difficult circumstances in recent years. Even relatively well-off urban residents lack access to adequate health care, education, and other social services. Many children have seen acts of violence committed against members of their family or neighbours. They have also observed corruption, and have had reason to question standards of justice after seeing perpetrators of crimes remain free. Some may have been permanently affected as a result. Fortunately, most of Uganda is now relatively stable, and attention can be focused on children who remain especially vulnerable.

Orphans

The instability and violence of recent years has led to increased numbers of orphans in the most affected areas. In war-torn Luwero District, a 1987 study found that 1.7% of children 0-14 years of age were orphans, compared to 0.1% in the more peaceful Kabale District (Nalwanga-Sebina and Sengendo, 1987). If the average of these districts is applied nationally, the number of orphaned children may reach 50,000. Interestingly, researchers found that being an orphan *per se*, whether in the community or in an institution, was not associated with lower utilisation of health services or poorer health or nutritional status when compared to other children surveyed in the 0-4 age group. However, older orphaned children were less likely to attend school, and more likely to have been ill in the previous two weeks than other children. Institutionalised children did not appear to be physically worse off than similarly affected children in private homes.

Presently, about 2,500 children live in institutions in Uganda (SCF, Personal Communication, 1989), of whom approximately 25% have lost both parents. The remaining 75% of children have one parent surviving but their families are unable to care for them to the same standard as the institution.

Children orphaned or abandoned because of AIDS are becoming a social problem in some parts of the country. In normal circumstances, orphans could count on the support of the extended family to lead relatively normal lives despite the loss of a parent, and it was rare for a child to lose both parents. However, in a few isolated areas where the AIDS epidemic has hit hardest, so many adults in the productive age group are dying that family networks are breaking up.

AIDS orphans may suffer more physical and emotional deprivation than other orphans if they are ostracized by community members who fear contracting the disease.

Reported AIDS cases to date total approximately 8,000 for the country, mostly in the reproductive age group of 15-45 years. It is likely that each of these adults who died from AIDS left one or more dependent children. Since the number of cases is probably larger, and the total is not evenly distributed throughout the country, the additional number of dependents to care for, on top of the normal number of abandoned or orphaned children would represent a substantial burden in some communities.

Several church groups and NGOs have been providing assistance to orphaned children, usually through institutions. For the increasing number of AIDS orphans, these groups are investigating the possibilities of community-based programmes, where support to grandparents or guardians can be provided to assist them to care for the children within their own village. Institutionalised care will be necessary for a small percentage of orphans with special problems, but it is hoped that most will be able to remain in their own communities.

Disabled

Increased numbers of disabled children are another a legacy of the recent wars. Estimates from Luwero and Kabale Districts yield a rough national estimate of over 17,000 handicapped children aged 0-14 years. Many respondents in a recent survey cited disability as a reason for not attending school (Nalwanga-Sebina and Sengendo, 1987). Given the scarcity of public transport, and the lack of even simple devices, such as crutches or wheelchairs, disabled children will clearly not be able to take full advantage of existing health, education, and social services. Braille materials are not generally available for the blind. Some special schools for handicapped children exist, but they are not necessarily located in areas of greatest need. NGOs have recognised these problems, and are attempting to address them through the manufacture of simple aids and the education of family members to better care for special children.

Street Children

Despite the recent turmoil, the number of "street children" living away from their families appears small; NGOs working in this area estimate that there are between 300 and 800 living in Kampala. However, a much larger number of school age children who still live with their families are engaged in "street" activities to earn additional income for their families.

Profile

Karamojong Women: Problems of Displacement

War, violence, and famine have caused many people to flee from their homes to temporary refuge elsewhere in Uganda and in neighbouring countries. While some may be catered for in camps, others look for their own means of support. As time passes, the displaced seek to be integrated into the communities they are living among, while still longing for home. Four uprooted Karamojong women tell their story.

"We used to live happily in Karamoja with our families and cows. Our lives depended on cows. One family on average could have 200 - 1,000! We used to feed our children on milk and blood from the cows prepared in different ways. The children were very healthy and would never fall sick, unlike here where they keep on getting coughs and colds.

"Trouble began when we started fighting with the Turkanas. So many children and women were killed, which was unusual. Before, it was the men that fought and only the men that were killed. Our cattle were grabbed and those Karamojong that survived the battle were dying of hunger because all the cows were taken. Those of us that could walk, started walking south in search of food, with what was left of our families. We learned that some Karamojong were staying in Jinja, so we went and joined them.

"During the day, everyone looks after himself. Many move around looking for food in rubbish heaps and begging for money. This is mostly done by the women and children. A few of the older boys and men have started petty trades like selling cigarettes and other goods at the taxi park or as hawkers. What they earn, they use for rent and food.

"We have many problems. We would grow some food for ourselves, but we have no land. We cannot be employed because we did not go to school.

"Because we are unsettled, we cannot think of having babies and families. We feel very insecure. Our children will never know how the Karamojong life is led. Right now, we are no better than beggars: no land, cows, or family, nothing we call our own. We have to adjust to a vegetarian diet, and never have the chance to eat or drink our traditional milk and blood.

"Right now, we have no hopes of ever going back to our home land."

Displaced

After the disputed elections in 1980, dissatisfied political leaders took up arms against the Obote Government. The Luwero Triangle, comprising parts of Luwero, Mpigi, and Mubende Districts, was hardest hit by the warfare between 1980-85. Massacres of entire villages are believed to have taken place, and estimates of those killed range from 50,000 to 200,000. Many people were displaced and the population of the Triangle declined from 700,000 to 150,000 at the height of the problems. At the time, the Red Cross informally estimated infant mortality among displaced persons from this area seeking assistance to be 360/1000. Most surviving residents of the Triangle have returned since the Liberation War ended in 1986 and are now rebuilding their lives.

Displacement is still a problem in parts of Gulu and Soroti Districts in the North and Northeast, where instability and random violence continue. Although 330,000 Ugandan refugees have returned from neighbouring countries, especially Sudan, since April 1986, perhaps as much as 5% of Uganda's population, or between 150,000-200,000 children under five years of age, come from areas of instability. In these places, planting cycles are disrupted and access to traditional wild foods is hampered, resulting in increased nutritional vulnerability. Health services in areas of insecurity are even weaker than in other parts of the country, and many preventive services are not available because vaccines and other supplies cannot be transported or stored safely. Schooling and income-generating activities are limited. Older boys have been known to be co-opted into the fighting forces, and school girls have been unwillingly taken on as "wives" by the combatants.

Nutritionally Vulnerable Areas

The Karamoja region of Moroto and Kotido Districts, has always been an area of nutritional vulnerability. International attention concentrated there in 1980, when a major famine led to great loss of life. A minor food emergency occurred in 1985. In both cases, the causes were the cyclical pattern of low rainfall, general insecurity in the country, hampered access because of heavily-armed raiding parties of warriors, and the low priority given to this area by central Government. A nutrition surveillance programme established after the 1980 famine had to be abandoned when security worsened in 1985-86. Various NGOs, including Oxfam, Medecins Sans Frontieres, Save the Children Fund, Red Cross, and Action International Contre le Faim continue to provide services in accessible areas and report on conditions there. The region has been self-sufficient in food in recent years, but close monitoring is required to prevent the development of another nutritional emergency.

While Karamoja is the only region of Uganda to suffer recurrent wide-spread food problems, other areas experience occasional shortages. Pockets of nutritional vulnerability currently exist in parts of West Nile, Gulu, and Kitgum Districts due to poor rainfall, insecurity, and the breakdown of traditional food storage and preparation practices. Some evidence suggests that the urban poor also experience high rates of malnutrition.

Socio Economic Circumstances

Within the rural population, social and economic differences between families can lead some children to be at higher risk of death. In Mbarara District, approximately 34% of families are supported by subsistence farmers who have little land of their own, work on other people's farms, and have little education. This group is less likely to utilise health services or to treat diarrhoea adequately, and it is more likely to have underweight children (MOH et al., 1989). As yet no data exist to identify vulnerable groups in other areas of the country, but it appears that a sizeable part of national society is markedly worse off than the average, with children who are more likely to die or to grow up without access to schooling or other services.

Summary Analysis

Many Ugandan children live in especially difficult circumstances, but the actual number depends on the criteria used to define these children. The number of those at high risk of immediate violence and thus imminent death, disability, or loss of parents, is expected to decline over the next few years; the number suffering from AIDS and the number orphaned by AIDS will increase. National and international NGOs already active in this field will need support and encouragement to continue to find community-based solutions for these children.

Rapid changes in the number of persons and areas affected by insecurity or food shortages are always possible, and the situation in marginal areas requires close monitoring by the Government, with support from NGOs who have traditionally played a major role in this field, and international agencies.

The large proportion of the child population

which is disadvantaged because of their parents' socio-economic situation will only fall with long-term improvements in the economy, the school system, and other services. Most health interventions aim at universal coverage, which should help to protect vulnerable children against some of the direct threats to their physical well-being. At the same time, efforts appear to be underway to target the disadvantaged for special attention in some development programmes or to at least monitor them to ensure their inclusion in programme activities. Resistance Committees and Community Health Workers could be used to identify high risk groups for the special attention of the immunisation programme and other services.

Profile

The Woman Who Was an Orphan

An increasing number of orphans in Uganda must be cared for by other relatives, but often their position remains precarious. Sarah, left without her parents as a child, is now aged 22.

"My father died before I was born. My mother looked after me until I was four and she married another man. He told my mother that he would marry her only if she left me behind.

"My only other relative was my grandmother, an old woman who died when I was six. I was then left on my own with a plot of land about two acres large, so I was forced to start working for my living. I worked as a baby-sitter or housegirl wherever a neighbour was willing to employ, clothe, and feed me.

"When I was 17, some friends advised me that if I married, my husband would look after me, and I could end my so-far miserable life that I had led since my mother left me. So I got married to a man who lived nearby, and very soon I was pregnant. Unfortunately, I delivered twins. Among my people [the Baganda] there are certain ceremonies that one has to carry out in respect of the ancestors in thanksgiving for the twins. Failure to do so leads to the whole family being cursed. As I did not have any parents and knew nothing about worshipping my ancestors, I could not carry out the required ceremonies. My husband was afraid he would be cursed so he sent me and our children away.

"I tried to get a job, but because I have no formal education whatsoever, there seems to be no job for me. I had no choice but to return to the land that my grandmother had left me. I was very disappointed and was sure that I would be cursed by my ancestors. I started growing some food on my land and selling off some so as to maintain my children. Nobody in the neighbourhood could look after me in exchange for my services as a housegirl as they used to, because now I had children to look after too. Now the twins are four years old and I am pushing on in the same way as before, selling excess food from my garden. Survival is tough for us, and so far I have no hopes of ever sending my children to school.

"A few men have approached me, wanting to marry, but I am afraid something will go wrong again."

The Situation of Women

Background

While global concern for women was developing in the 1970s and early 1980s, Uganda's civil strife precluded any advancement in this field. In the late 1980s Government moved to redress this and created a Ministry of Women in Development which serves as the focal point for the development of strategies to address the concerns and needs of women.

The limited information available on the situation of women is drawn largely from a 1988 Survey on Women's Problems and Needs conducted in four regionally representative districts by a task force of women's groups led by Action for Development (ACFODE).

Women's Workload

A Ugandan woman's workday is long and hard; she rises early and does not stop until evening. The reported work day of rural women varies from 12-18 hours (ACFODE, 1989). In addition to having sole responsibility for all household chores, rural women do a disproportionate share of farm labour.

While women's workload is heavy, two of the more demanding daily tasks, fetching firewood and water, appear to be relatively easier than in many neighbouring countries. The majority of women surveyed walk less than one kilometre to fetch water (from protected or unprotected sources) or gather firewood, although considerable regional differences exist.

Seeking treatment for illness makes up a significant portion of women's workload. Women and their children are frequently ill and walking to a health facility and waiting for consultation are time-consuming. Seventy-six percent of women in Mbarara had been ill in the two weeks prior to their interview, and 40% of these women had sought treatment for their illness. Forty-two percent of children under five had been ill in the previous two weeks, and in 69% of these cases the mother took the child to a clinic for treatment (MOH et al., 1989). Caring for sick children at home also adds to a mother's workload.

Women's Isolation

Women's strenuous workloads make it difficult for them to socialise, and very few women are members of clubs or formal groups. Only 30% of the women in districts surveyed in 1984 were members of any social organisation, and the Survey on Women's Problems and

Proportion of Farm Work Carried Out By Women Selected Districts, 1986

District	Woman Works Alone	Husband Seldom Assists	Husband Occasionally Assists	Husband Always Assists
Arua	30%	23%	28%	19%
Gulu	24%	48%	12%	16%
Jinja	28%	39%	31%	2%
Kabale	36%	38%	14%	12%
Kasese	43%	50%	4%	3%
Mbale	48%	34%	5%	13%
Mbarara	55%	39%	0%	6%
Masaka	22%	36%	9%	33%

Source: Harmsworth, The Economic Status of Rural Women in Uganda, 1986, p. 155

In some areas, men carry out only the heavy farm tasks and leave all other work to their wives.

Needs found only 50% nation-wide to be members. Membership was most common in women's (18%) and religious groups (13%). Membership in informal groups is higher. For example, 40% belong to "Friend-in-Need" mutual assistance groups. Regular participation in public meetings is low; only 37% of the women surveyed had attended any meeting in the previous six months.

Ministries and church groups with extension workers are expected to make visits to women in their homes. In reality, however, these workers are providing minimal household contact. Community-based and traditional structures are more active.

This isolation is compounded by the failure of the mass media to reach rural areas. Although radio transmissions cover most of the country, only 43% of surveyed homes had a radio or could listen to a neighbour's or friend's (ACFODE, 1989, 3.5.1). Even for those with access, listening hours were severely limited by the scarcity and high cost of batteries.

The majority of women surveyed walk less than 1 kilometre to fetch water (protected or unprotected) or gather firewood.

Average Distance Walked for Water and Firewood, Four Districts, 1988

	% of Respondents Activity	
Distance	Water	Firewood
0 - 1 km.	78%	74%
1 - 2 km.	17%	21%
2 km or more	5%	6%

Source: ACFODE, Survey on Women's Problems and Needs, 1989, p. 12

Ministries and church groups with extension workers are expected to make visits to women in their homes. In reality, however, these workers are providing minimal household contact.

Households Visited by Various Officials in Past Six Months, Four Districts, 1989

Type of Official	% of Households Visited
Health Worker (MOH or NGO)	2%
Agricultural	5%
Cooperative	2%
Comm. Development	1%
Religious	1%
Political Cadre	1%
RC Women's Secretary	17%
Other RC members	44%
Gombolola Chief	14%

Source: ACFODE, Survey on Women's Problems and Needs, 1989

Marriage

Marriage in Uganda is regulated by the Marriage Act and the Customary Marriage (Registration) Decree of 1973. Moslem marriages are regulated by Mohammedan Law.

Traditionally, a marriage was not just a contract between husband and wife but between two families. It involved payment of varying amounts of bridewealth by men and their families to their prospective in-laws.

Today many marriages are not properly formalised. This situation may be a result of the inability to pay bridewealth, lack of parental control, or family dispersal. Often the bridewealth is only symbolic rather than economically or socially meaningful.

Because marriage is no longer always solemnized in accordance with prescribed social rituals, the line between girlfriends and wives has blurred. Socially a woman is considered to be a wife if she has borne a child and the man has accepted responsibility for it.

Most women are married according to customary law but not all of these unions are registered. Eighty-

two percent of women heads of household visited to assess women's problems considered themselves married. There are, however, regional differences and in some areas many mothers are raising their children alone.

Polygamy

Polygamy is socially accepted, and 28% of the married respondents in the Survey on Women's Problems were in polygamous marriages. Polygamy can be supportive; co-wives sometimes work together, mind each other's children, and help out in times of need, but it can also be a cause of conflict in the home. In the North the word for co-wife is *nyeke* and *nyeko* means jealousy (Laker-Ojok, 1987). The wives compete for income and resources, each trying to find favour for herself and her children.

Divorce and Separation

In traditional marriage, a divorce theoretically requires the repayment of the bridewealth; when the value of the bridewealth was high, divorce was uncommon. Increasingly however, there is no formality over separation. In 1980, it was estimated that 3.5% of all men and 6% of all women were divorced or separated (MPED, 1988a). The Survey on Women's Problems and Needs found a similar rate for women in 1988.

Divorce laws are biased against women. A man may divorce his wife for adultery alone, while a woman must have two grounds for divorce; her husband's adultery is not sufficient reason.

If a marriage breaks down and the couple separates, it is extremely difficult for a woman to obtain support from her former husband for any children who live with her. Most women have no idea how to obtain child support assistance through the law; if they do receive a favourable settlement, the maximum maintenance is only U. Sh. 200 a month.

Rights to Property

There are no statutes that prevent a woman from acquiring property, but according to custom property acquired during marriage belongs to the husband. If a woman leaves her husband, she may have to leave most of her property behind. In a survey of nine contrasting ethnic communities, one of the reasons women cited as a difficulty in owning livestock was that their husbands could claim the animals at any time (Cited in Laker-Ojok, 1987).

Traditionally, women are not their husband's automatic heirs. In some districts, if a husband dies and the wife has only young children, she may be allowed to continue to occupy the house and work the land she was using when her husband died. In other areas she may be forced to leave or to marry a brother or other near male relative of her late spouse.

Under the legal system, a wife (or wives jointly) may claim only 15% of the husband's estate. On the other hand, when a wife dies, whatever she possessed automatically becomes the property of her husband, unless he cannot prove he married her. In such cases, the property may be claimed by her father or brothers. The Ministry of Justice is in the process of revising the statutes affecting women and children; the Uganda Women Lawyers' Association is reviewing the draft and many discriminatory laws are expected to change.

Women Head of Households Raising Children Under 5 Years Without Adult Male Present in Six Districts, 1988

District	% of Respondents
Masaka	26%
Hoima	15%
Kabale	11%
Iganga	6%
Mbale	11%
Arua	19%
Total	15%

Source: UNICEF, CDD KAP Survey, 1988

The great majority of families with children under five years of age have a man present in the household, although he may not be the biological father of the children or the legal husband.

Profile

The Farmer's Wife: Conflict between Wives for Resources in Polygamous Marriages

Many men avoid agricultural work, and much of the burden of cultivation is left to women. In polygamous families, this often results in increased conflict between wives. Cecilia has eight children and has been married to Robert for 18 years. They live about 16 kilometres from town.

"When Robert and I were first married, we used to help each other a lot on the work that had to be done. Although Robert would never help with the cleaning of the house or cooking because he would be laughed at by all the neighbours for doing a woman's job, he would clean up the compound. When it came to the garden, he did the most strenuous work and even carried back food that was harvested if it was heavy.

"After about five years, Robert started changing. He no longer helped so much at home and spent much of his time drinking with his friends.

"By that time we had three children, and I had no one to help look after them. I would wake up very early each morning, leave the two older children in bed sleeping, then go to work in the gardens with the baby tied on my back. I would then rush back and care for the children, cook, and do the housework. In the evenings, I would go back to the garden, this time with all three children, since there was no one at home I could leave them with. It was all very strenuous on me, and Robert rarely helped, but he was always ready to sell off the harvested food.

"One day, after seven years of marriage, Robert went to town to sell off the harvests and returned a day later without anything new for the house. When I asked him why he had not returned yesterday, Robert said he had gone to pay the brideprice for another wife.

"I was heartbroken! All my sweat and hard work had been used to pay for another wife. Two of our children were now in school, and their fees had not even been paid.

"Since then Robert only comes to stay with me occasionally, and always during harvest time to sell off my harvests. He keeps the money mostly for his new family and for drinking.

"I now sell off some produce myself, especially the food crops which can be harvested at any time of the year, so that I raise some money to maintain my family.

"When Robert comes to stay with me these days, he no longer helps with any work. He wants to be waited upon like a lord, then later he goes drinking with his friends. I am lucky because he does not beat me up when he gets drunk, like so many other men do in their homes."

Women's Access to Income

Forty-four percent of Uganda's GDP and 95% of its export earnings come from agriculture. Most of the labour for producing this mainstay of the economy is done by women.

Farming

Although women do a very large proportion of the work for both cash and food crop production, men usually control the cash crop marketing and the generated income. Women have more control over the proceeds from the sale of food crops than cash crops, but the relative price of traditional foods is very low. There are many constraints to the expansion of food production. The single greatest factor cited in the Survey on Women's Problems and Needs was the lack of additional labour, demonstrating the heavy workload facing women and the limited resources available for hiring casual help. Tractor services or subsidised farm inputs could be addressed by active cooperatives. Unfortunately, only 6% of surveyed women were members of agricultural cooperatives, although 32% occasionally sell their produce to cooperatives (ACFODE, 1989, 3.6.1 and 3.5.0).

Women have more control over the proceeds from the sale of food crops than cash crops, but the relative price of traditional foods is very low.

Primary Source of Labour and Control of Income for Agricultural Produce By Sex, 1988

	Food Crop	Cash Crop
Women Grow Crop	68%	53%
Women Sell Crop	30%	9%
Women Decide Use of Funds	27%	10%
Women and Husband Decide Use of Funds	12%	7%

Source: ACFODE, Survey on Women's Problems and Needs, 1989, 3.3.5(a) and (b)

The single greatest constraint to the expansion of food production is the lack of additional labour, demonstrating the heavy workload facing women and the limited resources available for hiring casual help.

Constraints to Agricultural Production

Problems	% Stating	Suggested Solutions	% Stating
Lack of Labour	32%	Tractor Services/Money for Labour	26%
Lack of Tools/Drugs	25%	Credit/Subsidies	12%
Lack of Land	17%	More Land/Move to Fertile Land	16%
Poor Soil/Bad Weather	16%	Apply Fertiliser	12%
Pests/Vermin	4%	Pesticides	14%

Source: ACFODE, Survey on Women's Problems and Needs, 1989, 3.3.1(e)

The income from these activities was fully controlled by the women themselves but the amounts involved were very small.

Income-Generating Skills Among Women Four Districts, 1988

Skill	Knew the Skill	Used As Source of Income
Basket/Mat Weaving	74%	18%
Beer Brewing	49%	18%
Embroidery/Needlework	40%	NA
Simple Book-Keeping	21%	NA
Sale of Cooked or Fresh Foods	NA	23%

Source: ACFODE, Survey on Women's Problems and Needs, 1989, 3.5.2

Other Income Generating Activities

Most women in Uganda learn various skills which can be used to generate additional income although few apply them. 29% of those surveyed were not engaged in any extra income generating activity.

The income from these activities was fully controlled by the women themselves but the amounts involved were very small, ranging from less than U.Shs. 500 (87%) to U.Shs. 2,000 (3%). The main constraint to practising the skills they knew were lack of equipment (42%) and/or capital (18%).

Women probably under-reported their earnings and over-reported the need for equipment and capital; however, it seems that the present potential for increasing women's access to income lies in supporting strategies to increase agricultural production rather than in supporting low-profit, traditional income-generating activities.

Access to Credit

Only 9% of surveyed women had title to the land they farmed. This places a severe constraint on women's ability to secure loans through the formal banking system. Government has recognised both the need for special credit approaches for women and their inability to provide collateral. There are two schemes which specifically extend credit to women: the Uganda Women's Finance Credit Trust (an affiliate of Women's World Banking), and the Rural Farmers' Credit Scheme of the Uganda Commercial Bank.

One potential problem facing these initiatives is that most rural women want to borrow such small sums and have such weak financial skills that bank plans will be unable to assist the majority.

Only 31% of women interviewed by the Survey on Women's Problems and Needs had ever tried to borrow money. The amounts were very small; more than 60% of all loans were for less than the equivalent of US$ 3.00 each. Although 31% of women knew of the Rural Farmers' Credit Scheme loans, only 1% had tried to obtain loans through it--all of whom were successful. The reasons given for not trying for a loan included lack of assistance with the loan procedure, illiteracy, fear of not being able to repay, and poor access to banks in their areas (ACFODE, 1989, 3.9.2).

Women Working in the Formal Sector

Women work in most of the non-agricultural sectors, including the service sector, trade, industry, banking, health care, education, and Government administration. However, very few women occupy posts at the higher levels of their organisations. Only 0.05% of the senior positions in the Civil Service are held by women, although they constitute 30% of all Government employees (MPED, 1988b).

Women are strongly represented in the trading sector; at least one-half of traders are women, and they own many of the small businesses in urban areas.

Many Ugandans feel that women should remain in traditional roles. Seventy-two percent of mothers want their daughters to be nurses, doctors, teachers, or secretaries (ACFODE, 1989, 3.2.6). In 1982, only 6% of the students in Makerere's Technical College were women, compared to 57% in the College of Commerce (Balyamujura et al., 1985, p. 85; Bitamazire, 1988).

Use of Income

Women are increasingly responsible for meeting household expenses that were once paid for by men's cash crop income. Income controlled by women is used primarily for the maintenance of the home and support for the children. School fee payment was traditionally a husband's responsibility, but in 1988, thirty percent of women with children at school paid all or part of their children's expenses (ACFODE, 1989, 3.5.5).

Profile

The Progressive Woman Farmer who Obtained a Loan

The Ugandan Government is endeavouring to involve women more directly in development activities. Recognising their contribution to the farming sector and their limited access to credit through formal channels, it has instituted a Rural Farmers' Credit Scheme to encourage women to seek loans. Florence, 36, is the recipient of one of these loans.

"I used to live in Kampala with my husband who had a job, but in 1984 we decided to buy six acres of farm land. I moved to the land and my husband remained in town. We see each other at weekends.

"I started farming with poultry, sweet potatoes, beans, and maize. I joined the Rural Farmers' Association, where I was able to get advice from its members about the best farming methods.

"In 1988, I applied for a loan from the Rural Farmers' Credit Scheme to start a dairy farm. After an expert examined the farmland and decided it was suitable for dairy farming, the loan was granted to me. I was given a grace period of four months before starting to pay back the loan.

"Getting exotic cows from the Government for the farm took some time, because demand for the cows is much greater than the supply. I had to wait eight months for my five animals.

"I was very happy when the cows arrived. I gave each one a name, hired a man to look after them, and made sure they lacked nothing.

"For the first two months, the cows gave me no problem. In the third month however, three of them were poisoned by malicious neighbours and died. I was very disappointed and even wanted to give up, but my husband urged me on. I wrote a letter and informed the bank what had happened, and they pushed forward the grace period another year. I now graze the two cows left in my compound at home, so that I can keep a better eye on them. I also find it cheaper to feed them on Guatemala grass from my garden and dairy feed since maintaining the paddocks was quite expensive. The cows give about 30 litres of milk a day, which I sell to my neighbours.

"With the money I earn from the milk, I not only pay most of my daily domestic expenses, but also help keep our children in boarding schools, where they get a better education than in public schools."

School fee payment was traditionally a husband's responsibility, but in 1988 thirty percent of women with children going to school paid all or part of their children's school expenses.

Demands on Women's Income in Households with Adult Male Present, Selected Districts, 1986

District	School Fees	Children's Clothes	Other Domestic Expenses
Arua	6%	50%	68%
Gulu	10%	44%	56%
Jinja	4%	22%	34%
Kabale	10%	20%	18%
Mbale	20%	42%	46%
Mbarara	6%	42%	44%
Masaka	0%	35%	24%

Source: Adapted from Harmsworth, The Economic Status of Rural Women in Uganda, 1986, p. 158

Education (For more information see the chapter on Education)

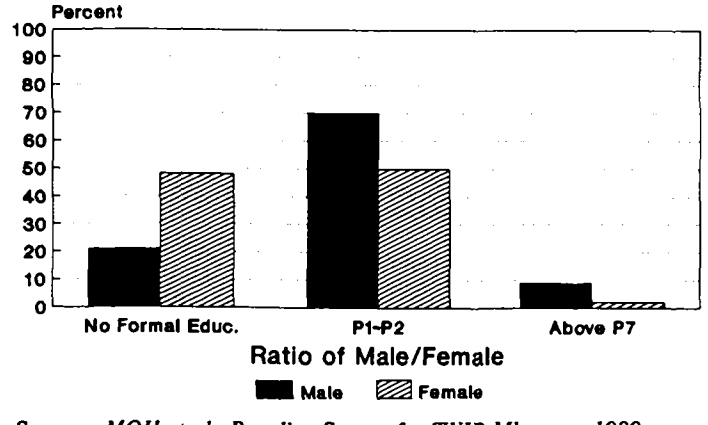
Women continue to receive less formal education than men. While 44% of pupils in primary schools are female, they constitute only 26% of all secondary students and only 16% at university level. Girls do less well than boys in examinations in all districts, both urban and rural. In the primary leaving examinations for 1982 and 1987, boys outscored girls in every subject except English.

Eighty-two percent of women interviewed for the Survey on Women's Problems and Needs wanted their daughters to reach the same level of education as their sons. In reality women have had unequal access to education. Forty-eight percent of rural mothers in six districts had no formal education, and only 5% had gone beyond primary school (UNICEF, 1988a). These figures are significantly different from the educational attainment of males found in Mbarara District in the same year.

Lack of school fees was cited by 83% of women as the main reason why their girls did not attend school (ACFODE, 1989, 3.2.6). However, the decreasing proportion of girls attending school at successively higher levels indicates that a choice is being made to use available funds to educate boys rather than girls.

Women have had unequal access to education. Forty-eight percent of rural mothers in six districts had no formal education, and only 5% had gone beyond primary school.

Educational Attainment By Sex in Mbarara District, 1988



Source: MOH et al., Baseline Survey for SWIP Mbarara, 1989

Profile

A Woman Who Never Went to School

Perhaps one-half of the women in Uganda have never attended school. Their experience often influences how they educate their own children. Ednance has never been to school.

"When I was young, many girls never went to school. My father was one of the most educated men in the village, but he was not interested in educating me. He only wanted his sons to go to school. My father married me off to get the bridewealth and marry another wife for himself. I do not regret that I never went to school, but I do regret having married too young to a much older man.

"Like many of my friends, I cultivate the land, but my husband's farm is very small. I make extra money from brewing beer. It not only makes money but brings company and social life to my home. Men come and discuss all sorts of things while they are drinking, and when they are here I feel I am at the centre of happenings in my village.

"I had 12 children, but three died in infancy. Six of the others were girls, and I did not much bother with educating them. In fact, none of my children went beyond primary school and even those who went to school were not much interested to go very far with their education. My two elder sons now regret that they did not stay in school long enough to learn how to read and write.

"Most of my daughters are now married. The eldest has taught herself sewing and makes dresses on a sewing machine her brother bought her. The second is separated from her husband and lives with me. She and the youngest help with brewing and selling beer. The third and fourth are with their husbands, where they dig and care for their homes. A fifth is now living in another district where she cultivates and brews beer.

"I'm satisfied with my life. I can get the things I want--a radio-cassette, a new pair of shoes--but sometimes I dream of worlds beyond my village. I would like to help develop my village, but because I am illiterate it is difficult for me to take part in leading others. I do not belong to any women's groups, and most of my socialising centres around the beer pot in my home."

Health (For more information see the chapter on the Health Situation of Women and Children)

Women have special health needs related to their role as mothers. High fertility rates and limited maternal and child health services are responsible for a large share of female morbidity and mortality. It was in Uganda that Jelliffe coined the term Maternal Depletion Syndrome as the general diagnosis for the increased morbidity and risk of death during each succeeding pregnancy after a sixth child.

Maternal and Child Health Care and Maternal Mortality

Attendance at Maternal and Child Health clinics is low and delivery in health units is even lower, averaging 38% in 1988-89 (MOH and DHS, 1989). Maternal mortality in Kampala hospitals has been increasing, from 1.00/1000 deliveries in 1970 to 2.65/1000 deliveries in 1980-85. The majority of identified causes are essentially preventable and could be addressed by improved management and hygiene in hospitals (Kampikaho, 1988). The maternal mortality rate outside of Kampala hospitals is not known, but it is likely that deaths due to sepsis and tetanus are higher in household deliveries.

Fertility and Family Planning

Optimal family size remains high, with 46% of women expressing a desire for eight or more children (ACFODE, 1989, 3.4.7); this number is only slightly higher than the estimated total fertility rate of 7.3 (MOH and DHS, 1989).

Although many women recognise the drain on their health caused by frequent child birth, social and economic pressures lead many of them to have more children than they would otherwise choose.

Couples desire many children who they hope will help them in their old age. Parents of many children are well respected, and large families are perceived as a way of raising social status. The desire for children is related to the rate of child mortality. In three studies in the South, 48% of respondents had experienced the loss of at least one child.

There are large differences in fertility intentions by age; as might be expected, younger women are much more likely to want another child within the next two years than older women.

Despite an overall desire for large families, the Demographic and Health Survey found that among married women 23% do not want any more children, and 33% want to wait at least two years before having another child. This finding implies that over one-half of married Ugandan women might be receptive to family planning to limit or space births.

However, while 84% of women surveyed in 1988-89 knew of at least one method of contraception, actual practice was very low. Only 7% had ever used a modern method and only about 3% were actually using one at the time of interview. Traditional methods, such as periodic abstinence and withdrawal, had been more frequently practised at some time (MOH and DHS, 1989).

Optimal family size remains high, with 46% of women expressing a desire for eight or more children.

Mean Number of Children Ever Born and Surviving, and Fertility Rates for Five Years Preceding Survey by Age, 1988-89

Age of Woman	Mean Children Ever Born	Mean Children Surviving	Fertility Rate-Age Specific
15-19	0.40	0.34	0.19
20-24	1.86	1.53	0.33
25-29	3.65	3.01	0.32
30-34	5.04	4.10	0.27
35-39	6.79	5.55	0.22
40-44	7.24	5.76	0.10
45-49	7.77	5.97	0.04
Total	3.49	2.83	7.30

Source: MOH and DHS, Uganda Demographic and Health Survey, 1989

Profile

A Woman Who Rejects Family Planning

Most women in Uganda do not use contraception because they value having many children. There are also other social pressures that discourage them from family planning. Jennifer is aged 29 and has six children. She does not believe it is a good idea to limit the number of children one has.

"I only studied up to Primary 4, then I stayed at home until I got married.

"Children are a blessing from God. I think that people have no right whatsoever to go against God's wish and use contraceptives to stop children from being born. God gave women the capability to give birth to very many children. If to have many children is bad, why are women made capable of delivering even as many as 18 children? My six children are difficult to look after, but I manage.

"My husband has four other wives. The wives are all competing to get as many children as possible, because they believe that the more children a woman has, the more of a woman one is, and therefore the more a husband is likely to love and support her.

"Besides, when you have many children, in your old age you get much more attention and help from all of them put together than if you have only a few. You will have children going into all professions, and they can then help each other. When they grow up they can rely on one another and manage better. If one is not able to help me, then there is always another one who can.

"Women who have few children are either lazy or short sighted. Who will help them when they are old?"

The desire for children is related to the rate of child mortality. In three studies in the South, 48% of respondents had experienced the loss of at least one child.

Ideal Family Size by Present Number of Children

Area	Year	Ideal Size		Present Number	
		1-5	6+	1-5	6+
Entebbe	1986	31%	69%	73%	27%
Busoga	1988	20%	80%	84%	16%
Northeast	1985	50%	50%	NK	NK

Source: Opio, The Views of Peri-Urban Ugandan Men and Women on Their Fertility, 1986; GOU et al., Baseline Survey Northeast Uganda, 1985

Only 5% of women use any method of family planning.

Knowledge and Use of Contraceptive Methods Among Currently Married Women, 1988/89

Method	Percent Who Know Method	Percent Who Ever Used	Percent Currently Using
ANY METHOD	84.0%	21.5%	4.9%
ANY MODERN METHOD	77.9%	7.0%	2.5%
Pill	67.7%	5.0%	1.1%
UD	21.1%	0.5%	0.2%
Injection	40.8%	1.3%	0.4%
Diaphragm/Foam	11.6%	0.2%	0.0%
Condom	31.1%	0.7%	0.0%
Female Sterilisation	62.6%	0.8%	0.8%
Male Sterilisation	8.8%	0.0%	0.0%
ANY TRADITIONAL METHOD	62.4%	17.4%	2.4%
Periodic Abstinence	45.0%	13.6%	1.6%
Withdrawal	22.0%	4.8%	0.3%
Other	33.4%	3.0%	0.4%

Source: MOH and DHS, Uganda Demographic and Health Survey, 1989, Table 8

Summary Analysis

A female Ugandan's life is more difficult than for her male counterpart; she works longer hours, has more economic responsibilities, and has additional health risks because of child-bearing. She is less likely to go to school and thus be able to improve herself, and she has few opportunities to participate in community activities.

Fortunately, the Government has recognised these problems, and positive moves are underway to improve the lives of women. Women have been incorporated into Resistance Committees, and a minimum of one seat per district is reserved for them in the National Resistance Council to ensure that their needs are considered at the national level. In addition, some laws prejudicial to women are being revised. However, Government agricultural programmes are not targeted to women, even though women are the main producers. Much work remains to be done to help society recognise the important role women already play in Ugandan life and to give them the self-confidence and economic support they need to improve their situation.

Water and Environmental Sanitation

Background

Rural access to safe water has always been limited, reaching 17.5% of the population in the 1960s. Urban areas were more fortunate. By 1970, piped water supply systems were functioning in the principal towns in all (then) 18 districts. Powered water systems also functioned in many rural hospitals and training institutions.

Improved sanitation facilities were widespread in the 1960s, with up to 90% of rural households equipped with some form of latrine. Urban sanitation was well developed, with underground sewers and organised refuse collection in many towns.

Environmental sanitation and vector control programmes also functioned. Uganda's towns were clean, and major advances had been made in rural areas, including programmes for better house construction and home improvement. An educated and well-staffed health inspectorate provided supervision and support for sanitation education and enforcement.

The collapse of the economy and respect for authority during the 1970s seriously affected mechanised water systems and health inspection activities. By 1980 town water supplies, including the system in Kampala, no longer functioned regularly. Water-borne sanitation systems were clogged and piles of refuse littered the streets. Broken water and sewage pipes added to the clutter. Urban vector control was suspended as salaries went unpaid, and staff retreated into private enterprise and farming for survival.

By 1983, only 36% of rural boreholes were functioning (MLWR and UNICEF, 1983). Protected springs were also in disrepair. In many areas, population increases coupled with falling by-law enforcement led to a decrease in the proportion of homes with pit latrines.

Rural vector control programmes also collapsed. Malaria eradication and the bush clearance projects which had virtually eliminated sleeping sickness from human populations and trypanosomiasis in cattle were suspended for lack of finance early in Amin's regime. As a consequence, sleeping sickness has returned to large areas of the Southeast and Northwest. Due to the breakdown of protected rural water sources and population movements, guinea worm disease has spread from its isolated focus on the Sudanese border into Kitgum District.

Hydrology

Uganda has 36,260 sq. km of open water and 5,180 sq. km of swamps. Uganda's part of Lake Victoria, with its intricate submerged northern coastline and elevated western plains of sand bars and lagoons, lies in strong contrast to the regular faulted basin lakes of the rift valley.

The Lake Kyoga system and the Koki lakes in Ankole are similar to Lake Victoria. The smaller lakes of Kigezi were formed by lava flows or craters, while the crater lakes of the western rift were formed by gaseous explosions. The tarns of Ruwenzori resulted from glacial erosion.

Most of the southern part of the country drains into Lake Victoria. The flow of many of the perennial streams of the plateau is impeded, and they are clogged with swamps. In the Northeast, many of the water courses are seasonal.

Hydrogeology

Although water has been found in all rock groups, the majority of boreholes have been sunk in the mainly gneissous rocks of the basement complex which occupies three-fifths of the country. Water is normally obtained from interconnected fissures at an average depth of 40-50 metres, where the rocks are moderately to partially weathered. Sub-artesian conditions are common; water when struck often rises to a rest level only a few meters from the surface.

Borehole water is generally hard, but tests indicate that the concentration of dissolved salts is usually well below harmful levels.

Water Supply in the 1980s

Both urban and rural water supply systems have received considerable attention in the 1980s, and safe water coverage rates are returning to the level of the 1960s. Major urban projects are concentrating on Kampala and six other large towns, working through the National Water and Sewerage Corporation. Rural water supply initiatives are coordinated between the Water Development Department of the Ministry of Water and Mineral Development and the Ministry of Health.

Urban Water Supplies

Government investment priorities strongly favour the urban minority. The 1988-92 Rehabilitation and Development Plan highlights six water and sanitation projects for priority funding; five of the six projects are for urban water projects which make up 66% of the total funding requirements.

This bias toward urban supplies is even more striking when considered on a per capita basis. The urban population is scheduled to receive US$ 91.36 per capita for water supply improvement, while the rural population will receive only US$ 4.65, or 5% of the urban per capita level.

Government investment priorities strongly favour the urban minority.

Urban Piped Water Supplies by Type 7 Major Towns, 1983

	Population in (000's)	Percent Served	Source of Those Served: Private Connection	Private Standpipe	Public Standpipe
Kampala	686	57%	32%	12%	56%
Jinja	119	56%	43%	39%	18%
Entebbe	22	86%	57%	9%	34%
Masaka	35	90%	20%	47%	33%
Mbarara	32	90%	16%	62%	22%
Tororo	27	80%	18%	42%	40%
Mbale	34	94%	14%	57%	29%
TOTAL	995	62%	31%	24%	45%

Source: World Bank, Staff Appraisal Report, June, 1988

Rural Water Supplies

The availability of surface water and access to protected water sources varies greatly between regions and even within districts. The hydrogeological conditions conducive to widespread surface springs are found in only eight districts, primarily along the perimeter of the southern and central areas. The North has relatively few protectable springs, and the region is commonly referred to as "the borehole belt."

Availability of surface water and access to protected water sources varies greatly between regions and even within districts.

Rural Water Supplies Estimated Population Coverage by Period/Year, 1960s-1990

Period/ Year	Boreholes	Protected Springs	Other Safe Sources	Total Sources	Sources Working At Any Given Time	% Of Rural Population Served
1960s	4,342	1,205	50	5,597	79%	17.5%
1970s	5,089	1,655	96	6,840	80%	15.5%
1980	5,089	1,741	103	6,933	31%	4.7%
1983	5,089	1,976	103	7,168	46%	6.4%
1985	5,887	2,763	122	8,772	59%	9.9%
1988	7,739	4,016	160	11,915	62%	13.0%
1990*	8,909	5,420	221	14,550	77%	18.3%

Source: UNICEF, Internal Document, 1988

The shortfall however, remains formidable and is rising due to population growth. With an annual growth rate of 2.8%, Uganda requires an additional 1,300 protected water sources per year (based on an average of 350 persons per source) just to maintain the present coverage rate. If all protectable surface water sources and scheduled boreholes were completed by January 1990, only 28% of the rural population would have access to safe water and only Kabale and Rukungiri Districts would approach the WHO target of one safe water source per 200 inhabitants.

Depending on location, a percentage of the unserved population could benefit from rainwater harvesting or water-hole and valley dam systems. These options require water treatment and filtration to be made safe. For others, the only potential for safe water will be through the drilling of new boreholes.

contaminated, and 11% of 295 sampled sources proved to be unsafe on the day of testing (UNICEF, 1988b).

Domestic Water Treatment Storage

Recent surveys have found that a surprisingly high percentage of rural households claim to boil their drinking water. Almost 30% of households in the central and southern areas always boil water, and a further 15% sometimes do so, in contrast to only 3% of northern households. Most rural households and many urban ones store drinking water in clay pots, and 71% of families interviewed cover their drinking water containers.

Domestic water treatment affects water quality. Forty-two percent of households in Luwero District with contaminated water sources made their water safe through boiling. Conversely, 17% of households drawing water from safe sources had contaminated their water through poor storage practices.

Estimated Rural Water Source Costs By Unit and Beneficiary, 1988

Source	Beneficiaries per Source	Approx. Cost per Source	Cost per Beneficiary
Rehabilitated Borehole	300	$ 2,800	$ 9.33
New Borehole with Pump	300	$ 7,000	$23.33
Protected Spring	200	$ 1,200	$16.20

Source: UNICEF, Internal Document, 1988

The cost of water source development varies greatly between types of systems.

Water Source Development

Complete safe water coverage for the projected 1990 rural population would cost an estimated US$ 153 million, 60% of which would be for drilling boreholes in areas without surface or rainwater options. At a rate of 85 boreholes per year per rig. Uganda would require 15 rigs drilling continuously until 1999 to reach the 1990 target set for the International Drinking Water Supply and Sanitation Decade. At the same time an additional 18 rigs would be required to keep up with the population growth rate.

Rural Water Quality

The quality of rural water sources, protected or unprotected, is largely unknown. Data from over 750 samples collected in Luwero District found that 60% of unprotected water sources were contaminated with fecal matter and unsafe. Protected sources can also become

Water Quantity and Distance

Studies in Mbarara and four other southern districts found that families use an average of nine litres of water per person per day. In Luwero District, average water use was 12 litres per person per day. There was no significant difference in quantity used by those served by boreholes and families with unprotected sources (UNICEF, 1988b).

In Luwero District, the 140,000 estimated beneficiaries of a borehole drilling project realised a 36% reduction in distance to water sources compared to comparable groups who did not receive boreholes; average time taken to draw water fell from 66 to 44 minutes (UNICEF, 1988b).

Water quality varies by type of source, and some unprotected sources are more likely than others to be contaminated.

Fecal E. Coli Water Source Contamination Luwero District, 1986-87

Source	Safe	Unsafe
Borehole	89%	11%
Protected Spring	89%	11%
Rain Water	52%	48%
Spring	48%	52%
Swamp	35%	65%
River	11%	89%
Water Hole	20%	80%

Source: UNICEF, Luwero Water and Sanitation Survey, 1988

At a rate of 85 boreholes a year per rig Uganda would require 15 rigs drilling continuosly until 1999 to reach the 1990 target.

Rural Water Supply Requirements By Source Type, 1990

Description	Estimated Potential	Funded to 1990 Completed	Funded to 1990 To be Done	Shortfall No. Units	Shortfall Estimated Cost US$
Boreholes Rehabilitated	5,089	3,416	424	1,249	3,497
New Boreholes	17,000	2,735	1,085	13,180	92,260
Protected Springs	12,669	4,099	1,321	7,249	20,297
Gravity Schemes	80	8	3	69	4,485
Wells/Pumps	5,000	160	50	4,790	21,555
Rainwater Harvest	175,000	65,000	NA	110,000	8,800
Waterhole Valley Dam	15,000	704	NA	14,300	2,030
Total					$153,014

Estimated Costs in (000's)

Source: UNICEF, Internal Document, 1988

Water Source Maintenance

One of the most significant advances for rural water supplies in the 1980s was the introduction of the concept of community ownership and maintenance. Developed in Luwero District in 1986, the system has proved to be a cost-effective mechanism for keeping handpumps working. Prior to the Luwero experiment, water source maintenance and service was solely the function of the Water Development Department. With limited resources, vehicles, and equipment there was little capacity for the Department to service the national borehole network.

Average handpump downtime continues to vary dramatically with the type of maintenance system. In the first part of 1989, areas without community-based handpump mechanics reported breakage-to-repair periods of two to five months. By contrast, the recorded downtime for the more than 500 handpumps in Luwero District is two days or less.

Average annual per capita cost in 1988 for the community-based maintenance system among beneficiaries in Luwero was approximately US$ 0.04 including the price of replacement spares, mechanic services, and system supervision.

Treatment and Storage of Drinking Water By Households

District	Storage				
	Boil	Clay Pot	Jerrican	Saucepan	Other
Arua	3%	92%	5%	3%	0%
Hoima	22%	77%	21%	1%	1%
Iganga	8%	98%	2%	0%	0%
Kabale	40%	21%	43%	2%	34%
Masaka	47%	24%	35%	30%	12%
Mbale	30%	93%	7%	0%	0%
TOTAL	24%	70%	18%	6%	7%

Source: UNICEF, CDD KAP Survey, 1 988

Recent surveys have found that a surprisingly high percentage of rural households claim to boil their drinking water.

Sanitation

While household latrine coverage has fallen since the 1960s, an exceptionally high level of ownership of at least some form of basic latrine continues. Latrine ownership in 1988 was estimated to be between 65% and 82% nation-wide, with wide regional variations (MOH and DHS, 1989; UNICEF, 1988a). This finding indicates the acceptance in all regions of the basic concept of latrine construction.

In contrast to the high level of latrine ownership, rural families do not have a tradition of improved rubbish disposal. Less than 5% of households had rubbish pits in 1988, and 91% of families surveyed scattered their refuse within or outside their household compounds.

Latrine Ownership and Quality Six Districts, 1987

District	Some Form of Latrine	Type of Latrine Owned		
		Open	Mud/Wattle	Permanent Materials
Hoima	68%	43%	51%	6%
Masaka	74%	38%	68%	8%
Iganga	51%	25%	71%	4%
Mbale	89%	53%	35%	11%
Arua	47%	30%	66%	4%
Kabale	63%	8%	75%	16%
Average	65%	34%	58%	8%

Source: UNICEF, CDD KAP Survey, 1988

The quality of construction varies widely with over 20% of families with latrines being satisfied with the construction of a basic pit without superstructure.

In Luwero District there was a significant reduction in distance walked, and consequently time consumed, to gather water for beneficiaries of borehole drilling project.

Kilometres from Source of Water Selected Districts, 1988-89

Area	Wet Season				Dry Season			
	<1/2	1/2-1	1-5	5+	<1/2	1/2-1	1-5	5+
Arua	51%	31%	18%	0%	44%	24%	27%	0%
Mbarara	50%	29%	21%	0%	44%	27%	26%	3%
Northeast	3%	45%	45%	7%	3%	39%	46%	12%
South	NA	NA	NA	NA	31%	47%	22%	0%

Source: CUAMM, Arua Survey, 1987; GOU et al., Baseline Survey Northeast Uganda, 1985; MOH et al., Baseline Survey for SWIP Mbarara, 1989; ACFODE, Survey on Women's Problems and Needs, 1989

In contrast to the high level of latrine ownership, rural families do not have a tradition of improved rubbish disposal. Less than 5% of households had rubbish pits in 1988.

Methods of Rural Rubbish Disposal Six Districts, 1987

District	Throw Outside Compound	Throw in Compound	Burn/Bury	Other
Masaka	72%	13%	9%	5%
Hoima	55%	34%	10%	1%
Kabale	59%	34%	7%	0%
Iganga	56%	37%	7%	1%
Mbale	62%	30%	8%	0%
Arua	32%	63%	5%	0%
Total	56%	35%	8%	1%

Source: UNICEF, CDD KAP Survey, 1988

Summary Analysis

Safe water supplies and sanitation are among the necessary prerequisites for protecting the health of women and children. Uganda continues to commit major resources and channel donor interest to this sector to ensure expanded water supplies. However, the distribution of resources is heavily biased toward urban residents who are already better served, and the planned level of investment is only sufficient to provide 20% of the national population with access to safe water by 1990.

While the proportion of the population served by safe water is similar to that in the 1960s, sanitation coverage has fallen for the same reasons that health care and education have declined--low worker motivation due to low salaries, lack of supervision, supplies, etc. This situation, combined with little effective community education and involvement, means that latrines and protected water sources are not necessarily maintained in a safe condition.

Initiatives to develop community maintenance systems for improved water supplies at a low cost seem to be effective in limited areas, and health education is being revitalised. However, increasing investment in rural water supplies to reach larger areas of the country will be a major challenge for Government.

Communications

Media

Background

Communications have followed the fate of other economic and social service activities. From an advanced level of development in the first ten years of independence the sector fell into disrepair and mismanagement. Recovery began in the mid-1980s but coverage remains substantially below the peak levels of the pre-Amin years. For example, the state-owned television station, which was opened in 1963, had a geographic coverage of 65% of the country in the late 1960s and early 1970s, but by 1985 transmission reached less than 15% of the country. Individual access to television is less than 1% of the population.

Newspapers

Newspaper publication is limited to Kampala, where a number of private, Government, and religious presses have been established. Distribution has expanded in recent years to include many of the major rural towns, and papers published in Kampala can generally be found in limited supply in outlying towns on the day of issue.

Actual newspaper readership is unknown but price and availability restricts circulation to the upper income levels in Kampala and major rural towns. Access to lower income groups and rural areas is essentially nil.

Regional newspapers are planned for four major rural towns, and presses have already been established in Mbarara and Gulu.

Literacy

National literacy levels are unknown, but there is evidence that it is rather limited in rural areas. Nineteen percent of rural mothers surveyed in six districts in 1987 could read a simple English text while 43% could read the same text in the district's dominant vernacular language (UNICEF, 1988a).

Radio

The Government-owned Radio Uganda broadcasts 17 hours a day in 22 languages. One station transmits in northern and northeastern languages, while the other carries programmes in the eastern, central and western languages, with each language taking up two to three hours of daily transmission. Most of the airtime is devoted to news and features, which include health and education programmes. There are plans to rehabilitate regional medium wave stations but future broadcasting is constrained by access to power supplies. The regional stations are scheduled to broadcast in vernacular languages and to emphasize educational programmes.

Radio listenership is limited by ownership and access to batteries, which are expensive when available. Approximately 26% of the population owned radios in 1987. Listenership is limited to short periods of the day, targetted to news and the personal announcements that immediately follow the news.

Television

Uganda Television transmits 5-6 hours daily to an estimated audience of 50,000 in Kampala and the immediately surrounding areas. Foreign education films and entertainment programmes predominate. Locally produced material is limited to the nightly English news broadcast and occasional news and education features.

Regional transmission booster stations operate in Mbale, Masaka, and Mbarara. The addition of these stations has raised potential coverage to 60% of the population. However, the high price of television sets and limited rural electricity dictates that television access will remain restricted to the elites of Kampala and a few of the major rural towns.

Advertising

All newspapers as well as radio and television accept advertising. Contact is generally made directly with the media managers to develop messages and layouts. The few advertising firms in Kampala are generally of low quality. Television production facilities can be arranged through freelancing Uganda Television personnel.

News Services

The Ministry of Information and Broadcasting has established the Uganda News Agency to gather information from rural areas through Information Officers. The Officers work together with the RC

Secretaries for Information who are responsible for collecting news about activities in their area. The Agency is at a very rudimentary stage, and the untrained field representatives receive little support and instruction.

An association of Journalists for the Child was launched by the Ministry of Information and Broadcasting in 1987 with UNICEF support. It consists of print media journalists, and radio and television broadcasters who have gone through training on Child Survival and Development topics and who have taken a special interest in children's issues, producing television and radio documentaries, and increasing press coverage.

Regional newspapers are planned for four major rural towns and presses have already been established in Mbarara and Gulu.

Major Newspapers, Kampala, 1988

Name	Ownership	Language	Frequency	Circulation
New Vision	Government	English	Daily	30,000
Munno	Catholic Church	Luganda	Daily	10,000
Star	Private	English	Daily	7,500
Ngabo	Private	Luganda	Daily	10,000
Financial Times	Private	English	3-weekly	2,000
Weekly Topic	Private	English	Weekly	6,000
Taifa Empya	Private	Luganda	Daily	3,000
Citizen	Democratic Party	English	Weekly	1,500

Source: Sebunya and Bakunzi, Print Media in Transition, 1989

Radio listenership is limited by ownership and access to batteries which are expensive when available at all. Radio ownership in 1987 was approximately 26%, with strong regional variations.

Radio Listenership, Various Districts, 1987

		Language of Listeners			
District	Regularly Listen	English	Swahili	Vernacular	Unknown
Masaka	35%	2%	5%	92%	1%
Hoima	33%	5%	1%	80%	14%
Kabale	22%	10%	2%	88%	-
Iganga	35%	6%	2%	78%	14%
Mbale	28%	10%	6%	81%	3%
Arua	26%	22%	8%	70%	-
TOTAL	30%	9%	4%	81%	6%

Source: UNICEF, CDD KAP Survey, 1988

Informal Communication

A commonly used form of communication is the drum, whose different sounds convey varying messages, especially for public gatherings. This medium has been used very effectively by the Ministry of Health AIDS Control Programme for education on AIDS prevention. Drama and song are also very popular and are often found at important public events and celebrations. There are about 300 drama groups in the country, with 200 in urban areas. The Uganda Theatrical Groups Association helps groups perform in various parts of the country. Although basically commercial, the groups are now being cultivated for development purposes and to popularize child survival messages.

First Programme Choice and Listening Time Among Those Who Listen to Radio, 1987

District	Choice				Time			
	News	Announce-ments	Other*	Any	Afternoon	Night	Other*	Anytime
Masaka	52%	14%	21%	12%	36%	39%	5%	16%
Hoima	62%	4%	22%	11%	19%	52%	13%	13%
Kabale	50%	8%	29%	12%	13%	51%	7%	29%
Iganga	48%	4%	36%	12%	38%	21%	18%	18%
Mbale	28%	1%	27%	43%	6%	29%	15%	49%
Arua	62%	4%	28%	6%	80%	6%	9%	6%
TOTAL	51%	6%	16%	27%	33%	32%	13%	21%

* Specific programme or time mentioned

Source: UNICEF, CDD KAP Survey, 1988

Radio Listenership is limited to short periods of the day, targetted to news and the personal announcements that immediately follow the news.

Strategic Alliances For Child Survival

Working relationships have been established with various local institutions and NGOs which have the capacity and potential to support and strengthen child survival programmes. The first allies were the religious organisations which have an extensive national infrastructure of churches and mosques, schools, and health units.

The Resistance Committee system has proved to be an effective means of eliciting community participation in health activities and generating resources from communities for self-help projects. The community-financed handpump maintenance system which is now part of the national water programme was largely possible because of the Resistance Committee system. The Committee members are now being sensitised and mobilised to assist in the promotion of UNEPI, CDD, and AIDS control.

The Scouts and Guides Associations have promoted immunisation activities, mainly in the urban areas where their branches are well established.

Transportation

Uganda has a good network of roads, and settlement often occurs in the form of ribbon development along them. Villages and homesteads are also interconnected by a network of footpaths. By 1972 there were 2,300 km of bitumen and 25,933 km of all-weather gravel roads (Office of the President, 1973). No new roads have been built in the past 15 years; however, rehabilitation of existing principal and feeder roads has been a priority of the present Government. Between 1983 and mid-1988, over 2,700 km of road had been rehabilitated. Due to insecurity, most of this activity is at present in the south of the country, with the exception of the Pakwach-Arua road in the North.

Over the past decade Uganda's roads have been increasingly used by transit lorries from Kenya going to Sudan, Zaire, Rwanda, and even western Tanzania, and 300,000 tonnes of transit goods were recorded in 1987. This heavy traffic has had significant responsibility for the past deterioration of the road system.

Motor Vehicles

Lack of vehicles inhibits the development of public transport in some districts. While Government has imported large numbers of buses for the main inter-district routes, intra-district travel is often very difficult and continued insecurity constrains the development of public transport in some areas. In general, road travel is relatively cheap but unreliable.

In 1987 it was estimated that there were 31,307 motor vehicles of all types licensed in Uganda (including 3,235 lorries, 553 buses, 1,980 minibuses, and 5,933 pickups and vans) as compared to 50,419 in 1970, of which 15,108 were commercial or public service vehicles (Office of The President, 1973; MPED, 1988a, Table 43).

Railway

A rail network links Kampala with Mombasa on the Kenyan coast, and with Kasese in western Uganda. Another line passes through Mbale, Soroti, Lira, and Gulu Districts, but it has been largely immobilised for the past two years due to insecurity. The line to Kasese is frequently disrupted by technical difficulties.

Present Government policy favours greater use of the railway to reduce transport costs. However, the lack of railcars and external cooperation has undermined this objective. There has also been recent investment in renewing lake transport to improve access to the Port of Dar-es-Salaam and speed the transit of goods to Mombasa using the lake route via Kisumu.

Posts and Telecommunications

At present less than one-half of Uganda's districts are linked by telephone, and phoning inside Kampala remains difficult. Mail services have also foundered; deliveries between major towns may take several weeks and arrival is not guaranteed. In the more remote areas and all the northern districts, the local runner remains the most common mode of transmission for intra-district mail.

Summary Analysis

The mass media are very poorly developed in Uganda, and do not reach the majority of the population. Most people communicate and receive information through informal and traditional ways, particularly personal communications. Public education programmes will need to identify channels of communication that will look beyond the mass media to reach the rural population.

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Note: This report is based largely on unpublished documents, and complete bibliographic references for some sources are not available. Personal communications, newspaper reports, and reports cited for multiple years are not all listed. All referenced documents can be found in the UNICEF Kampala Library.

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List of Abbreviations

ACFODE	Action for Development
ACP	AIDS Control Programme
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
BSF	Belgian Survival Fund
C	Centrigrade
CDD	Control of Diarrhocal Diseases
CFR	Case Fatality Rate
CHW	Community Health Worker
CUAMM	Colleguo Universitario Aspiranti Medici Missionari
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
DMO	District Medical Officer
EEC	European Economic Community
GDP	Gross Domestic Product
GOU	Government of Uganda
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IFAD	International Fund for Agricutural Development
IMR	Infant Mortality Rate
IPH	Institute of Public Health
IYC	International Year of the Child
KAP	Knowledge, Attitudes, and Practices
KM	Kilometre
MLWR	Ministry of Land and Water Resources
mm	Millimetre
MMR	Maternal Mortality Rate
MOA	Ministry of Agriculture (and Cooperatives)
MOE	Ministry of Education
MOH	Ministry of Health
MPED	Ministry of Planning and Economic Development
NGO	Non-Governmental Organisation
NRA	National Resistance Army
NRC	National Resistance Council
NRM	National Resistance Movement
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
RC	Resistance Committee (numbers after RC indicate level)
RFCS	Rural Farmer's Credit Scheme
SCF	Save the Children Fund (United Kingdom)
SSS	Sugar Salt Solution
SWIP	Southwest Integrated Health and Water Project
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UEDMP	Uganda Essential Drugs Management Programme
UNDP	United Nations Development Programme
UNEPI	Uganda National Expanded Programme on Immunisation
UNESCO	United Nations Education, Scientific and Cultural Organisation
UPE	Universal Primary Education
USAID	United States Agency for International Development
U. Sh.	Uganda Shilling
UTV	Uganda Television
WCARRD	World Conference on Agrarian Reform and Rural Development
WDD	Water Development Department
WHO	World Health Organisation
WNAS	Women's Needs Assessment Survey
W/H	Weight-for-height

Children and Women In Uganda
A Situation Analysis

For every 1,000 children born in Uganda today, 172 will die before their fifth birthday. Every year 153,000 children's lives are lost, mainly due to preventable causes. Maternal mortality is also unacceptably high. In Kampala hospitals 2.65 mothers die for every 1,000 deliveries.

With the economic decline of the past 20 years, the social services have been grossly underfinanced, leading to a sharp decline in the quality and access to services. The burden of service financing has gradually shifted from government to families, and particularly to women.

The challenge is to work within this environment to develop intervention strategies which will reduce morbidity and mortality, and support the realization of the full potential of women and children in Uganda. Such strategies must be sustainable, and firmly rooted in the community.

An essential prerequisite for the design of effective strategies is the full understanding of the present situation and the context within which progress is possible.

"The information contained in this Situation Analysis goes a long way in enabling us to respond to the very difficult challenges of our times. It is welcome as a useful tool for all those who hope to work to improve the well-being of children and women in Uganda."

Dr. S. B. M. Kisekka
Prime Minister

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