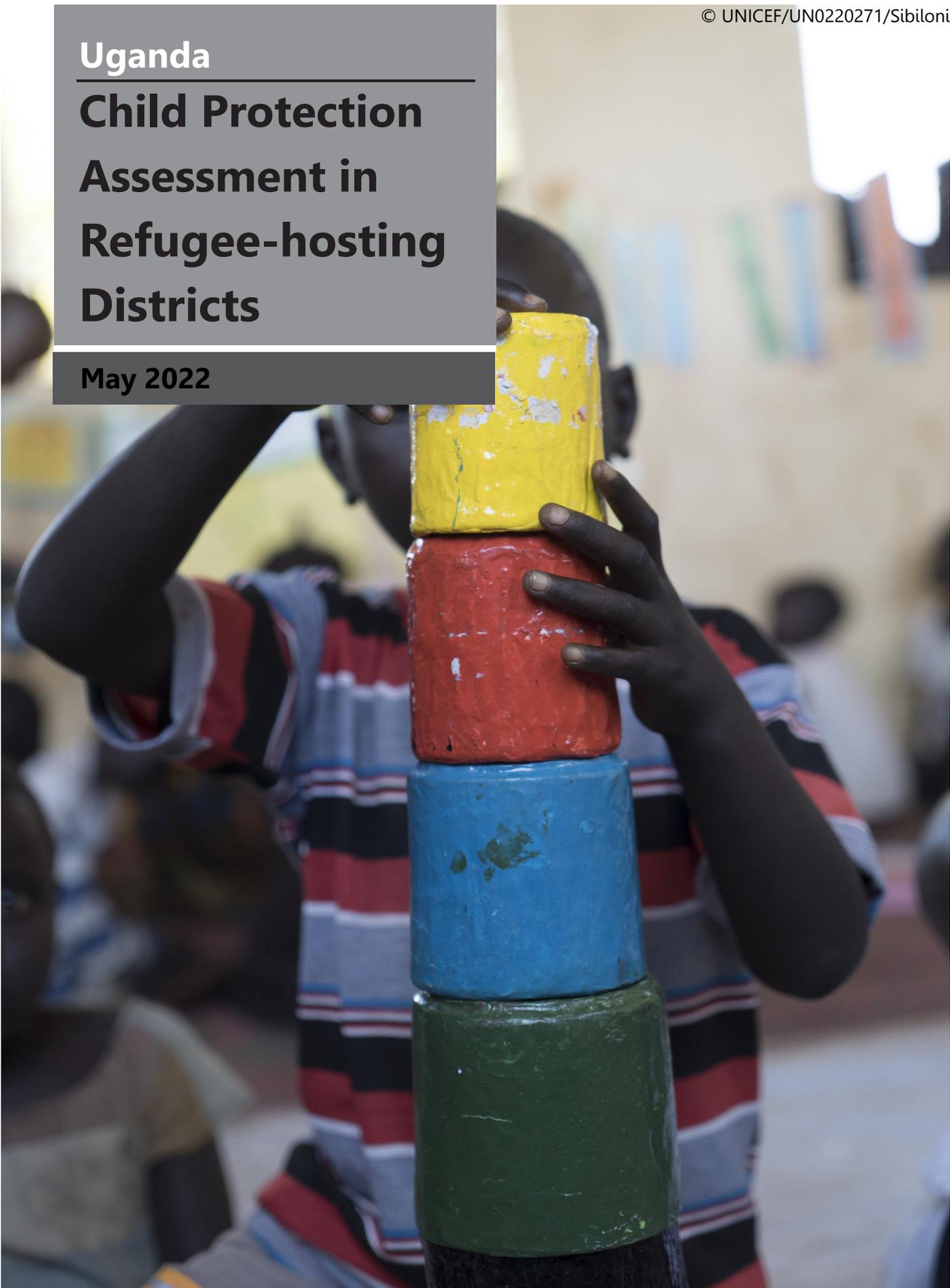


Uganda

**Child Protection
Assessment in
Refugee-hosting
Districts**

May 2022



Funded by
European Union
Civil Protection and
Humanitarian Aid



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Acknowledgements

This assessment was completed in partnership with the Child Protection Sub-Working Group (CPSWG) under co-leadership by UNHCR and UNICEF. In addition, child protection partners contributed to the collection of data in the field.



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Key Findings

Overview

- The risks refugee and host community children most frequently reported to be concerned about over the past three months are child labour, physical violence, and child marriage.
- The top three risks that refugee and host community caregivers reported having witnessed occurring in their communities over the past three months are child labour, child marriage, and physical violence.
- Caregiver respondents reported an increase of several child protection risks in their communities during the COVID-19 period. In particular, these risks include children engaging in harsh and dangerous labour, substance or alcohol abuse amongst caregivers and children, and sexual violence against children.

Child Labour

- In addition to reports of child labour, reports of harsh and dangerous labour have increased since the beginning of the COVID-19 period.
- There are only slight regional differences in the reported prevalence of child labour and these regional differences are only present amongst the refugee community.
- Reports show that adolescents (children between the ages of 12 and 17) are most likely to be affected.
- Causes for the increase in child labour related to COVID-19 are economic and socio-economic (e.g., loss of household income) and failure to engage children due to extensive durations of school closures from March 2020 to January 2022.

Violence Against Children (VAC)

- Proportion of caregivers reporting VAC occurring in their households is roughly similar across refugee and host communities.
- Among caregivers reports of VAC are more common in the West Nile region as compared to the south-west of Uganda.
- Physical violence and verbal abuse are the two most commonly reported types of violence.
- Caregivers report that girls are more likely to be affected as compared to boys.
- The main three causes of VAC as reported by caregivers are drug and alcohol abuse amongst adults, conflicts over resources, and high stress amongst adults.

Sexual Violence, Child Marriage, and Teenage Pregnancy

- Rates of sexual violence as reported by caregivers are similar across refugee and host communities.
- Rates of sexual violence as reported by caregivers do not vary at the regional level but are slightly more commonly reported by refugee caregivers in Imvepi, Kiryandongo, and Rhino Camp.

- The five most frequently reported places where sexual violence occurs are all public places including firewood collection areas, the market, and areas both inside and outside of the community.
- The three most common causes of sexual violence as reported by caregivers are COVID-19 related restrictions, lack of law-enforcement, and socio-economic conditions.
- Qualitative data strengthens findings from secondary sources indicating a rise in child marriages and teenage pregnancies during the COVID-19 period.

Psychological Distress

- Nearly two fifths of caregivers reported having observed mainly negative behaviour changes amongst children under their care during the COVID-19 period and almost one third of children in each community reported the same about their caregivers.
- Negative behaviour changes were more commonly reported in the West Nile region.
- Causes of psychological distress were reported to most often take the form of a lack of food, extra hard work for children, and children not being able to go back to school.

Unaccompanied and Separated Children (UASC)

- Separations were more commonly reported amongst the refugee community, most likely due to the increased risk of separation during flight or relocation.
- Separations were more commonly reported in the West Nile region as compared to the south-west.
- Data on UASC indicates that caregivers may have been under-reporting on this risk perhaps due to lack of clarity around the terminology amongst respondents.
- The most frequently reported cause of separation amongst both communities was death or illness of the caregiver.

Service Provision and Barriers to Access

- On average host community respondents reported much lower availability of services as compared to refugee respondents.
- The availability of child protection services as reported by refugees in Kampala is very low.
- Service provision is reportedly on average lower in the south-west as compared to the West Nile region.
- NGO staff, government, and police working in the child protection sector reported that COVID-19 has impacted their ability to provide services and has simultaneously led to a decrease in the availability of funds, causing further strain on already stretched resources.
- Service providers have reported both limited staff availability and capacity in the child protection sector.

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LIST OF ACRONYMS

CP	Child Protection
CPMS	Minimum Standards for Child Protection in Humanitarian Action
CPSWG	Child Protection Sub-Working Group
FGD	Focus Group Discussion
IDI	In-Depth Interview
KII	Key Informant Interview
MGLSD	Ministry of Gender, Labour, and Social Development
MHPSS	Mental Health and Psychosocial Support
OPM	Office of the Prime Minister
UAM	Unaccompanied Minor
UASC	Unaccompanied and Separated Children
VAC	Violence Against Children

INTRODUCTION AND BACKGROUND

As of 31st May 2022, Uganda is hosting more than 1.5 million refugees and asylum seekers, the largest number in the region. Most have fled civil unrest and conflicts in neighbouring countries of South Sudan, the Democratic Republic of the Congo (DRC), Somalia, and Burundi. According to interagency contingency plans, it is expected that there will be a steady refugee influx to Uganda over the next years due to ongoing conflicts, wars, unrest and human rights violations in neighbouring countries.⁰¹ The majority of refugees and asylum seekers are children making up over 61% (over 900,000) of the total registered refugee population in Uganda.⁰²

According to the May 2022 United Nations High Commissioner for Refugees (UNHCR) quarterly report on child protection, 19,803 children are unaccompanied or separated, there are 776 open cases of violence against children, abuse or neglect of children, and nearly 6,500 children have been identified to be at risk of violence, abuse, neglect, child labour, early marriages, and other risks.⁰³ The UNHCR quarterly child protection report from Q4 2021 indicates that the Child Protection (CP) sector has over 350 case workers and the case worker to child ratio then stood at 1:113, falling significantly short of the global case worker to child ratio standards of 1:25.⁰⁴ Moreover, child protection concerns such as violence against children, teenage pregnancies, child labour and child marriage have been exacerbated by the impact of COVID-19 in Uganda.⁰⁵ The closure of schools, child friendly spaces and the suspension of group-based activities since March 2020 has negatively affected capabilities for case identification of children at risk and children's overall positive development.⁰⁶

To provide both refugee and host community children with specialized protection services there is a need for coordinated and comprehensive effort among aid actors to ensure that all children of concern receive appropriate support in line with the national child protection system and guidelines, UNHCR's Framework for the Protection of Children, and the Child Protection Minimum Standards in Humanitarian Action (CPMS).

While partners in the Child Protection Sub-Working Group (CPSWG) are documenting and responding to CP concerns, there is a need to update and expand on the evidence-base currently underpinning the response. Much of the data currently informing the CPSWG partners is derived from mainly qualitative assessments focusing on one specific child protection concern or one geographic location. Partners thus expressed the need for a single, holistic assessment of child protection concerns and the effectiveness of services across the refugee response.

Child Protection Work in Uganda and Knowledge gaps

An assessment that includes comparable, statistically representative findings will provide valuable support to the CPSWG leads and their partners to guide in the implementation of the Refugee Response Plan (RRP) 2022 – 2025, the prioritisation of service coverage in line with needs, as well as in advocacy and fundraising efforts. As co-chairs of the CPSWG, UNICEF and UNHCR expressed the urgent need for a more data-driven child protection response, as the lack of quantitative, robust data significantly hinders CPSWG ability to ensure targeting according to needs and gaps while also obstructing their ability to make effective funding appeals. The latest comprehensive CP research was the Violence Against Children (VAC) assessment conducted in 2015 and was nationwide but not specific to refugee-hosting districts. Partners report they frequently cite this document in their design of programmes and funding appeals, despite the information not being specific to refugee hosting districts and being from 2015. The findings from this assessment will enable the CPSWG and its partners to develop more targeted programmes for the benefit of communities.

This assessment was conceived to establish an evidence-base and increase partner understanding of the prevalence and severity of child protection concerns currently affecting refugee children living in all thirteen settlements and Kampala, as well as host community children living in the sub-counties that host settlements. A particular focus was placed on how gender and age affect exposure to risks, and on assessing the effectiveness of services in place to assist affected communities.

01. [Operational Data Portal- Uganda Refugee Response Plan](#)

02. [UNICEF Uganda's emergency response to refugees](#)

03. [Uganda Refugee Response: Child Protection Case Management dashboard May 2021](#)

04. [Uganda Refugee Response: Child Protection Dashboard, Q4 2021](#)

05. [Impact of the COVID-19 Resurgence in Refugee Hosting Districts Uganda, July 2021](#)

06. [Uganda Refugee Response: Child Protection dashboard Quarter 2 2021](#)

METHODOLOGY

This assessment was comprised of two stages. The first stage was a secondary data review (SDR) and the second stage involved primary data collection. During the SDR a review of published partner reports was conducted in addition to a general review of information on child protection in Uganda. This helped identify the existing information gaps and specific CP concerns in the Ugandan context. In addition, information gathered during the SDR was used to provide contextualization and insights into the current CP landscape in Uganda to help inform the primary data collected in the second stage of this assessment. The primary focus of data collection was refugee populations, but a limited sample of host community respondents living in refugee-hosting districts were also targeted to ensure their inclusion in the overall findings and allow for a comparison between host and refugee populations. For the purposes of this assessment, as is standard in the Ugandan refugee response, the host community is defined as those living in the vicinity of (the sub-counties covering) the refugee settlement areas.

Primary data collection followed a mixed-methods approach using quantitative and qualitative interviewing techniques. Two quantitative surveys were developed in collaborative efforts between REACH, the CPSWG co-chairs at national and field level, as well as sector members. The below surveys were included:

1. One of the surveys targeted both refugee and host community caregivers to children 17 years or younger.
2. The other was aimed at both refugee and host community children aged 12 – 17.

The caregiver survey was administered at household-level whereby the head of household was targeted. The survey aimed at children was an individual-level survey. The sample for both refugee and host community children (individual) and caregiver (household) surveys were drawn using a stratified random sampling approach, with strata determined by geographical location. A purposive sample were also drawn for urban-based refugees living in Kampala. For this group, random sampling was not an option since generating reliable random GPS points based on data currently available was not feasible in the city environment. Data collection took place between the 31st of January and the 17th of March 2022.

Simultaneous to quantitative data collection, qualitative data was collected in five out of 13 refugee-hosting districts. The five districts were purposively selected as refugee settlements with diverse contexts to represent the wider response. These five locations included Adjumani,⁰⁷ Bidibidi, Kiryandongo, Kyaka II, and Nakivale. Qualitative data collection was comprised of a mix of Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs).

1. KIIs were conducted with child protection humanitarian response actors, as well as relevant government institutions such as OPM and MGLSD that coordinate the response or provide CP services.
2. FGDs were held with refugee children aged 12 – 17 years, as well as refugee caregivers. Both FGDs with caregivers and children were organized by gender to capture relevant differences in experience and perceptions.
3. In-depth Interviews (IDIs) were held with primary recipients of CP services such as refugee foster caregivers, child-headed households and children at risk (including specifically teenage mothers/pregnant girls) and unaccompanied children aged 12-17.

The refugee samples for both caregivers (household-level) and children (individual) allow for findings with a 95% confidence level and an 8% margin of error at the settlement level. The host community samples for both caregivers (household-level) and children (individual) allow for findings with a 95% confidence level and an 8% margin of error at the regional level (see figure 01 for a definition of which settlements were grouped into which region for the purposes of this assessment).

Sampling followed a stratified random sampling approach, with sample sizes calculated based on the most updated population figures from the Office of the Prime Minister (OPM) Refugee Information Management System (RIMS) for refugees, and the Uganda Bureau of Statistics (UBOS) for host community population figures (see table 01 for exact sample sizes by location). GPS points were randomly generated within the boundaries of the settlement for refugee interviews, and

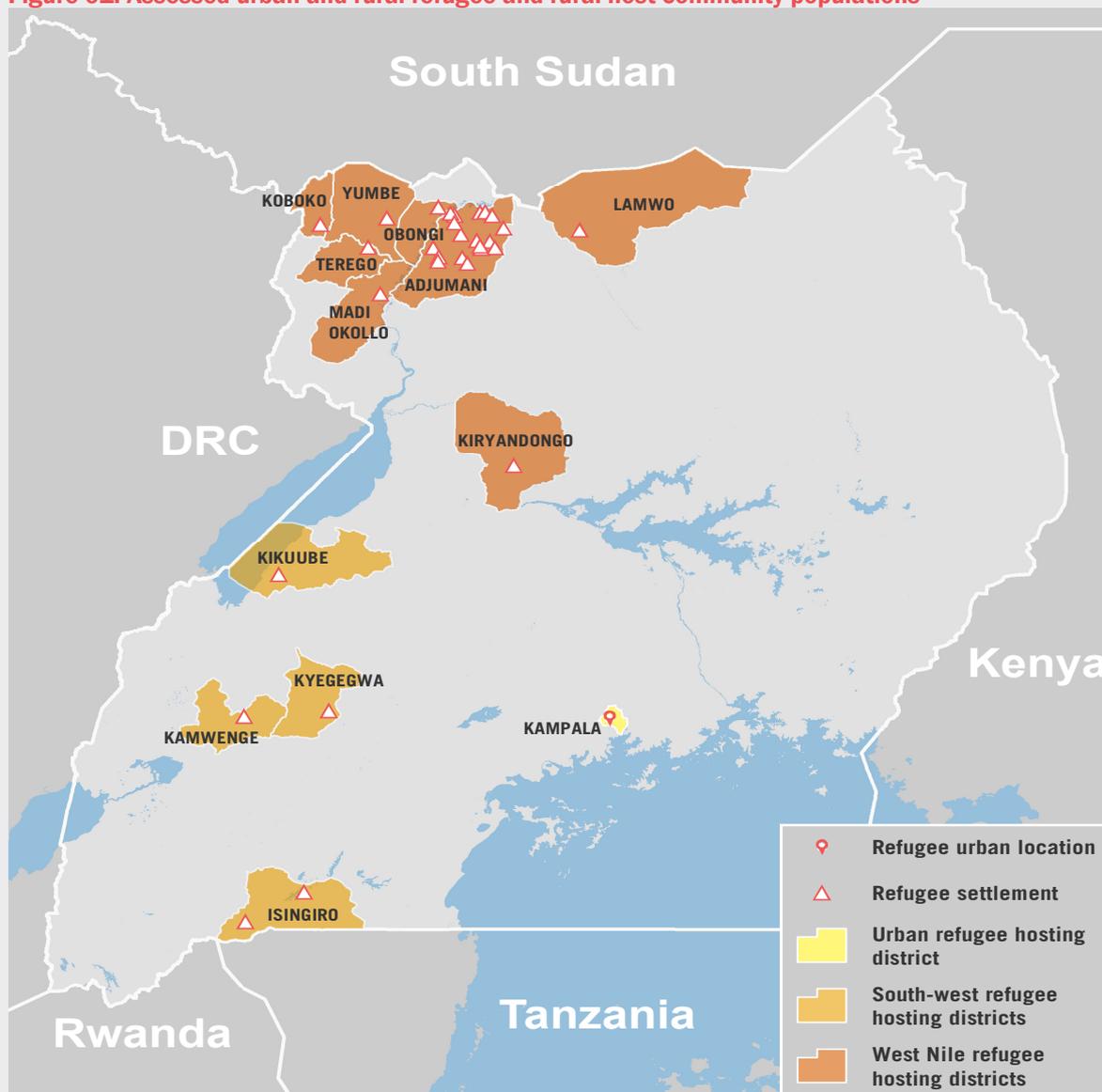
07. Adjumani is a district housing 19 refugee settlements of various sizes (1,000-50,000 individuals) which, for the purposes of this assessment were grouped into one large settlement. The total refugee population in Adjumani district is over 241,000 individuals.

within the parishes covering the settlement for host community interviews. In cases where multiple eligible persons were present in one household, enumerators randomised the selection of respondents within the household.

Area of study and Population of Interest

For refugees: All refugee settlements in 13 refugee-hosting districts (Rhino, Imvepi, Bidibidi, Palorinya, Lobule, Adjumani, Palabek, Kiryandongo, Kyangwali, Kyaka II, Rwamwanja, Nakivaale, Oruchinga) plus Kampala (Central and Makindye division). For host community: All sub-counties that lie within refugee-hosting districts and that cover the settlement area. Refugee-hosting districts included were (Adjumani, Madi-Okollo, Terego, Kikube, Isingiro, Koboko, Kamwenge, Kyegegwa, Kiryandongo, Lamwo, Obongi, Yumbe) (see figure 01).

Figure 01: Assessed urban and rural refugee and rural host community populations



The main populations of interest for quantitative data collection were a) refugee households with caregivers to children below the age of 18; b) host community households with caregivers to children below the age of 18; c) refugee children aged 0 – 17 years (Note that only children above the age of 12 were targeted for interviews); and d) host community children aged 0 – 17 years.⁰⁸

08. Although children with disabilities were not the focus of this assessment, respondents were asked if they or anyone living in their household has a disability or chronic illness at the time of data collection. This report will reflect whether or not assessment results differ for families with and without a member with a disability or chronic illness

In lieu of accurate population figures for each population, sample size was calculated based on available statistics on the superseding populations, e.g., total number of refugee households per location, number of host community households per location. A randomized sample was drawn based on available data since experience has shown that the number of refugee households containing a caregiver and children below the age of 18 is very high, meaning the chance of running into ineligible households during data collection is limited.

Definition of “caregiver”:
For purposes of this assessment, a caregiver is defined as any person bearing primary responsibility of care for any child below the age of 18.

The main populations of interest for qualitative data collection were a) child protection practitioners (both humanitarian and local government); b) community members (both caregivers and children); and c) primary recipients of CP services.

Table 01: Sample sizes by location, survey and community type

Settlement / District	Refugee Children	Refugee Caregivers	Host community Children	Host community Caregivers	Total
Adjumani*	161	166	32	31	390
Bidibidi / Yumbe*	160	167	58	67	452
Imvepi / Terego	162	165	22	22	371
Kiryandongo*	174	165	23	22	384
Kyaka II / Kyegegwa*	152	167	35	40	394
Kyangwali / Kikuube	161	172	30	33	396
Lobule / Koboko	150	150	8	9	317
Nakivale / Isingiro*	166	167	80	77	794
Oruchinga / Isingiro	152	152			
Palabek / Lamwo	168	149	8	7	332
Palorinya / Obongi	165	165	4	4	338
Rhino Camp / Madi Okollo	165	168	10	10	353
Rwamwanja / Kamwenge	165	168	15	13	361
Kampala	127	138	-	-	265
Total	2,220	2,259	325	335	5,139

*Qualitative data collection locations

Limitations

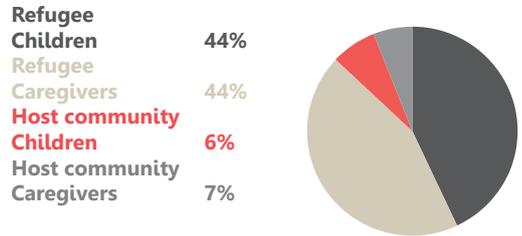
- Questions relating to specific child protection risks aimed at assessing slightly different things amongst caregiver and child respondents. In particular, children were asked about their personal experiences with certain risks while caregivers were asked either about the occurrence of the risks in their own households or in their communities. This means that data from these two sources are generally not comparable.
- In addition, there are incentives for caregivers to under-report different risks occurring in their own households due to the sensitive nature of the topics discussed. On the other hand, the occurrence of risks in the community at large may be overreported since one incident may have been witnessed by several respondents.
- Although the questionnaire administered to caregivers, included separate questions on unaccompanied and separated children, survey results indicate that interviewees were unable to effectively distinguish between these two categories of children. Thus, results reporting the level of prevalence of UASC should be read to be indicative rather than representative.
- Because only five locations were included in the collection of qualitative data, and because the child protection contexts in each of the thirteen settlements in Uganda are diverse, it is possible that this report glances over or overlooks some situations that are encountered in settlements not targeted for the qualitative data collection component.

DEMOGRAPHICS

Refugee respondents in the settlements and the host community

Due to the methodology chosen, a majority (87%) of respondents interviewed for this assessment were refugees. Amongst refugee respondents the proportions of caregivers and children interviewed were equal (50% respectively or 43.5% of the overall sample respectively). Thirteen percent (13%) of respondents interviewed were host community members also almost equally split between caregivers (51% of all interviewed host community members or 7% of the overall sample) and children (49% of interviewed host community members or 6% of the overall sample) (see figure 02).

Figure 02: Proportion of respondents by community and survey type



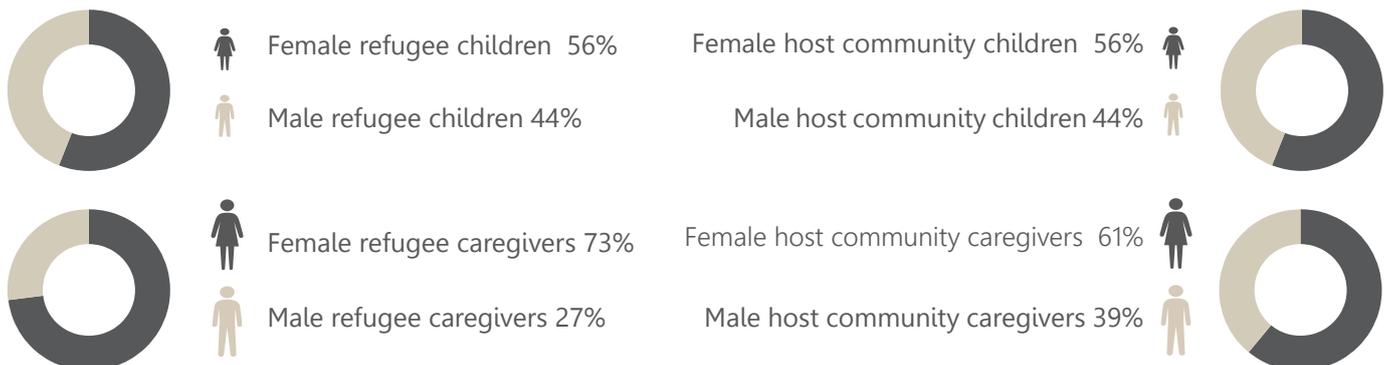
Age: Due to the level of maturity of children and the complexity of the questions, this assessment did not target any children below 12 years. About half of all interviewed children were between the ages of 12 and 14 and 15 and 17 respectively (see figure 03). Amongst caregivers, a majority of respondents were working-age adults while minorities were older persons and children.

Sex: More female than male children were interviewed in the refugee settlements and hosting districts (see figure 04). Similarly, respondents to the caregiver survey in both communities were slightly more likely to be female. Contextually, this aligns with the majority of the refugee population consisting of women as well as the tendency of refugee and Ugandan women to remain at home to complete household work during the day while men are more likely to leave the home during the day to look for work.

Figure 03: Age breakdown of child (top) and caregiver (bottom) respondents in refugee settlements (left) and refugee hosting districts (right)

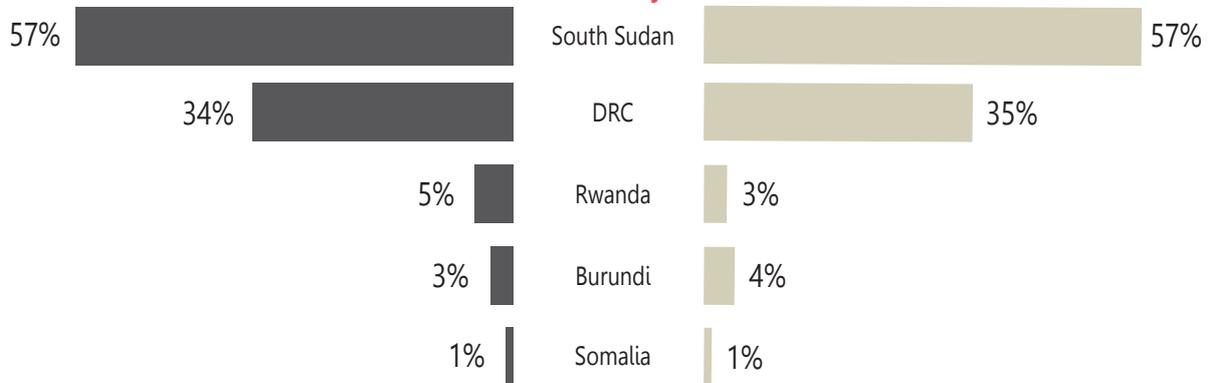


Figure 04: Gender breakdown of child (top) and caregiver (bottom) respondents in refugee settlements (left) and refugee hosting districts (right)



Nationality: Amongst refugee children and caregivers interviewed in settlements, a majority were South Sudanese, about one third were from the Democratic Republic of Congo (DRC) and minorities were from Rwanda, Burundi, and Somalia (see figure 05).

Figure 05: Proportion of refugee respondents by survey type (children on the left, caregivers on the right) and their nationality

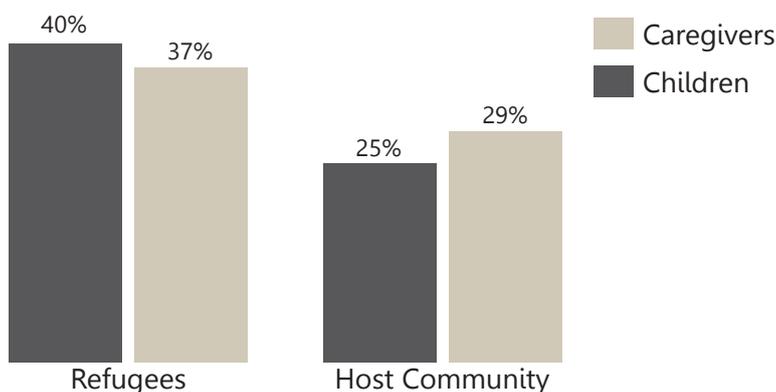


Disability and chronic illness: Similar proportions of caregivers and children from both refugee and host communities report living in a household with at least one member with a chronic illness or a disability. These proportions are slightly larger for the refugee population (40% of children and 37% of caregivers) as compared to the host population (25% of children and 29% of caregivers) (see figure 06).

When asked which role is held in the household by the person with a chronic illness or disability, a majority of respondents from all demographic groups that had reported living with a household member with a chronic illness or a disability, reported that that household member is a child. In fact, over 51% of all host community children, 56% of all refugee children, 57% of host community caregivers and 55% of refugee caregivers who reported living with a household member with a disability or chronic illness, reported that this individual is a child.

It is important to note that the indicator used for the purposes of this assessment captures all household members that are reported to have a disability or chronic illness that affects their abilities to perform routine tasks. This includes members of the household who may have difficulty seeing, hearing, walking, concentrating, communicating in their language and making themselves understood, or with self-care such as washing or getting dressed without help. However, this assessment did not use the Washington group set of questions, rather a modified set of questions was used which also included a condition about chronic illness. In other words, the definition used for this indicator for the purposes of this assessment is broad and should not be understood to measure prevalence of disability alone or on an individual level. Rather it is used to indicate whether the experiences of households who include at least one member with a disability or chronic illness, differ from the experiences of households who do not.

Figure 06: Proportion of respondents reporting living in a household with at least one member with a chronic illness or disability by survey and community type



Education: Reported education levels amongst refugee and host community caregivers are similarly low with 62% of refugee caregivers and 61% of host community caregivers reporting having only a low level of education⁰⁶ (see figure 07). However, this is slightly more pronounced amongst refugees as 32% of refugee caregivers reporting having no education at all compared to 21% of host community caregivers. This corresponds with slightly higher proportions of host community caregivers reporting middle (12%) and higher (4%) levels of education as compared to their refugee counterparts (6% reporting

Figure 07: Proportion of caregivers by community type and their highest achieved level of education⁰⁹

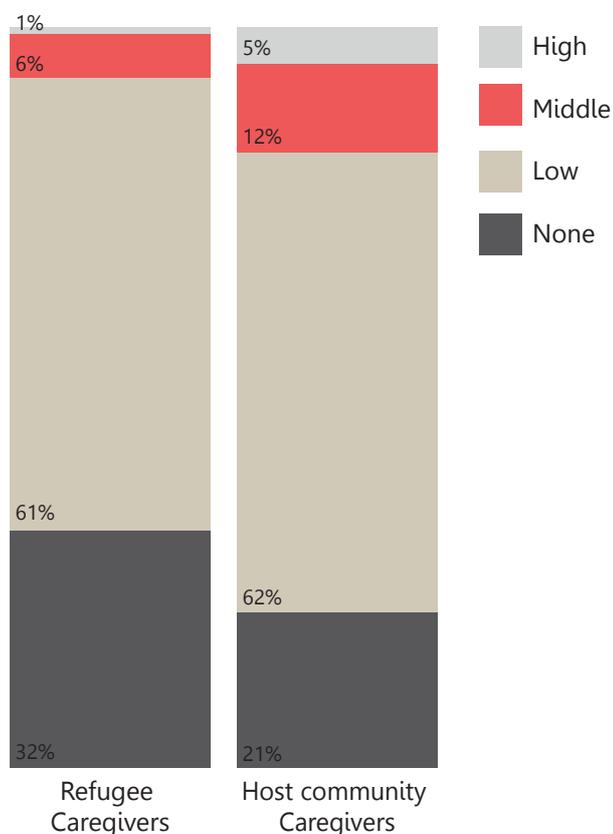
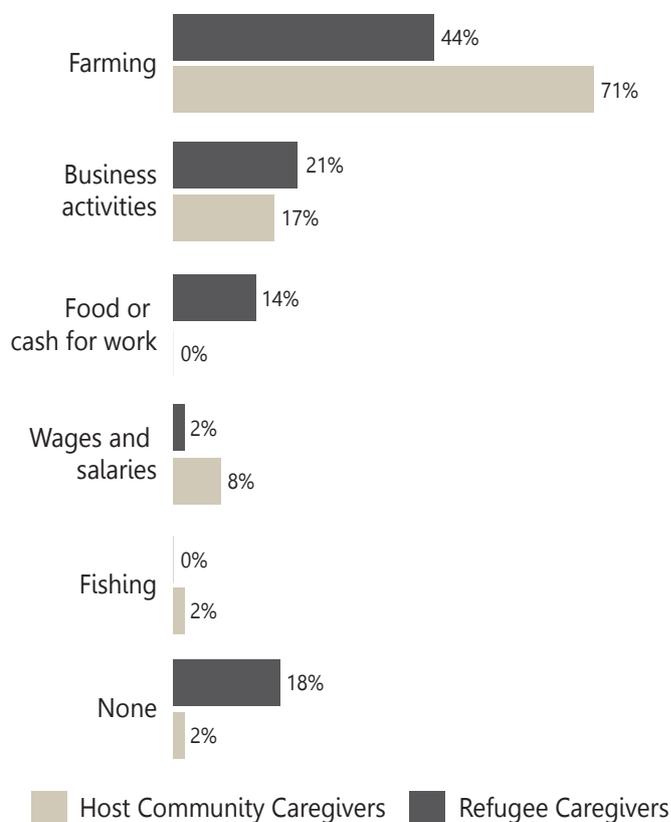


Figure 08: Proportion of caregivers by community type and their reported main income generating activity



middle- and 2% higher-level education). Reports from caregivers align closely with those from child respondents.

Household economic activities: When asked about the household’s main income generating activity, farming and business activities were most frequently named by both refugee and host community caregivers (see figure 08). However, 18% of refugee caregivers also reported “none” in comparison to only 3% of host community caregivers. This in combination with the slightly lower reported education levels amongst refugee caregivers may indicate lower economic stability and access to livelihood opportunities amongst refugee households as compared to host community households.

Demographics of Refugees in Kampala

In Kampala, only refugee children and caregivers were interviewed. Host communities were not included for this location. As noted in the methodology section, the Kampala sample is not representative, so findings presented in the sections related to Kampala should be taken as indicative only. The samples for caregivers and children are also relatively small, so the number of possible disaggregations is limited. The split between caregivers and children in the sample is close to even. A total of 127 children aged 12-17 were interviewed (48% of Kampala sample) and 139 caregivers were interviewed (52% of Kampala sample).

Age: No children under the age of 12 were interviewed. The age distribution of children in the Kampala sample matches the distribution of refugee children in the settlements, with a small majority of respondent children being 12-14 years old (see figure 10). The age distribution of caregivers also closely matches the distribution of refugees in the settlements, with the large majority of respondents being of working age.

09. For the purposes of this assessment, respondents were classified as having a “high” level of education only if they reported completed a university or professional degree; as having a “middle” level of education if they had an incomplete university or professional degree, or if they had completed secondary

education or a vocational training; as having a “low” level of education if they reported having begun but not completed secondary education or if they had either completed or not completed primary education.

Figure 09: Gender breakdown of child (left) and caregiver (right) respondents in Kampala



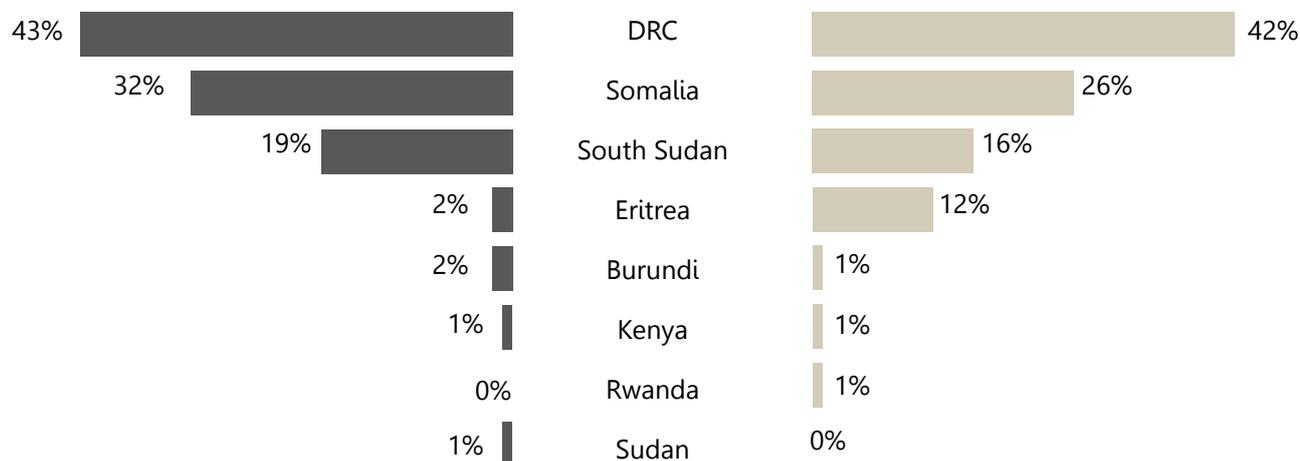
Figure 10: Age breakdown of child (left) and caregiver (right) respondents in Kampala



Sex: Female respondents make up the majority of both the child and caregiver samples in Kampala (see figure 09). The gender imbalance in the sample is especially large among caregivers. This is likely due to the same dynamic mentioned in the section above, where refugee households are more likely to be women-headed.

Nationality: The composition of the Kampala sample is quite different from the settlements when it comes to nationality (see figure 11). The main differences are that there are relatively fewer refugees from South Sudan (19% of children and 16% of caregivers in Kampala) and instead, the largest group consists of refugees from DRC (43% of children and 42% of caregivers). There is also a larger proportion of Somali refugees (32% of children and 26% of caregivers).

Figure 11: Proportion of respondents in Kampala by survey type (children on the left, caregivers on the right) and their nationality



Disability and chronic illness: As with the refugee population in the settlements, children in Kampala were slightly more likely to report living in a household with at least one member with a chronic illness or a disability (see figure 12). Among all child respondents in Kampala, 23% reported that they themselves have a chronic illness or disability.

Figure 12: Proportion of respondents in Kampala reporting living with a household member with a chronic illness or disability by survey type



It is important to note that the indicator used for the purposes of this assessment captures all household members that are reported to have a disability or chronic illness that affects their abilities to perform routine tasks. This includes

members of the household who may have difficulty seeing, hearing, walking, concentrating, communicating in their language, and making themselves understood, or with self-care such as washing or getting dressed without help. In other words, the definition used for this indicator for the purposes of this assessment is broad and should not be understood to measure prevalence of disability alone or on an individual level. Rather it is used to indicate whether the experiences of households who include at least one member with a disability or chronic illness, differ from the experiences of households who do not.

Education: Caregiver respondents in Kampala appear to have achieved generally higher levels of education than the refugees in the settlements (see figure 13). As per the demographics section on the settlements, 32% of refugees in settlements reported having completed no formal education. In contrast, 19% of interviewed refugee caregivers in Kampala finished no education. Additionally, 42% of the caregiver respondents in Kampala reporting having achieved middle or high education, compared to 7% of refugees in the settlements.

Figure 13: Proportion of caregivers in Kampala by their highest level of education achieved

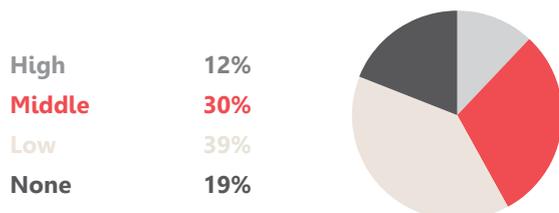
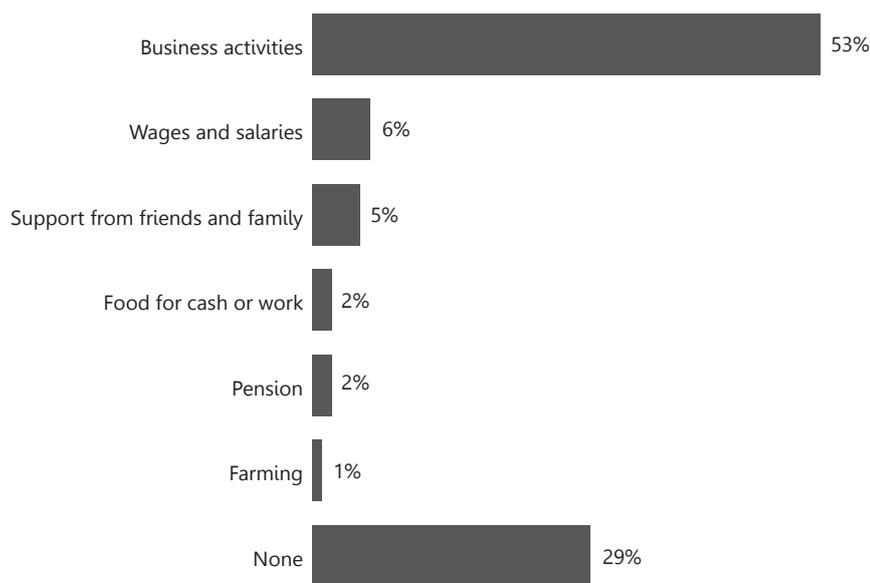


Figure 14: Proportion of caregivers in Kampala by their reported main income generating activity



Household economic activities: The main income generating activities reported by caregivers in Kampala differ to some extent to the activities reported by refugees in the settlements. The key difference is that the most commonly reported main economic activity among respondents in Kampala is business activities (see figure 14). The most commonly reported activity among refugees in the settlement was farming, which was the least commonly reported income generating activity in Kampala. Furthermore, a higher proportion of refugee caregiver in Kampala reported engaging in no income generating activities (29%) compared to refugee caregivers in the settlements (18%). It is important here to reiterate that the findings for Kampala are not representative, but indicative only.

CHILD PROTECTION RISKS

Overview of Risks

All four main demographic groups assessed for this report (i.e. children and caregivers in refugee and host communities) agree on the top prevalent risks children in their communities have been concerned about over the last three months (please note that children were asked about their concerns so it refers to their perception of risks rather than their own immediate experience.¹⁰ Caregivers were asked: “In the past three months, which risks to the protection of children have you or members of your household witnessed most in your community?”). However, respondents were not always in agreement on the ranking of these risks. For example, 33% of refugee and 31% of host community children, report that they were concerned about “no particular risk” over the last three months and thus appear to be less worried about child protection risks overall than caregivers (see figures 15 and 16). This may be linked to the children’s understanding and awareness of risks differing to that of caregivers.

10. The specific question asked to children was: “In the past three months, which protection risks or threats have you been most concerned about for your safety?”

All groups agree that child labour is both the risk that children worry most about and that is actually occurring in refugee and refugee-hosting communities in Uganda.¹¹ In addition, physical and sexual violence, which are both considered under the umbrella of violence against children (VAC), child marriage and child neglect are risks that children worry about and that caregivers have witnessed affecting children living in their communities. The proportions of refugee and host community caregivers reporting on these risks is roughly equal, indicating similar levels of severity in the two communities.

However, disaggregation by region shows that refugees and host community members living in the West Nile region report a higher prevalence of risks overall and in particular for physical violence and child marriage, as compared to those living in the south-west. In fact, only 26% of refugee children and 17% of refugee caregivers in the West Nile report “no particular risk” when asked which risks they are concerned about or have witnessed in the last three months.

In comparison, these proportions stand at 42% and 35% respectively for their counterparts in the south-west. Host community respondents reported a similar difference between the two regions. This discrepancy between the regions is mainly caused by higher proportions of children and caregivers of both communities reporting either worrying about or having witnessed child marriage or physical violence in the West Nile region as opposed to the south-west. This indicates that child respondents in the West Nile overall, as compared to those in the south-west, are more concerned about child protection risks. Similarly, this data shows that caregivers in the West Nile, as compared to those in the south-west, are more likely to report to have witnessed a child protection risk taking place in their community. This in turn may indicate a higher prevalence of child protection risks in the West Nile as compared to the south-west region. A detailed discussion on this can be found in the sections on “violence against children” and “sexual violence, child marriage and teenage pregnancy”.

Figure 15: Top six risks that refugee and host community children report to have been most concerned about over the past three months¹²

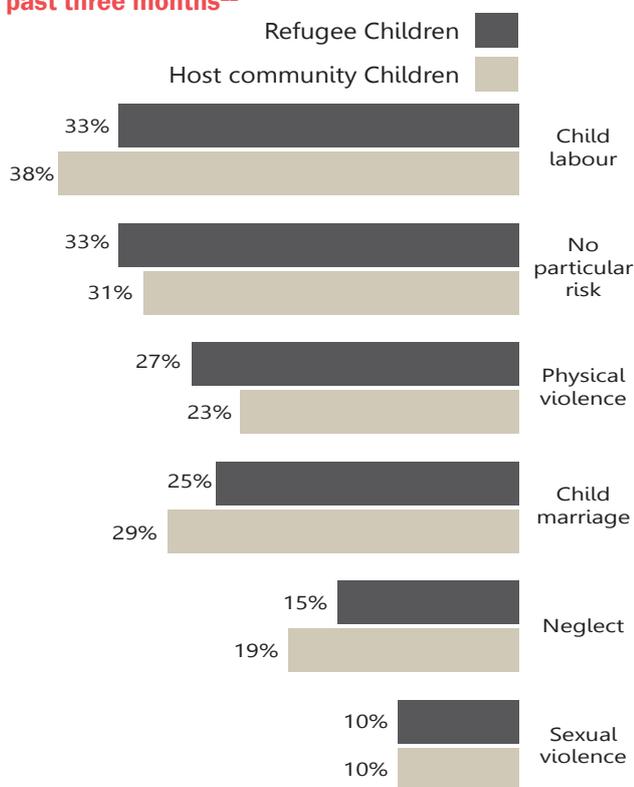
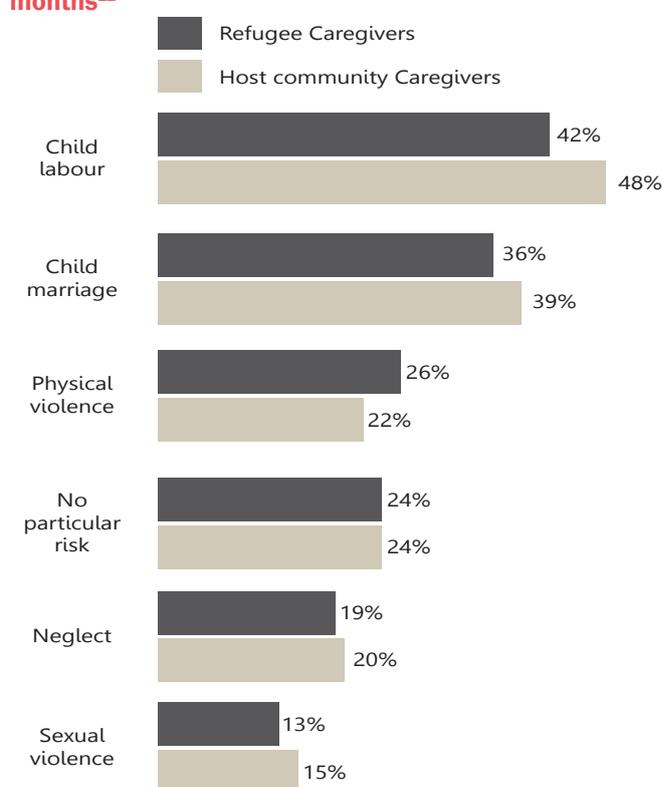


Figure 16: Top six risks that refugee and host community caregivers reported having witnessed over the past three months¹²

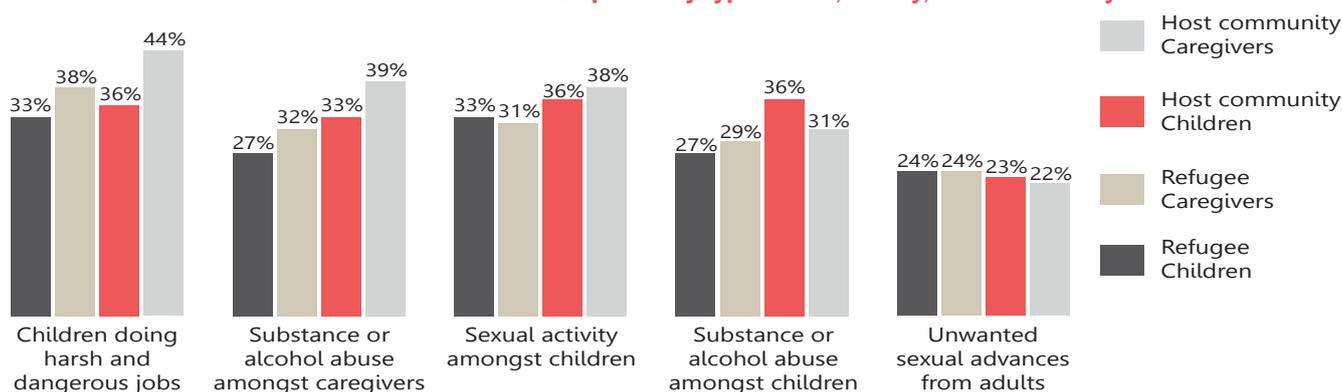


11. Note that caregivers were asked about risks they have witnessed in their wider communities because they were assumed to be better positioned to report on individuals other than themselves while children were asked to reflect only on their own feelings.

12. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Finally, it is important to note that when results from caregivers are disaggregated by those who have reported living with a household member with a disability or chronic illness, refugee caregivers living with a household member with a disability or chronic illness were less likely than other caregivers to report having witnessed child labour in their communities (37% vs 45%). In contrast, host community caregivers living with a household member with a disability or chronic illness were more likely than other caregivers to report having witnessed abandonment of children in their community (16% vs. 8%).

Figure 17: Proportions of respondents reporting perceiving that child protection risks have increased in their community, since the start of the COVID-19 period by type of risk, survey, and community¹³



Impact of COVID-19

Respondents from all demographic groups agreed that child protection risks in their communities increased during the COVID-19 period. Specifically, respondents from all demographic groups agreed that children doing harsh and dangerous labour, drug abuse amongst caregivers and children, and sexual violence against children are key risks that have increased since the start of the pandemic (see figure 17). Analysis in the sections on child labour, VAC, sexual violence, and psychological distress discusses some of these increases and decreases in household income and food security.

Outline

This report will discuss each of the risks identified that are the most concerning or most frequently witnessed as reported by children and caregivers respectively. First, the reader will find a section on child labour discussing its prevalence, key disaggregations, types of child labour as well as the availability, use, and effectiveness of services targeting this specific risk. Subsequently, there is a section on VAC which includes a discussion on physical violence based on responses from caregivers. Although sexual violence is also a part of VAC, it has been placed into a section of its own and is discussed, based on caregiver responses, and in conjunction with child marriage as well as teenage pregnancy. Finally, neglect is discussed as part of the section on psychological distress, which precedes sections on UASC and other risk. Although each section includes a discussion on protection services dedicated to that particular risk, the report also includes a discussion on child protection service delivery in general and how COVID-19 and preventive measures against it have impacted these.

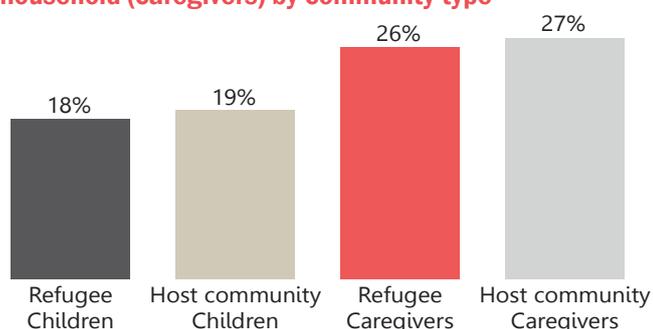
The reader is encouraged to note the difference between risks that children are concerned about and that caregivers have witnessed in their wider communities and the levels of risks reported to have occurred in assessed households. For example, 42% of refugee and 48% of host community caregivers report having witnessed child labour taking place in their communities in the last three months, but only 26% of refugee and 27% of host community caregivers report that a child in their household currently engages in child labour. These proportions all assess different things (e.g., personal experience vs. witnessed in the community vs. witnessed in the household) and thus are not directly comparable. Readers should further keep in mind that many of the indicators reported here are susceptible to being underreported (please see the “limitations” section for further details on reporting bias).

13. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Child Labour

The prevalence of child labour as reported by caregivers is slightly higher as compared to the prevalence reported by children in both community types. More specifically, 26% of refugee caregivers and 27% of host community caregivers report that a child in their household is engaged in child labour. In comparison, only 18% of refugee and 19% of host community children report engaging in child labour themselves (see figure 18).

Figure 18: Proportion of respondents reporting engaging in child labour (children) or it occurring in their household (caregivers) by community type



Definition of “child labour”: For purposes of this assessment, child labour is defined as work that exceeds a minimum number of hours, depending on the age of a child and on the type of work.¹⁴ Child labour can include domestic chores as well as economic labour depending on the number of hours the child is made to perform these tasks. Relevant age groups are <5, 5 – 11, 12 – 14, 15 – 17. The table below shows the thresholds for each type of labour and the given age groups. If either or both of the conditions are met, the child is considered to have engaged in child labour.¹⁵

Age group	Threshold for domestic chores	Threshold for economic labour
<5 years	at least 1 hour a week	at least 1 hour a week
5-11 years	at least 21 hours a week	at least 1 hour a week
12-14 years	at least 21 hours a week	at least 14 hours a week
15-17 years	no threshold	at least 43 hours a week

In addition, it is important to note that these proportions are lower than those reported when respondents were asked about the occurrence of child labour in the communities at large (e.g., outside of their own household) (see page 15 for exact percentages). This difference may be a result of the calculation done to assess whether a child qualifies as having engaged in child labour or has engaged in domestic chores or economic work which does not qualify as child labour (see definition box above). More specifically, the lower proportions reported in this section were calculated using the official definition of child labour while the proportions reported in the overview on page 12 include self-assessed involvement in child labour which may have caused over-reporting due to a lack of knowledge around the official definition.¹⁶ In sum, the lower but nevertheless concerning proportions reported in this section, may be slightly more accurate.

When disaggregating geographically, caregivers report no regional differences with 28% of refugee caregivers in the south-west and 24% in the West Nile region reporting that children in their household engage in child labour. These proportions are nearly identical amongst host community caregivers. In contrast, 24% refugee children in the south-west report that they are engaging in child labour while this proportion stands at only 14% in West Nile region. Although, host community children also report slightly lower rates of child labour in the West Nile (18%) as compared to the south-west (22%), this difference is not as pronounced. In sum, the data indicates that there is no geographic difference in the rates of child labour amongst the host community.

Table 02: Proportion of refugee respondents reporting child labour by settlement

Settlement	Refugee Children	Refugee Caregivers
Kyangwali	31%	36%
Nakivale	23%	23%
Rwamwanja	21%	29%
Oruchinga	20%	25%
Kyaka II	20%	24%
Rhino Camp	18%	39%
Adjumani	17%	23%
Imvepi	15%	21%
Kiryandongo	15%	44%
Palorinya	13%	23%
Lobule	12%	25%
Palabek	11%	21%
Bidibidi	8%	13%

14. In order to calculate the proportion of households in which child labour is taking place, respondents were asked if they themselves (in the case of children) or children in their household were performing domestic chores and/or economic labour and if so, how many hours a week the children were engaged in these tasks.

15. Definition of child labour taken from UNICEF

16. Data collected by interviewing children allowed for calculation of whether

or not a child has undergone child labour based on the method described in this definition. However, data collected by interviewing caregivers did not. Therefore, if a child mentioned in the caregiver survey fulfilled one of the conditions defined here, it was determined to have undergone child labour. However, it was not possible to check for both thresholds for each child. Meaning, if a child met both conditions, it would have been counted twice in the caregiver survey.

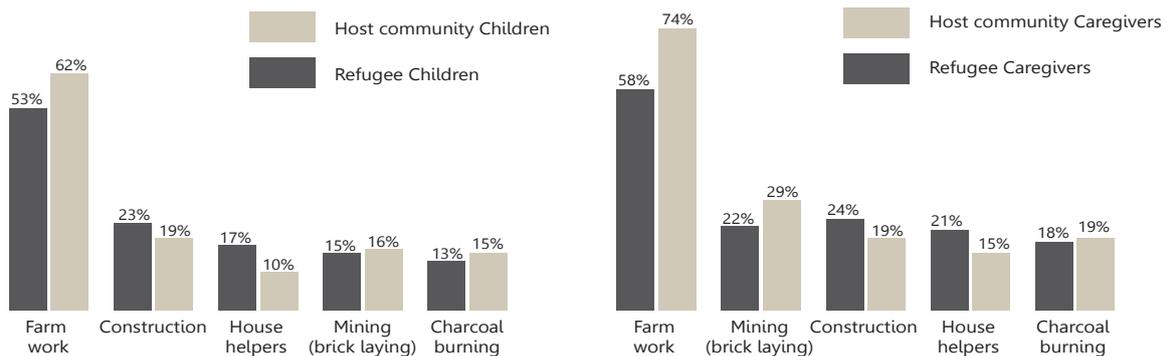
to be somewhat lower in the West Nile as compared to the south-west region, table 02 shows that there is no clear indication of which settlements are most affected.

Disaggregating the data by age shows that all those children reporting being engaged in child labour are adolescents. This is unsurprising given the fact that only children that were 12-years of age or older at the time of data collection were interviewed about their experiences. Further, most children included in this group reported to be between 12 and 15 years old. This could be explained by the higher threshold for child labour applying to 15-17-year-olds (see definition box on page 17). Reports from caregivers align with these findings but also highlight that some younger children (specifically 5-11-year-olds) are also affected.

No differences were found when disaggregating the data by sex or when accounting for households who reported having a member with a disability.

Children from both communities agree on the top five most common types of economic work they engage in. These include farm work, construction, house helpers, mining (e.g., brick making), and charcoal burning. Reports from caregivers align with this data (see figure 19). The children engaging in economic labour are most commonly paid in cash, with 83% of refugee and 92% of host community children who report being involved in economic labour, reporting this modality. The second most frequent type of payment is food.

Figure 19: Top five most commonly reported types of economic work children are involved in as reported by refugee and host community children and caregivers¹⁷



Harsh and Dangerous Labour

Similar proportions of respondents from all main demographic groups report that children in their wider communities are involved in harsh or dangerous work. In the context of this assessment, this is a category of work that includes exposure to physical, emotional or sexual abuse, extreme working environments including extreme heat, dangerous machinery or heavy loads and other difficult conditions (see definition box on the right

Definition of “harsh or dangerous labour”: For the purposes of this report, harsh and dangerous labour is defined as work that is performed by children in dangerous and unhealthy conditions that can lead to a child being killed, injured or made ill as a result of poor safety and health standards or employment conditions. This includes work that interferes with schooling, is excessively difficult or performed over long hours, or takes place in a hazardous environment or may impact on children’s physical or mental health in the short, medium or long term.

as well as figure 20). More specifically, 22% of refugee and 27% of host community children and 28% of refugee and 33% of host community caregivers report that children in their community are involved in these types of labour. Specific types of harsh and dangerous work reported by caregivers in both community types are the same and most frequently include construction, charcoal burning, handling of heavy loads, bonded labour, stone quarrying, and sand mining.

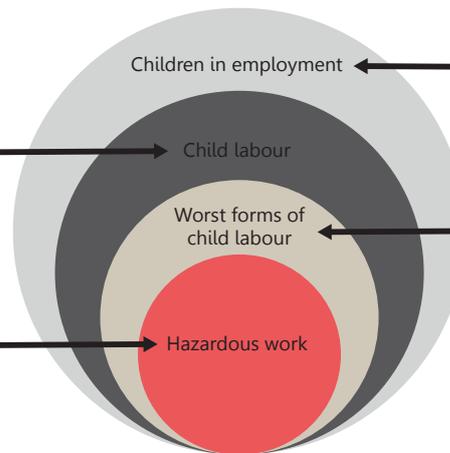
The reported prevalence of harsh and dangerous labour may be due to an accepted culture of children helping adult household members with chores. Although only 10% of each of the main demographic groups interviewed agreed or strongly agreed that it is acceptable for a child to perform a dangerous job to earn money; 49% of host community

17. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 20: Categories of child labour¹⁸

Work performed by children that is:
 • mentally, physically, socially, or morally dangerous and harmful to children; and/or
 • interferes with their schooling
 This includes hazardous unpaid household services.

All forms of child labour that involve:
 • Exposure to physical, psychological, or sexual abuse;
 • Work underground, under water, dangerous heights, confined spaces;
 • Dangerous machinery or heavy loads;
 • Unhealthy environments;
 • Long hours, work at night, other particularly difficult conditions.



Children below 18 years of age engaged in any activity to produce goods or to provide services for use by others or for their own use

- All forms of slavery
- The use of children for prostitution or for the production of pornography
- The use of a child for illicit activities
- Hazardous work

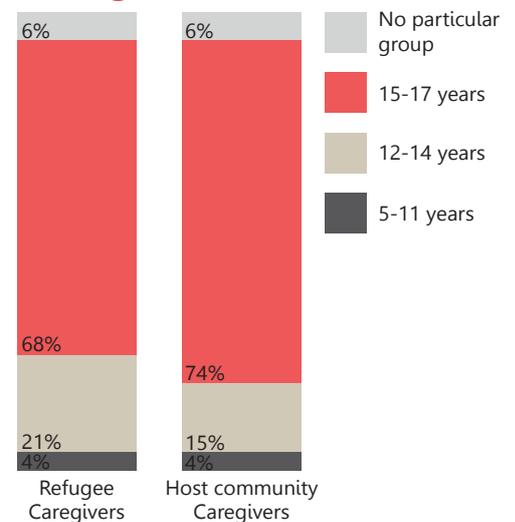
children and 46% of host community caregivers agree or strongly agree that it is acceptable for children to do chores that require a lot of strength. This reflects an overall acceptance of caregivers to engage children including those of young age in household chores. Examples given when asking this question were collecting water or firewood. These proportions are very similar amongst the host community. Triangulation with qualitative data further strengthens this hypothesis:

“Mainly children from 10 years-old [and above] suffer because they have to help their parents in doing some chores.” (FGD with caregivers conducted in the south-west region)

Further, the data indicates that boys are more affected by harsh and dangerous work as compared to girls. Although half of refugee and 41% of host community caregivers reported that boys and girls are equally affected by this type of labour, an additional 39% of refugee and 52% of host community caregivers reported that boys are more at risk. In comparison, only 8% of refugee and 6% of host community caregivers reported that girls were more at risk of engaging in harsh and dangerous labour than boys.

Finally, the data indicates that older adolescents may be the most affected, with 68% of refugee and 74% of host community caregivers reporting that children between the ages of 15 and 17 years are most affected by their engagement with harsh and dangerous work (see figure 21). This stands in contrast to the results for child labour more generally, which reportedly more frequently affects younger adolescents between the ages of 12 and 14.

Figure 21: Proportion of refugee and host community caregivers reporting the age of children most affected by harsh and dangerous work

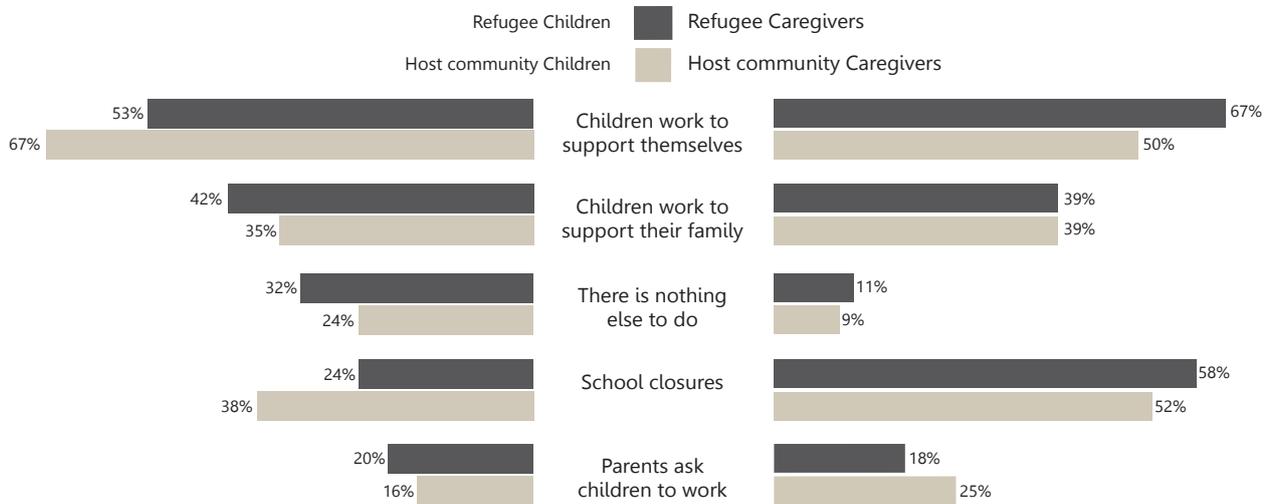


Causes of Child Labour

Expectedly, reports of child labour are often linked to economic factors and in some cases to a lack of access to education. The top five reported reasons to start working reported by refugee and host community children include the need to support themselves (refugee 53% and host community children 67%), the family needing money (refugee 42% and host community children 35%), having nothing else to do (refugee 32% and host community children 24%), school closures (refugee 24% and host community children 38%), and parents or caregivers asking children to start working (refugee 20% and host community children 16%). The top five reasons for children to do harsh or dangerous work are reported

18. Information in this graphic was compiled by IMPACT initiative from various sources by IMPACT initiatives including: Avis, W. (2017). [Data on the prevalence of the worst forms of child labour](#). K4D Helpdesk Report. Brighton, UK: Institute of Development Studies.; ILO & UNICEF (2021). [Child Labour Global Estimates 2020. Trends and the Road Forward](#); ILO (1073). [Convention No. 138 on Minimum Age](#); ILO (1999). [Convention No. 182 on Worst Forms of Child Labour](#); ILO (2018). [ICLS/20/2018/Resolution IV, 20th International Conference of Labour Statisticians](#). Geneva, 10-19 October 2018; ILO (2022). [Child Labour Statistics: Manual on methodologies for data collection through surveys](#). [Accessed 10 June 2022]; ILO (2022). [The worst forms of child labour \(IPEC\)](#) [Accessed 10 June 2022]; ILO (2022). [What is child labour \(IPEC\)](#) [Accessed 10 June 2022]; UNICEF (2022). [Tools - UNICEF MICS](#) [Accessed 10 June 2022]; UNICEF DATA (2022). [Percentage of children \(aged 5-17 years\) engaged in child labour \(economic activities\) - UNICEF DATA](#). [Accessed 10 June 2022]; United Nations. (1989). [Convention on the Rights of the Child](#). Treaty Series, 1577, 3.

Figure 22: Top five reported reasons for children to start working as reported by refugee and host community children (left) and the top five reasons for children to engage in harsh and dangerous labour as reported by refugee and host community caregivers (right)¹⁹



to be the same by refugee and host community caregivers. However, they are reported at slightly different frequencies (see figure 22).

The two causes of child labour most frequently reported by children indicate that there is a link between child labour and economic factors. This link is further strengthened by the group of refugee and host community caregivers who report harsh and dangerous work in their communities. Nearly half (45%) of the 28% of refugee caregivers and 53% of the 28% of host community caregivers who reported harsh and dangerous labour in their communities, also reported that children from families with low economic status were most affected by this. Further, no other particular groups of children were identified to be at heightened risk of harsh and dangerous work, indicating that the economic situation of the family is the most significant factor influencing whether or not a child is engaged in this type of labour.

A further notable factor influencing child labour is education. Although only small minorities of respondents from all four major demographic groups agree or strongly agree that it is acceptable for children to stop school in order to work, qualitative data indicates that some children have either dropped out of school to work or have not returned to school after the COVID-19 period in order to continue to do so. In fact, 92% of refugee and host community children each, and 93% of refugee and 96% of host community caregivers either disagree or strongly disagree with the statement that it is “ok for children to stop going to school so that they can work”. However, respondents in FGDs and IDIs reported that children often drop out of school in order to earn extra income for the family. One interviewee explained:

“Some children drop out of school because of the work they have to perform in their homes to contribute to the family. Caregivers tend to stop children from going to school so that they can move with them for work that brings money/food to the family.” (FGD with male children in Kiryandongo)

In addition, school fees can reportedly represent a significant financial burden to families and therefore create further barriers, particularly for children from less privileged backgrounds or large families:

“Some children drop out of school because of how their parents struggle to get fees especially for higher education; it’s not free like primary education.” (IDI with a foster parent in Adjumani)

School fees that apply to secondary but not primary school may help further explain why adolescents are reportedly more at risk of child labour. Children from families which are able to provide their children with scholastic materials but are unable to pay school fees may drop out of school and start working when they have completed primary school.

It is possible that this, along with the school closures during the COVID-19 period, can explain the factor of “idleness”

19. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

reported by children and caregivers. In other words, the data indicates that if a child is unable to attend school either due to school closures or possibly because their family is unable to pay the necessary fees, that child is at risk of engaging in child labour. During a FGD in Kiryandongo one respondents stated:

“Most parents used domestic work as a way of keeping children at home and engaged, so children would be doing chores every day without rest and play.” (FGD with female children in Kiryandongo)

Finally, reports from children and caregivers support the possibility that children sometimes work because their caregivers tell them to. In fact, 41% of refugee and 43% of host community caregivers and 33% of refugee and 36% of host community children report that the parents of a child jointly decide whether that child should work or not. It is important to note that whereas children most frequently state that they make such a decision by themselves, in the case of caregivers, the parents are most frequently reported to be responsible for this decision.

Conversely, child labour may also be a contributing factor to other child protection concerns. In fact, children from both communities cite labour as a source of stress (see section on psychological distress and neglect for more details).

Impact of COVID-19

Child labour has reportedly increased during the COVID-19 period. In fact, just under two thirds of children in both communities (refugees 63% and host community 64%) reported that they have had to work increased hours or days since the start of the COVID-19 period. Similarly, about two thirds of caregivers in each community (refugees 64% and host community 66%) reported that the number of children involved in harsh or dangerous labour in their community has increased since the start of the pandemic. In addition, when asked which risks, if any, have increased during the COVID-19 period, respondents from all demographic groups most frequently reported an increase in the number of children doing “harsh and dangerous work” (see figure 17 on page 16).

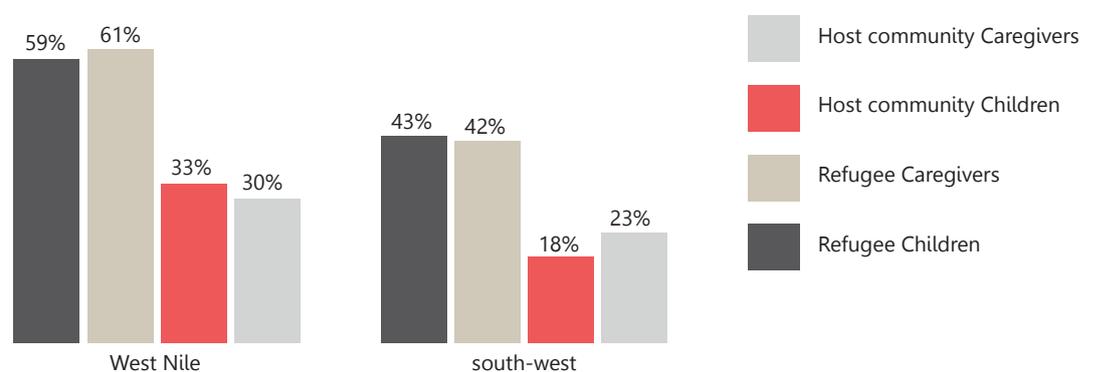
In particular, qualitative primary data and secondary data indicates that COVID-19 has exacerbated the factors that cause child labour most notably economic instability and lack of educational opportunities. For example, Human Rights Watch reported that the increase in Child Labour in Uganda was caused, in part, by school closures and the economic impact of the pandemic on household incomes.²⁰ A respondent in a FGD with female children explained:

“Children were at home, and they had to work to help out parents in the quarrying places and gardens since we had to help them make money for the family.” (FGD with female children in Nakivale)

Specific Child Protection Services Offered in Response to Child Labour

Just over half of refugee respondents (52% of children and 53% of caregivers) report that services that can protect children from or support children who are affected by harsh or dangerous work are available in their community. These proportions are lower in the host community with

Figure 23: Proportion of respondents reporting the availability of services addressing child labour in their community by community type, survey type and region



only 27% of children and caregivers each reporting the availability of such services in their communities. In addition, all respondents agree that service provision is higher in the West Nile region as compared to the south-west (see figure 23). A reported gap in services targeting this particular child protection risk may also be caused by a lack of knowledge surrounding the risk itself and therefore a lack of knowledge surrounding the available services. One FGD participant

20. Human Rights Watch. (2021) [Uganda: COVID-19 pandemic fueling child labor](#)

explained:

“There are no services. Most of them don’t even know that they are doing child labour.” (FGD with male caregivers in Nakivale)

Of the respondents that reported having access, only minorities reported actually having sought to benefit from the protection services that aim to protect children from and support children who are engaged in harsh and dangerous labour. In fact, only 44% of refugee children and 41% of refugee caregivers report having sought child protection services in relation to child labour. These proportions are even lower amongst the host community at only 33% for children and 32% for caregivers.

Figure 24: Top three most frequently reported service providers addressing child labour by survey and community type²¹

Refugee children Refugee caregivers		Host community children Host community caregivers	
1	59% 58%	1	64% 52%
2	55% 49%	2	60% 49%
3	30% 29%	3	12% 25%

Of the respondents who do report having access to services protecting children from or supporting children who are engaged in harsh or dangerous labour, a majority from all demographic groups report that these services are easy to access. In fact, 84% of refugee children, 86% of refugee caregivers and 87% of both host community groups report this. The minorities that reported access barriers, most often cite long distances, delays in case management services, or lack of knowledge on where to find the services as reasons for this.

Amongst refugees the top three most frequently reported protection providers around child labour are 1) child protection committees 2) NGO or UN agencies and 3) the government. Similarly, the top service providers in the host community are 1) government, 2) community members and 3) child protection committees (see figure 24). In contrast, para-social workers were named as providers of services against child labour by only 10% of refugee and 12% of host community caregivers and by 7% of refugee and 9% of host community children.

The top three services provided by these organizations to the refugee community are 1) awareness raising and sensitization, 2) case management and 3) basic support from CPCs and para-socials and to the host community 1) enforcement of bylaws on child rights, 2) awareness raising and sensitization and 3) case management.

When those individuals who reported having access to and experience with using these services were asked about the effectiveness of these services, a majority of respondents from each of the four main demographic groups interviewed reported that they were effective or very effective.

21. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Violence Against Children (VAC)²²

The proportion of caregivers reporting that children in their households have experienced VAC is roughly similar across both communities. Twelve percent (12%) of refugee caregivers and 9% of host community caregivers reported that children in their household have experienced VAC over the last three months. Similarly, when caregivers were asked, how frequently children in their wider community experience violence, 18% of refugee caregivers stated either “often” or “very often”. Amongst host community caregivers this proportion stands at 11%. This data indicates that the prevalence of VAC is roughly similar amongst refugee and host communities.

Definition of “violence against children or VAC”: For purposes of this assessment, VAC is defined as any form of violence that inflicts harm, pain, or humiliation on children or otherwise affect their self-worth. It can include physical, sexual or emotional abuse. It can occur in many settings including the home, school, community and over the internet.

Table 03: Proportion of refugee respondents reporting VAC by settlement

Settlement	Refugee caregivers
Imvepi	30%
Rhino Camp	21%
Kiryandongo	19%
Palabek	18%
Lobule	18%
Palorinya	18%
Rwamwanja	9%
Nakivale	8%
Bidibidi	7%
Adjumani	7%
Kyaka II	5%
Oruchinga	4%
Kyangwali	3%

Disaggregation shows that VAC is more commonly reported by caregivers in the West Nile region as compared to the south-west. More specifically, 16% of refugee and 12% of host community caregivers in the West Nile region reported that VAC has been perpetrated against children living in their household while only 6% of refugee and 5% of host community caregivers in the south-west did so. Disaggregating the data from refugee caregivers further to the settlement level reveals that VAC is reported to be most prevalent in Imvepi settlement and Rhino Camp. The full list of proportions of refugee caregivers reporting VAC by settlement can be found in table 03.

Respondents in both communities often agree that both girls and boys are the victims of VAC. A majority of caregivers in both communities (64% of host community caregivers and 67% of refugee caregivers) report that both girls and boys are affected (see figure 25). Respondents who

reported VAC in their households agree that it most frequently affects adolescents (children between 12 and 17 years of age). Specifically, a majority (53%) of refugee and host community caregivers reported this. However, 27% of refugee and host community caregivers also reported that VAC affects all age groups evenly.

Perpetrators and Types of Violence

Caregiver respondents from both communities agree that parents or adult caregivers are the most likely perpetrators of VAC (see figure 26). However, greater proportions of host community than refugee caregivers reported parents or adult caregivers or other adults in the neighbourhood as perpetrators.

All respondents that reported VAC agree that such violence most often takes the form of physical violence (see figure 27). Host community caregivers reported physical violence most frequently (83%) but the proportions of refugee caregivers reporting physical violence is not

22. To comply with global guidelines on child protection, the sections on prevalence and causes of VAC and sexual violence will not include results from child respondents. However, the subsections on service provision for these risks do include child perspectives.

23. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 25: Proportion of caregiver respondents reporting the gender of the children most affected by VAC, by survey type

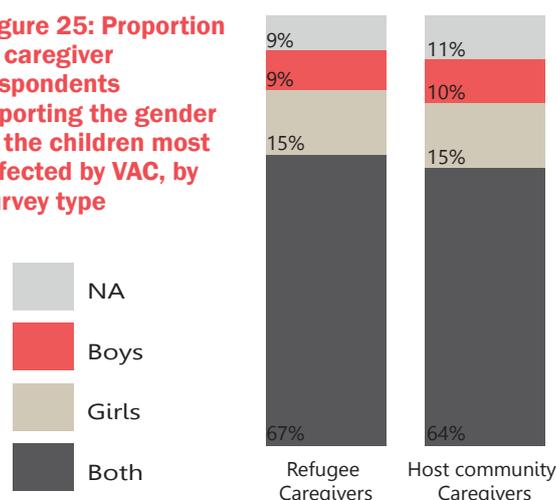


Figure 26: Top three most frequently reported perpetrators of violence against children by community type²³

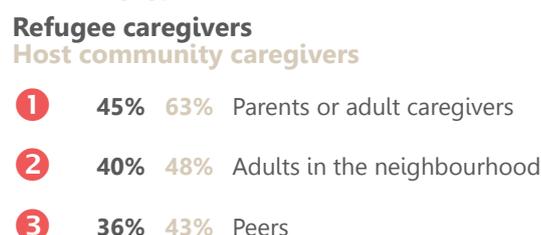
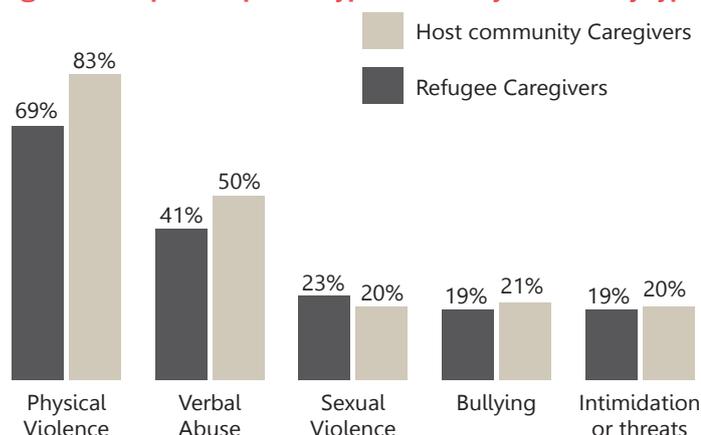


Figure 27: Top five reported types of VAC by community type²⁴



much lower at 69%.

Verbal abuse is the second most frequently reported type of violence experienced by children as reported by refugee and host community caregivers. However, this type of violence reportedly occurs slightly more often amongst the host community. Half (50%) of host community caregivers that reported VAC had occurred in their household in the past three months, reported it took the form of verbal abuse. This proportion was slightly lower amongst refugee caregivers (41%).

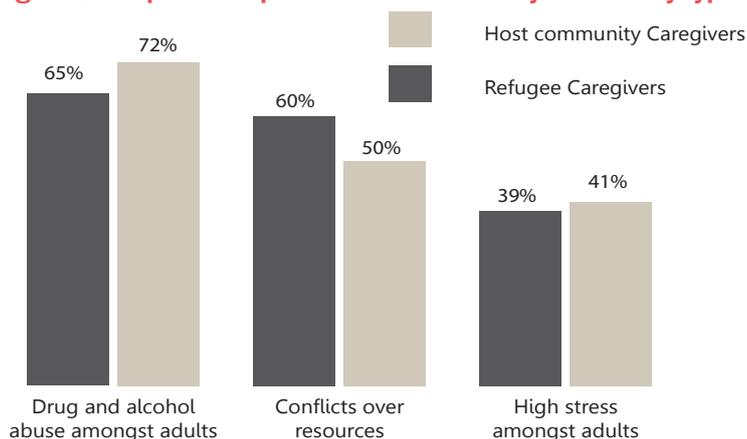
Finally, caregivers from both communities report bullying (including but not limited to online bullying) has been

experienced by the children in their households. Just over a fifth (21%) of host community and 19% of refugee caregivers who reported VAC stated that it takes the form of bullying. Further research is needed to understand exactly what form of bullying is perceived to be most common.

Causes of Violence Against Children

When asked about underlying causes leading to the occurrence of VAC, all caregivers who reported VAC agreed that the top three causes are drug and alcohol abuse amongst adults, conflict over resources, and stress in adults. Specifically, host community and refugee caregivers that reported VAC in their communities, reported drug and alcohol abuse amongst adults as the cause 72% and 65% of the time respectively, conflicts over resources as the cause 50% and 60% of the time, and stress levels amongst adults 41% and 39% of the time (see figure 28).

Figure 28: Top three reported causes of VAC by community type²⁴



It is important to note that although drug and alcohol abuse amongst caregivers was the leading cause of VAC reported by respondents to the quantitative surveys, caregiver respondents in qualitative interviews made no mention of this issue. However, four out of the eighteen KIIs interviewed mentioned drug abuse amongst caregivers as an issue affecting child safety. One of them explained:

“Some people [are] harsh [to] children when they are drunk or on drugs and at the end of the day, they realize their mistake but then it is too late.” (KII with a police officer in Nakivale)

Further, although the 2018 survey on VAC conducted by the Ugandan Ministry of Gender, Labour, and Social Development, states that children who have suffered VAC identified drug and alcohol abuse amongst caregivers as a key driver of this risk, this survey did not include specific data on refugee populations.²⁵ Thus further research is needed to unpack the issue of drug and alcohol abuse amongst caregivers and how it affects child safety amongst refugees in Uganda.

On the issue of resource conflict, it is noteworthy that this type of conflict is more frequently reported amongst refugees as compared to the host community. This may be linked to the higher prevalence of joblessness amongst the refugee population and is also reflected in stress levels amongst children caused by a lack of food (see “demographics” and “psychological distress and neglect” sections for further information).

24. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

25. [Uganda Violence Against Children Survey](#). Ministry of Gender, Labour, and Social Development, 2018

Finally, although community respondents did not discuss causes of VAC in-depth, one respondent did state that:

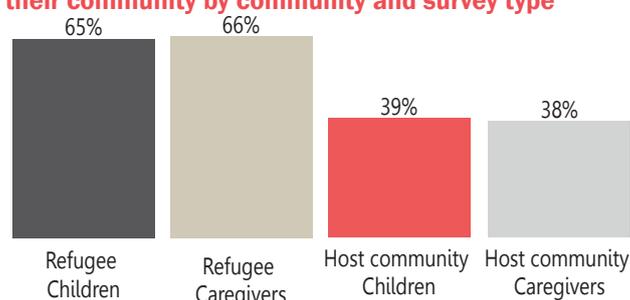
“Parents are very stressed due to the struggle they go through, they are worried and are short tempered, so they don’t consider how severe it will be if a child is heavily hit or denied food.” (FGD with female caregivers in Kiryandongo)

In addition, the finding that high stress amongst caregivers contributes to the prevalence of VAC is concerning given that 65% of refugee children and 62% of host community children reported that their caregivers are often stressed. In addition, 26% of refugee children and 29% of host community children reported an increase in mainly negative behaviours observed in their caregivers since the start of the COVID-19 pandemic. For a discussion on geographic nuances for this indicator please see the section on “psychological distress and neglect” below.

Specific Child Protection Services Offered in Response to Violence Against Children

Protection services targeting VAC are reportedly more readily available amongst the refugee community as compared to the host community. Two thirds (66%) of refugee caregivers who reported VAC in their communities and 65% of refugee children who reported it in their households also report that there are protection services available that address VAC. These proportions for the host community are only 38% and 39% respectively (see figure 29). Considering that the rate of prevalence of VAC was reported to be roughly equal in both communities, the data suggests that the gap in protection services to respond to VAC in the host communities is larger as compared to the refugee communities.

Figure 29: Proportion of respondents reporting that protection services addressing VAC are available in their community by community and survey type



Further, the data indicates that there may be more protection services preventing VAC and supporting children who have suffered from violence in the West Nile region as compared to the south-west. Amongst the refugee community, children report no regional difference in service provision but only 60% of refugee caregivers in the south-west report having access to services targeting VAC compared to 70% in the West Nile. Conversely, host community caregivers report no regional difference, but children do with only 31% of host community children in the south-west report having access to services as compared to 45% in the West Nile. However, given the higher reported prevalence of VAC in the West Nile region as compared to the south-west, this regional discrepancy in service provision may be expected and appropriate. A majority (over 80%) of respondents from all four major demographic groups interviewed who reported that services targeting VAC are available in their communities, also reported that these services are accessible to them. Amongst the minorities that reported access barriers, the most frequently reported barrier by host community respondents was long distance while refugee respondents more frequently reported delays in case management and lack of knowledge around where to find the services in addition to long distances as barriers to access.

However, less than a third of caregivers who reported having access to services that respond to VAC also reported actually having ever used these services. Amongst the refugee community the reported usage rate is slightly higher as compared to the host community with 33% of refugee caregivers but only 18% of host community caregivers reporting having used a service targeting VAC. Although only a minority of respondents have experience with service provision targeting VAC, nearly all respondents in this group report that the services were either effective or very effective. More specifically, 82% of refugee caregivers and 82% of host community caregivers reported this.

Refugee children and caregivers agree that NGO and UN agencies, child protection committees, and the government are the most prominent service providers targeting VAC. Although host community children and caregivers agree that the government and community members play a vital role in service provision targeting VAC, caregivers, similar to refugees, also name child protection committees while children more often report religious leaders and VHTs.

Finally, when asked what type of service is most often provided to prevent or to support children who have experienced

VAC, refugee respondents agree that awareness raising and sensitisation, case management services, and basic support from CPC or para-socials are the most common. In comparison, host community respondents also report awareness raising and sensitisation, and case management, but name the enforcement of bylaws on child rights most frequently.

Sexual Violence, Child Marriage, and Teenage Pregnancy

The proportions of caregivers from both communities who report that children living in their household have ever experienced sexual violence roughly align with 15% of refugee and 14% of host community caregivers reporting incidents. These proportions are relatively low when compared to reports from caregivers, that, when asked about the frequency of the occurrence of sexual violence in their wider communities, indicated higher incident rates of this risk. For example, 15% of refugee caregivers reported that sexual violence against children occurs

Definition of "sexual violence": For purposes of this assessment, sexual violence is defined as including all forms of sexual abuse and sexual exploitation of children. This encompasses a range of acts, including attempted and completed non-consensual sex acts, and abusive sexual contact. This also includes the exploitative use of children for sex or sexual purposes.

Table 04: Proportion of refugee caregivers reporting sexual violence by settlement

Settlement	Refugee Caregivers
Imvepi	26%
Kiryandongo	22%
Rhino Camp	21%
Lobule	19%
Palabek	18%
Nakivale	17%
Palorinya	16%
Kyangwali	14%
Adjumani	13%
Oruchinga	13%
Bidibidi	12%
Kyaka II	10%
Rwamwanja	8%

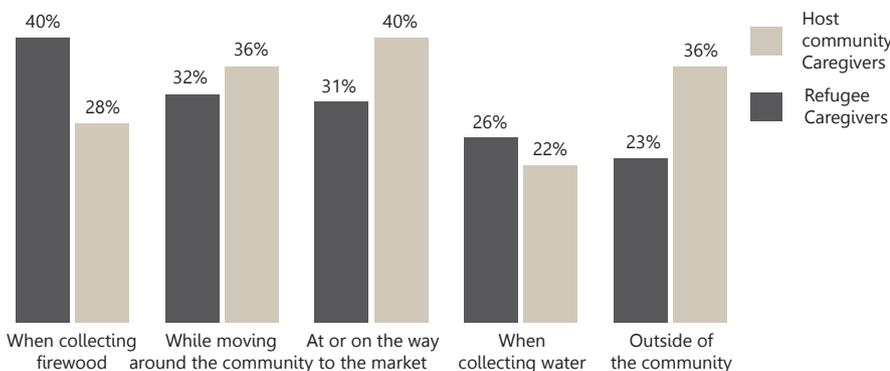
"often" or "very often" in their community and a further 26% reported that it occurs "sometimes". Similarly, 14% of host community caregivers report sexual violence occurring "often" or "very often" in their communities and an additional 23% reported that it occurs "sometimes". The discrepancy between these reports indicates that caregivers may be under-reporting the incidents of sexual violence happening in their own households or that they are biased against accurately reporting on these incidents occurring in their own homes. Considering the sensitivity of this topic, this is expected and represents a limitation of the topic of this assessment.

There are no indications of differences in the prevalence of sexual violence on the regional level. However, when disaggregating data from refugee respondents to the settlement level, the prevalence of sexual violence in Imvepi, Kiryandongo, and Rhino Camp stand out as the most severe (see table 04).

Of the respondents reporting sexual violence occurring in their communities, 94% of refugee and 92% of host community caregivers agree that adolescents (12-17-year-olds) are most affected by this risk. Further, respondents most frequently reported that girls are affected by sexual violence although some respondents report that children of both genders are affected

while minorities report that boys in their household have been affected. In fact, 63% of refugee and host community caregivers each reported that girls are most at risk while 30% of refugee and 27% of host community caregivers reported

Figure 30: Top five reported places where sexual violence occurs by refugee and host community caregivers²⁶



that boys and girls are evenly at risk of sexual violence. In comparison, only 4% of refugee and 7% of host community caregivers reported that boys, rather than girls, are specifically at risk.

Respondents in both communities most frequently reported public places to be the most likely areas in which sexual violence against children occurs. More specifically, refugee caregivers most frequently responded with "when collecting firewood", "when moving

26. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

around the community”, or “at or on the way to the market” when asked in which situations children in their community are most at risk of sexual violence. Host community members also frequently reported “at or on the way to the market” and “when moving around the community” but also more frequently identified places “outside of the community” (see figure 30).

Most frequently named perpetrators of sexual violence against children are other community members, aligning with the reports that public places are where sexual violence is most likely to occur. “Youths” and “police and security agencies” are second and third most frequently named perpetrators by respondents (see figure 31). The category of “youths” aligns with data from qualitative interviews during which some respondents reported that sexual experiences between minors have increased during the COVID-19 period, in particular as adolescents have had more free time.

Figure 31: Top five most frequently reported perpetrators of sexual violence against children by community type²⁷

Refugee caregivers		Host community caregivers	
1	63%	64%	Community members
2	30%	31%	Youths
3	18%	19%	Police or security agencies
3	18%	15%	Visitors from outside the community
3	13%	14%	Household members

“It has increased teenage pregnancy because children were idle so they would move to meet their friends” (FGD with female caregivers in Kyaka)

Causes of Sexual Violence Against Children

In line with the above, when caregivers were asked about the main causes of sexual violence against children in their communities, the three most frequently mentioned factors in both communities were COVID-19 and associated

Figure 32: Top three most frequently reported causes of sexual violence against children by survey and community type²⁷

Host community caregivers

1	52%	52%	COVID-19 restrictions or lockdown
2	42%	36%	Lack of law enforcement
3	39%	34%	Socioeconomic conditions

movement restrictions, lack of law enforcement and socioeconomic conditions (see figure 32). Child respondents agreed that they perceived that this risk rose in their communities during the COVID-19 period. A majority of child respondents (61% of refugee and 52% of host community children) reported that incidents of sexual violence against children in their communities have risen since COVID-19 started. This aligns with secondary data from a UNHCR report which stated that women and girls were disproportionately negatively affected by COVID-19 and that in particular “The loss of income within the household has contributed to an increased incidence of Gender-Based Violence (GBV) and negative coping mechanisms such as survival sex and sale of alcohol.”²⁸

Further, reports that socioeconomic conditions are an underlying cause of sexual violence against children are highlighted by data from caregivers. One third (33% of refugee and 38% of host community caregivers) of whom, when asked if there is a group of children that is at particular risk, identified “children from poor households”. One foster parent explained:

“And of course, poverty; there is no money; food rations and money have reduced. Parents cannot ably provide [for] all the needs and that’s why children resort to prostitution for money. Some children divert on their way to school, remove their uniforms and go to look for money.” (IDI with a foster parent in Kiryandongo)

Finally, secondary data and qualitative data indicates that COVID-19 and socioeconomic status are linked as underlying factors exacerbating sexual violence. One single female caregiver stated:

“COVID-19 increased poverty levels among the people and girls begun looking for other alternatives from the men who made them pregnant.” (IDI with a female caregiver in Kiryandongo)

Link to Child Marriage and Teenage Pregnancy

Qualitative data indicates that in the Ugandan context, sexual violence, child marriages and teenage pregnancies all

27. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

28. [Inter-agency report: refugee women and girls in Uganda disproportionately affected by COVID-19](#), UNHCR, December 2020

increased during the COVID-19 period. A factor linking these child protection risks may be socioeconomic status and an increase in poverty during the COVID-19 period. For example, similar to the main driving factors behind sexual violence against children, qualitative data suggests that girls from poorer households are more likely to become pregnant early. One teenage mother in Kyaka refugee settlement reported:

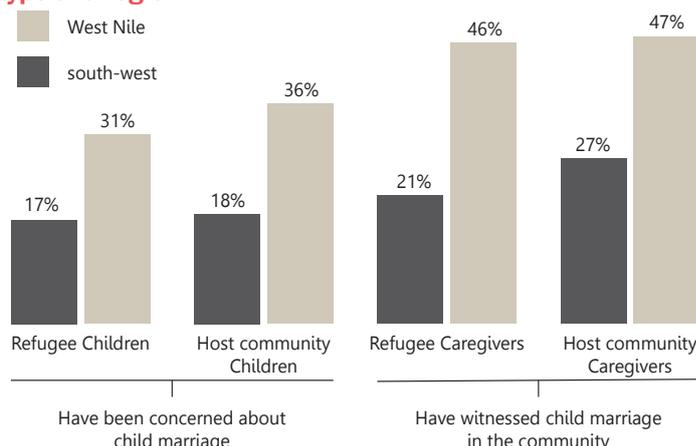
“Economic factors are key, it has driven parents, the economic circumstance has made most of the parents engage their children into child labour and also commercial sex.” (KII with an NGO worker in Kyaka)

Similarly, economic motivations are reportedly also contributing to a rise in child marriages. One unaccompanied child interviewed in Bidibidi refugee settlement explained:

“There are a lot of child marriage cases here because the children are left alone, and they opt for marriage as an alternative for survival. We had a lot of these cases when there was the lockdown.”

Although there is no primary data on child marriages occurring at the household or individual level, child respondents reported child marriage as a risk they have been concerned or worried about in the past three months and caregivers reported to have witnessed child marriages in their communities in the same timeframe (please see the “overview of risks” section on page 14 for a discussion on how these indicators differ). In particular, 25% of refugee and 29% of host community children reported having been worried about child marriage over the past three months (see “overview of risks” section). Amongst caregivers, 36% of refugee and 39% of host community respondents reported having witnessed a child marriage in their community over the same time period.²⁹

Figure 33: Proportion of respondents reporting having been concerned about (children) or witnessed (caregivers) child marriage in the last three months by survey and community type and region



Disaggregating this data by region shows that children from both communities living in the West Nile region were more likely to report having been worried about child marriage as compared to their counterparts in the south-west. Similarly, caregivers from both communities interviewed in the West Nile region more often reported having witnessed child marriage as compared to those from the south-west (see figure 33). Secondary and qualitative data indicate that there may be a cultural link to child marriage which would help explain the regional difference in the reports from child and caregiver respondents related to it. For example, participants in one FGD reported that:

“Some tribes have marriage agreements (...) and marry the children who live in the settlement at an early age. It is becoming a culture for the parents to arrange marriage for children.” (FGD with male caregivers in Kiryandongo)

This is despite a large majority of all respondents state that is not acceptable for parents to arrange a marriage for their child. In fact, 88% of refugee and 87% of host community children, and 85% of refugee and host community caregivers each reported that they “disagree” or “strongly disagree” when asked if it is ok for parents to arrange a marriage for their child.

In sum, primary data collected during this assessment indicates that both teenage pregnancies and child marriages have increased during the COVID-19 period. This aligns with secondary quantitative data. For example, a survey by War Child Holland found that 75% of the girls assessed got pregnant during school closures put in place to stem the spread of COVID-19.³⁰ In addition, the qualitative data collected for this assessment aligns with the reports from child respondents

29. Please note that this may be over-reported due to the possibility of multiple caregivers witnessing the same instance of child marriage

30. [Refugee girls report “torture” of early pregnancies due to COVID school closures](#), War Child Holland, November 2021. Please note that this was not a representative survey of refugee girls currently residing in Uganda.

in both communities stating that sexual violence has increased since the beginning of the COVID-19 period (see section on the “causes of sexual violence against children”).

Specific Child Protection Services Offered in Response to Sexual Violence

Similar to reports on child protection services targeting other risks, services that target children who have suffered sexual violence, are reportedly more common amongst refugees as compared to the host community. Although a slightly larger proportion of host community respondents report having access to services targeting sexual violence, when compared to VAC, it is still less than half of all host community respondents (see figure 34). In contrast, 72% of refugee caregivers and 70% of refugee children report having access to a service that protect children from or support children who have suffered from sexual violence.

A large majority of respondents from all demographic groups reported that access to services targeting sexual

violence is easy for the members of their household. Specifically, 85% of refugee and 90% of host community children, and 88% of refugee and 83% of host community caregiver reported this. Further, 30% of the refugee and 24% of the host community caregivers who reported having access to services targeting sexual violence, also reported having made use of these services. Encouragingly, 85% of refugee and 81% of host community caregivers who reported having ever made use of such services, also reported that they were “effective” or “very effective”.

Finally, refugee children and caregivers named NGO and UN agencies, child protection committees and the government as the top three service providers responding to sexual violence. Para-socials were only named by 8% of caregivers in refugee and host communities each as providers of services addressing sexual violence against children in their communities. Host community respondents reported the government, community members and child protection committees (see figure 35). The type of services that are reported to be most frequently provided in response to the risk of sexual violence in both communities are, awareness raising and sensitisation, case management services, basic support from para-socials, and the enforcement of bylaws on child rights.

Figure 34: Proportion of respondents reporting that protection services addressing sexual violence are available in their community by community and survey type

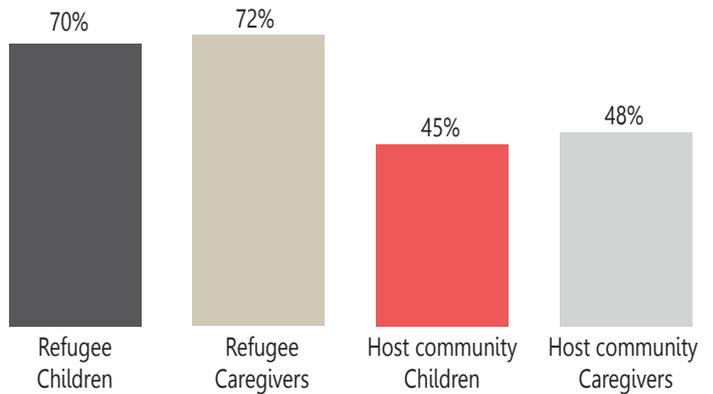


Figure 35: Top three most frequently reported service providers addressing sexual violence by survey and community type³¹



31. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Psychological Distress and Neglect

When asked if they are ever upset or worried, only 5% of refugee children and 8% of host community children selected “none” indicating that high percentages of children in the target communities have experienced stress. In addition, 38% of refugee and 40% of host community caregivers report having observed mainly negative changes in the behaviours of the children living in their household since the beginning of the COVID-19 pandemic.

Table 05: Proportion of respondents reporting having observed mostly negative behaviour changes in caregivers / children since the start of the COVID-19 pandemic

Settlement	Children reporting observing negative behaviour changes in caregivers	Caregivers reporting observing negative behaviour changes in children
Refugees in the West Nile	30%	45%
Host community in the West Nile	36%	45%
Refugees in the south-west	21%	30%
Host community in the south-west	19%	31%

Definition of “neglect”: For purposes of this assessment, neglect means the failure to meet children’s physical and psychological needs, protect them from danger or obtain medical, birth registration or other services when those responsible for children’s care have the means, knowledge and access to do so (includes physical neglect, psychological or emotional neglect, educational neglect, abandonment).

The rate of negative behaviour changes observed in children by caregivers is higher in the West Nile region as compared to the south-west.

Just under half (45%) of both refugee and host community caregivers in the West Nile report having observed such negative behaviour changes in the children they take care of since the start of the pandemic while only 30% of refugee and 31% of host community caregivers in the south-west region report this (see table 05). Disaggregating the data from refugee respondents further shows that refugee children living in Imvepi, Bidbidi,

and Palabek refugee settlements are reportedly most likely to have undergone such a change (see table 06).

In addition, 26% of refugee children and 29% of host community children report observing mainly negative behaviour changes towards them from their caregivers since the start of the COVID-19 pandemic. Qualitative data shows that these mainly negative behaviour changes may take the form of child neglect:

“Neglect of the children by their parents [occurs] because of the fact that they lost their jobs especially during the COVID-19 period. The parents could always go and do casual labour in the plantations of the nationals, but (...) there was a lockdown (...) and somehow COVID-19 disorganized the parents’ or caregivers’ source of livelihood so they would neglect their children(...)” (KII with a child protection officer in Nakivale)

Similar to behaviour changes in children, geographic disaggregation of the occurrence of negative behaviour changes in caregivers shows that these changes are more frequently reported in the West Nile. Nearly one third (30%) of refugee children and 36% of host community children in the West Nile region report such changes as compared to only 21% and 19% respectively in the south-west. Settlement-level data shows that the highest proportions of refugee children reporting negative behaviour changes in caregivers are in Imvepi settlement, Rhino Camp, and Palabek settlement (see table 06).

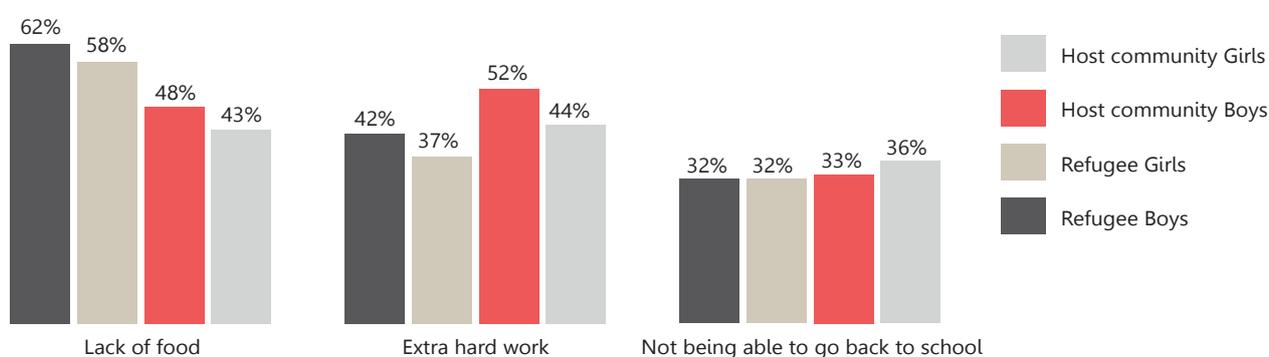
Table 06: Proportion of refugee respondents reporting having observed mostly negative behaviour changes in caregivers / children since the start of the COVID-19 pandemic

Settlement	Refugee children reporting observing negative behaviour changes in caregivers	Refugee caregivers reporting observing negative behaviour changes in children
Imvepi	44%	59%
Rhino Camp	41%	45%
Palabek	38%	47%
Palorinya	30%	46%
Kyangwali	29%	34%
Bidibidi	27%	54%
Lobule	26%	40%
Nakivale	22%	44%
Oruchinga	20%	26%
Adjumani	19%	22%
Rwamwanja	17%	14%
Kiryandongo	14%	39%
Kyaka II	14%	20%

Causes of psychological distress and neglect

Amongst children from both communities, the most frequently reported stress- or worry- inducing factors are lack of food, extra hard work, and not being able to go back to school. In fact, a majority of children from both communities (64% of refugee and 51% of host community children) report a lack of food as a worry- or stress- inducing factor in their lives. In comparison, the proportions of children reporting being stressed about extra hard work (27% of refugee and 37% of host community children) and not being able to go back to school (25% of refugee and 32% of host community children) are somewhat lower. It is notable that stress caused by lack of food is reportedly more pronounced amongst refugee children while host community children, in comparison, are roughly equally worried about the three factors. These findings are echoed by caregivers who report that the main causes of stress amongst boys and girls are these three main factors (see figure 36). Overall, the data highlights that children worrying about basic needs and a lack of access to food is a critical stressor affecting children’s wellbeing and development.

Figure 36: Top three factors creating stress for refugee and host boys and girls as reported by their caregivers³²



Disaggregating based on location shows that a larger group of host community children in the West Nile worry about lack of food and extra hard work as compared to their south-western counterparts. In particular, 59% of host community children in the West Nile worry about lack of food compared to only 38% in the south-west. Similarly, 42% of host community children in the West Nile report being worried or stressed by extra hard work compared to 29% in the south-west. In contrast, proportions of refugee children who reportedly worry about a lack of food, extra hard work, and not being able to go back to school are roughly equal across both regions. However, analysing the data on the settlement level, shows that 76%, 73%, and 70% of refugee children in Adjumani settlement, Kyangwali settlement, and Rhino Camp respectively report being stressed by a lack of food as compared to only 50%, 55%, and 55% in Bidibidi, Palorinya, and Kiryandongo settlements. This indicates that despite the lack of regional differences, there may be settlement-level factors influencing the level of stress children feel due to a lack of food. One of these factors may be the amount of assistance provided by WFP which was adjusted on the settlement level in November 2021. The assistance level remained the same in Adjumani at 60% of the food basket, was increased to 70% in Rhino Camp and was decreased to 40% of the food basket in Kyangwali. In addition, beneficiaries in Palorinya refugee settlement started receiving their rations in the form of cash rather than food starting in August 2021 which may have influenced a relatively positive outcome in this specific settlement.³³

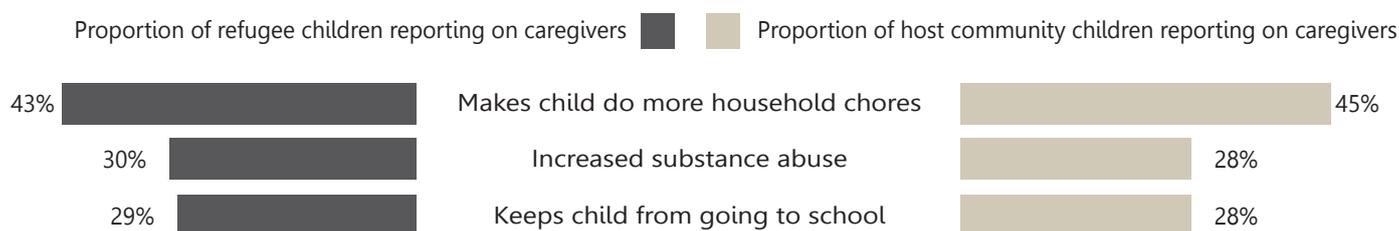
On the regional and national levels, larger proportions of refugee children, as compared to host community children, report being worried about a lack of food, which may be justified, given the shortfall in funding needed to cover the basic needs of all refugees currently residing in Uganda.³⁴ In addition, 18% of refugee caregivers are reportedly not engaged in income generating activities and thus may have no other way of feeding the children living in their households. This assumption is strengthened by the 44% of refugee and 36% of host community children that reported their caregivers are often stressed due to a lack of food.

32. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

33. [WFP Uganda Country Brief, August 2021](#)

34. [Uganda Refugee Response Plan funding update Q4 2021](#)

Figure 37: Top three most frequently reported negative behaviours observed in caregivers since the start of the COVID-19 period as reported by refugee and host community children³⁵



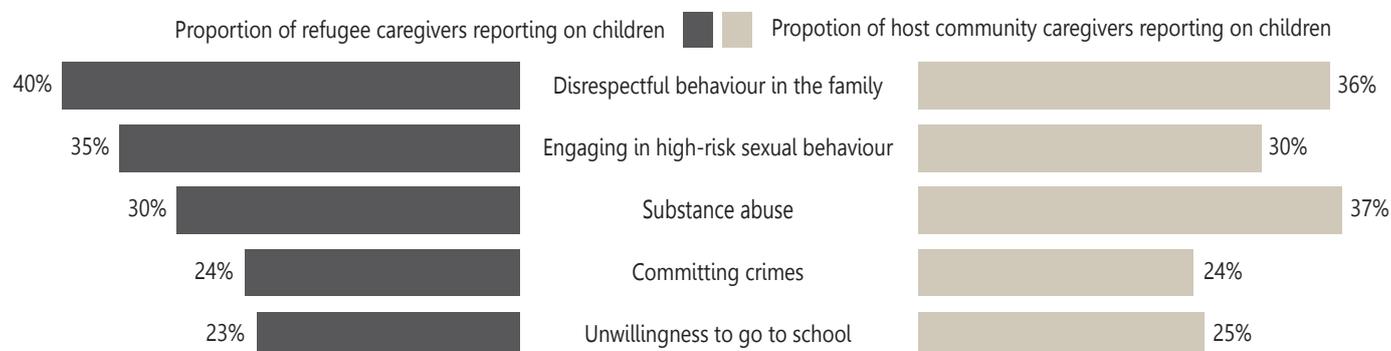
Worries around hard work and not going back to school may be further exacerbated by stress and behaviour changes in caregivers. Almost two thirds (65%) of refugee children and 62% of host community children report their caregivers are often stressed. Further, although nearly half of all child respondents (47% of refugee and 46% of host community children) report “no change” in their parents’ or caretakers’ behaviour since the start of the COVID-19 period, nearly one third (26% of refugee and 29% of host community children) report a negative change. These negative changes have reportedly most frequently included increasing the amount of labour the child is involved in, increased substance abuse, and has reportedly caused caregivers to keep children from going to school (see figure 37). This indicates that there may be a domino effect starting with psychological distress in caregivers which may cause increases in child labour which, in turn, may cause increased psychological distress in children. This dynamic highlights that psychological distress and neglect is interlinked with the psychological well-being of the caregiver.

Impact of COVID-19 and School Closures

The data indicates that refugee and host community children exhibited negative behavioural changes and that school closures may have contributed to an increase in child protection risks including teenage pregnancies and child labour. Of the caregivers having observed behaviour changes amongst children under their care since the start of the pandemic, a majority (73% of refugee and 71% of host community caregivers) report that both girls and boys are evenly affected. The data further indicates that adolescents were most affected with 75% of refugee and 80% of host community caregivers reporting that this age group exhibited behaviour changes.

Of the 57% of refugee caregivers and 62% of host community caregivers reporting having observed behaviour change in the children in their household since the start of the pandemic, 38% and 40% respectively reported that this behaviour change was mainly negative. When asked to specify what these negative behaviour changes look like, caregivers most frequently reported substance abuse, disrespect towards the family, high-risk sexual behaviour, committing crimes, and lack of interest in going to school most frequently (see figure 38). This aligns with secondary data which states that “in

Figure 38: Top five most frequently observed negative behaviour changes in children since the start of the COVID-19 period as reported by caregivers³⁷



35. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

35. [Emotional and Behavioral Impact of the COVID-19 Epidemic in Adolescents](#); Bera et al., February 2022

36. “Oppositional behaviours” may include being uncooperative, defiant, and being hostile towards peers and parents or other authority figures. *ibid.*

37. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

adolescents, negative emotions can result in greater irritability, aggressiveness and oppositional behaviours.^{35,36} These behaviours may be a result of increased stress levels amongst children caused by COVID-19 and the effects of associated preventative measures. Specific factors that may have caused increased stress during the COVID-19 period may be decreased educational opportunities and decreased economic security.

Uganda experienced the longest closure of schools in the world during the pandemic, implying that the impact of this measure on school-aged children in Uganda is unusually severe.³⁸ This assumption is strengthened by qualitative data which shows a strong indication of the negative effects of school closures and highlights that it may have caused increases in other child protection risks including teenaged pregnancies and substance abuse. A caregiver interviewed in Kiryandongo explained:

“School helped to keep children engaged productively, right now, children are idle and stressed so they spend time drinking, taking drugs and indulging in sexual promiscuity.” (IDI with a caregiver in Kiryandongo)

In addition, secondary data shows that school closures may have been especially detrimental for children from poorer families. Hoofman and Secord state that there was a “widening of the gap for those whose families could not absorb the teaching and supervision of education required for in-home education because they lack the time and skills necessary.”³⁹

Moreover, children from families with weaker socio-economic backgrounds may have suffered compounding negative effects because they could not access alternative solutions to education and, in addition, may have been at higher risk of having to engage in child labour. Secondary data discussing the Ugandan context specifically indicates that “some families hired private tutors or took advantage of online or televised lessons, [but] children from working-class backgrounds often spent the lockdown helping replace their parents’ lost income.”⁴⁰ This was also highlighted by respondents in qualitative interviews:

“Children from poor families who cannot afford school fees alongside other needs, often see education as a luxury need compared to food, shelter and clothing.” (FGD with male children in Adjumani)

Specific Child Protection Services Offered in Response to Psychological Distress

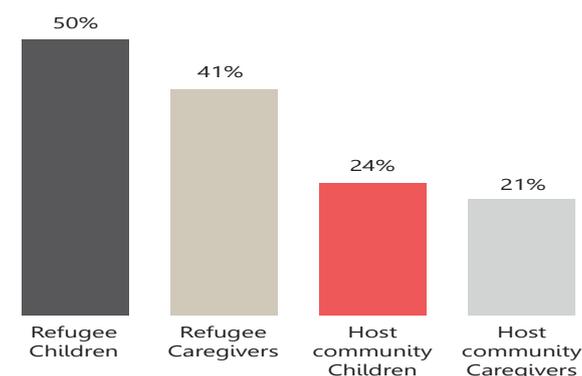
Given the variety of potential threats to mental health and the psychological wellbeing amongst both the refugee and host community, mental health and psychosocial support (MHPSS) service provision is essential for the children living in these communities. Unfortunately, the data shows that only 50% of refugee children and 24% of host community children report that such services are available to them and other children in their communities (see figure 39).

It is possible that this is why when children are upset or worried, they most often report seeking support within their own households and in their social networks (see figure 40).

However, those children that do report having services available to support them when they are upset or stressed, most often report that these services are easily accessible to them. Of the 50% of refugee children reporting the availability of a service, 89% report having easy access. Similarly, of the 24% of host community children reporting that a MHPSS service is available to them, 87% report that this service is easily accessible to them.

The minority of refugee children reporting difficulties accessing MHPSS services, most frequently reported a lack of information about the services, long distance, and not knowing the location of the services as the major barriers to

Figure 39: Access to services responding stress by community and survey type



38. [Term starts in Uganda – but world’s longest shutdown has left schools in crisis:](#) The Guardian, January 2022

39. [The Effect of COVID-19 on Education:](#) Hoofman and Secord, May 2021

40. [After 22 months closed, Uganda’s schools are struggling:](#) Green, February 2022

Figure 40: Top five most frequently reported people sought out by upset or worried refugee and host community children⁴¹

Refugee Children
Host community Children

1	56%	Parents or caregivers
	60%	
2	22%	Community leaders
	21%	
3	22%	Relatives
	24%	
3	20%	Peer groups
	20%	
3	13%	Neighbours
	11%	

access. The barriers most frequently reported by host community children are long distances, delays in case management, and not knowing the location of the services. Similar to services responding to different forms of VAC discussed above, only about half of the children who have MHPSS services available to them report actually having made use of them. More specifically, 56% of refugee and 41% of host community children who report having access to services targeting stress in children also report having previously used these services. Encouragingly, of the children that reported having ever used MHPSS services, a large majority (93% of refugee children and 79% of host community children) reported that the services were “good” or “very good”.

In sum, since only 5% of refugee and 8% of host community children reported not being worried or stressed, and only half of refugee children and about one fifth of host community children reported that a MHPSS service is available to them, the data indicates a gap in service delivery responding to psychological distress. Further, it is important to take note of the gap in service provision and perceived

quality of the services between refugee and host communities. Given similar rates of stress and worry reported by refugee and host community children, the data indicates that there is not only a larger gap in service provision in the host community but that the services available to host community children may also be of lower quality.

Further, given that levels of stress amongst caregivers may be a contributing factor to levels of stress amongst children and child neglect, MHPSS service provision to caregivers are relevant to any child protection assessment. Unfortunately, only a minority of caregivers report that there are protection services available to them for support when they are stressed. Similar to reports from children, there is a gap between communities with a larger proportion of refugee caregivers (41%) reporting having access to such services as compared to host community caregivers (21%) (see figure 38).

Similar to child respondents, 90% each of refugee and host community caregivers with access to services targeting stress have also sought those services. A majority of both caregiver groups (87% of refugee and 93% of host community caregivers) who reported having access to services also reported that these services were “effective” or “very effective”.

When asked about official service providers targeting MHPSS in their communities, refugee children and caregivers named NGO and UN agencies, child protection committees and community members as the top three service providers targeting stress. Host community respondents most frequently reported community members, religious leaders and VHTs and the government as organizations providing services (see figure 41). Para-social workers were reported to be a source of services addressing stress by 12% and 15% of refugee children and caregivers respectively. These proportions are 9% and 10% for host community respondents.

The most frequently named types of services available to respond to stress in the refugee community include awareness raising and sensitisation, case management services, and community based psychosocial support. Host community respondents more frequently reported that awareness raising and sensitisation, community based psychosocial support, case management services, and enforcement of bylaws on child rights are offered.

Figure 41: Top three most frequently reported service providers offering services in response to stress by survey and community type⁴¹

Refugee children	
Refugee caregivers	
1	50% NGOs and UN agencies
	45%
2	48% Child protection committees
	37%
3	35% Community members
	32%
Host community children	
Host community caregivers	
1	67% Community members
	57%
2	53% Religious leaders and VHTs
	38%
3	31% Government
	35%

41. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Unaccompanied and Separated Children

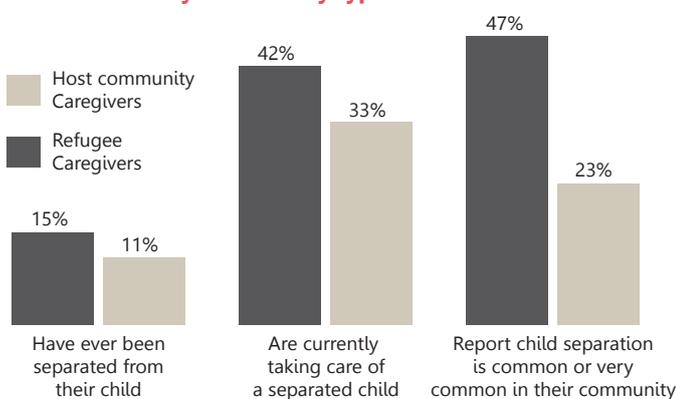
Data on child separations indicates that the occurrence of this risk may be underreported by caregivers and overreported by children. Just under one third (31%) of refugee children report that either them, their sibling or both their sibling and they themselves have ever been separated from their parents. Similarly, this proportion stands at 25% amongst host community children. Notably the proportion of parents reporting ever having been separated from their child is lower in both communities. Only 15% of refugee and 11% of host community caregivers report this. It is important to note that these proportions do not reflect current caseloads for UASC, rather the occurrence of separations across the life-spans of children and their caregivers. This means that the proportions reported here are a reflection of the number of children who have ever encountered a risk factor that has, at that point in time, increased the risk of them being separated from their caregivers

Definition of “separated children”: For purposes of this assessment, separated children are defined as children under 18 years of age who are separated from both parents or from their previous legal or customary primary caregiver but are accompanied by other family members that are not their biological or legal caregivers.

Definition of “unaccompanied minors or UAM”: For the purposes of this assessment, UAM are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.

When caregivers were asked how common it is for children in their communities to be separated from their parents, 47% of refugee and 23% of host community caregivers reported that this was either “common” or “very common”. In addition, when caregivers were asked if they are currently caring for a child that is not biologically their own (e.g., a separated child), over a third of respondents reported that this was the case (42% of refugee and 33% of host community

Figure 42: Proportion of caregivers reporting the prevalence of separated children in their households and communities by community type



caregivers). The discrepancy between the low proportion of caregivers reporting ever having been separated from their children and the relatively higher proportions of caregivers reporting prevalence of separations in the community at large and reporting currently caring for a separated child, indicate that caregivers may be biased towards underreporting ever having been separated from their own child (see figure 42). Nevertheless, the data does indicate that child separations may be more frequent amongst refugees as compared to host communities. This may be linked to heightened chances of being separated during relocation or flight as well as regular movement of refugee parents back to their countries of origin.

In accordance with this assumption, child separations are more frequently reported by refugee children living in the West Nile (36%) region as compared to the south-west (23%). Since refugees in this region on average have more recently relocated to Uganda,⁴² this difference may be similarly due to higher rates of relocations experiences by refugee children in the northern vs the southern region. Table 07 shows that particularly high rates of refugee children in Imvepi, Palabek, Rhino Camp, and Bidibidi report that separation has occurred in their households.

The data indicates that unaccompanied children may be similarly underreported. About half of the children in both communities (50% of refugee and 58% of host community children) reporting having ever been separated from their biological parents, also report being simultaneously separated from all other relatives. This works out at 16% and 15% of the whole sample respectively. However, virtually all of them report that an alternative care arrangement was then made. The alternative care arrangements reportedly most frequently took the form of placing the child with a neighbour

42. When refugee caregivers were asked when their family had first arrived in Uganda, a large majority (72%) of those in the West Nile reported “between 5-10 years ago” and a further 22% reported “between 1-5 years ago”. In comparison, 32% of those in the south-west reported “between 5-10 years”, 31% reported “between 1-5 years ago”, and 25% reported “more than 25 years ago”.

Table 07: Proportion of refugee caregivers reporting having ever been separated from their children and refugee children reporting that either they or their siblings have ever been separated from their parents

Settlement	Refugee Children	Refugee Caregivers
Imvepi	53%	25%
Palabek	43%	25%
Rhino Camp	41%	21%
Bidibidi	41%	13%
Kyangwali	32%	12%
Palorinya	30%	16%
Lobule	26%	19%
Nakivale	23%	10%
Adjumani	23%	18%
Rwamwanja	22%	15%
Kiryandongo	21%	13%
Oruchinga	15%	13%
Kyaka II	14%	5%

or other community member. Similarly, the proportions of caregivers reporting that children who are separated from their parents, are also separated from other relatives, stand at 1% of caregivers in each community across the whole sample. These findings indicate that there are no unaccompanied children amongst refugees or host communities across Uganda. However, when asked how common it is for children in their communities to be separated from their parents and all other caregivers, 37% of refugee and 15% of host community caregivers reported that it is “common” or “very common” that children in their communities are unaccompanied. This data stands in clear contradiction to the above indications that no UAC are present in the communities and implies that UAC may be more common than is reported to occur in the households of assessed children and caregivers.

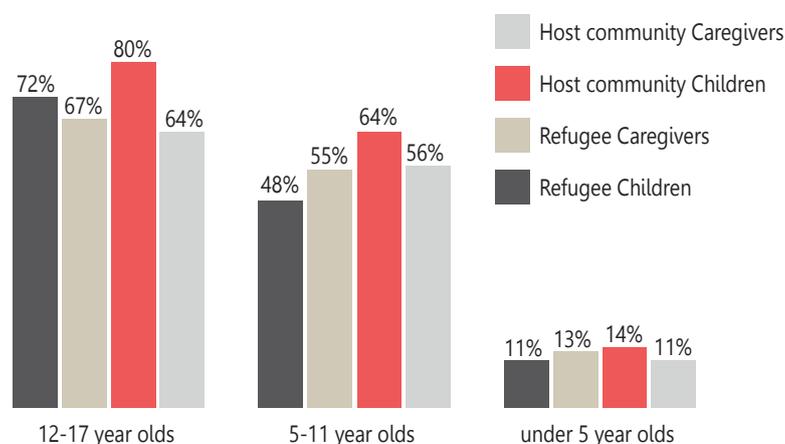
Secondary data further strengthens the conclusion that assessed caregivers and children are under-reporting the frequency of both separations of children from their parents and from all caregivers.

For example, the UNHCR’s refugee response plan (RRP) child protection dashboard from 2020-2021, cites almost 12,000 separated or UAC were receiving services at the time of the dashboard’s publishing and goes on to state that “provision and monitoring of alternative care arrangements (...) remains a critical priority”.⁴³ This indicates that alternative care arrangements are not yet capturing all separated children and UAC registered with the UNHCR and emphasizes that the prevalence of UAC is underreported here.

One factor that may have contributed to the underreporting of the prevalence of UASC specifically, is the difficulty in differentiating between separated children and unaccompanied children amongst community respondents. Although definitions of both concepts were read out to all respondents, qualitative data shows that refugee respondents were not always able to effectively differentiate between the two or that respondents simply used the terms “separated” and “unaccompanied” interchangeably. In addition, it is possible that parents shy away from admitting having ever been separated from their child or that their child may be unaccompanied due to shame. Qualitative data also indicates that due to the high incident rate, cases of separation and UAC may not always be reported properly.

“Separated children are many and remain unidentified. This is evidenced by the many children that come to distribution points to get food for their families. When the parents leave and go back to [South] Sudan, they leave children with female relatives who already have many children and can hardly keep up with all; so, the children do everything for themselves.”
(KII with an NGO worker in Kiryandongo)

Figure 43: Proportion of respondents reporting the ages of children affected by separation from their parents in the past by community and survey type^{44, 45}



43. Uganda Refugee Response Plan (RRP) 2020-2021, Child Protection Dashboard - Quarter 2, UNHCR

44. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

45. Please note that, since respondents were asked about the occurrence of separations over their lifespans, reports of older children being affected by separation over their life-spans are logically more common given that these children have had comparatively more time to be affected by this risk.

Due to the unreliable figures around UAC, the remainder of this chapter will focus solely on separated children. However, updated data on UASCs is currently being collected through the verification exercises in the different settlements.

Respondents from all demographic groups agree that children affected by separation from their biological parents are most often adolescents. However, caregivers from both communities nearly as frequently report that children between the ages of 5 and 11 are also affected (see figure 43). A majority of respondents in all demographic groups further report that both genders are equally affected by this risk. Finally, although all respondents agree that separation does also occur amongst under-five-year-olds, respondents agree that this is not the primary age group affected.

Causes of child separation

Most frequently reported causes of separation of children from their parents as reported by caregivers include death or illness of the caregiver, separation to find work (on the part of caregivers) or to stay with relatives or access improved education, and, for refugees, losing contact during displacement or relocation (see figure 44). In addition, host community caregivers also report that separation is caused by the detention or jailing of parents.

Given the reports of parents having to leave their children to find work or to send them to relatives to be taken care of it is likely that economic factors increase the risk of child separation. When caregivers were asked if any particular group of children faces an increased risk of being separated from their parents, over half of the respondents in both communities reported that children from poor households fit this description, further strengthening this assumption. In addition, when caregivers were asked if there were persons present or visiting this community who have tried to take children away by promising jobs, assistance, or better living conditions, 26% of refugee and 31% of host community caregivers, reported that this was the case (see figure 45). Some qualitative data affirms this. In sum, the data indicates that separations may not always be accidental but are in some cases driven by economic factors.

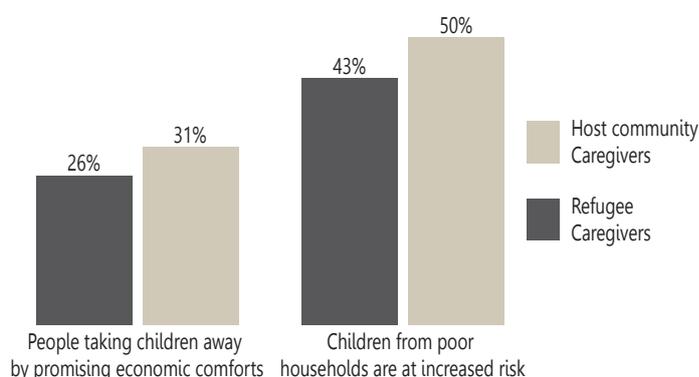
Finally, it is important to note that respondents from all demographic groups agree that children who have been separated from their parents, then face increases in other risks including child labour, child marriage, neglect, physical violence, and psychological distress. Respondents across all four of the main demographic groups assessed, agree on the top five risks which increase once a child is separated from their family (see figure 46). Qualitative data further highlights this, with respondents across both regions reporting that separated children face increased risks. One respondent even implied that the discrimination faced by separated children may lead to increased cases of UASC:

"There are many children who are separated from their parents because some parents willingly send their children to school here and some just go back and leave the children behind, these children are always at risk of being abused, overworked and sometimes leave home." (IDI with a foster parent in Kiryandongo)

Figure 44: Top five most frequently reported causes of child separation as reported by caregivers⁴⁶

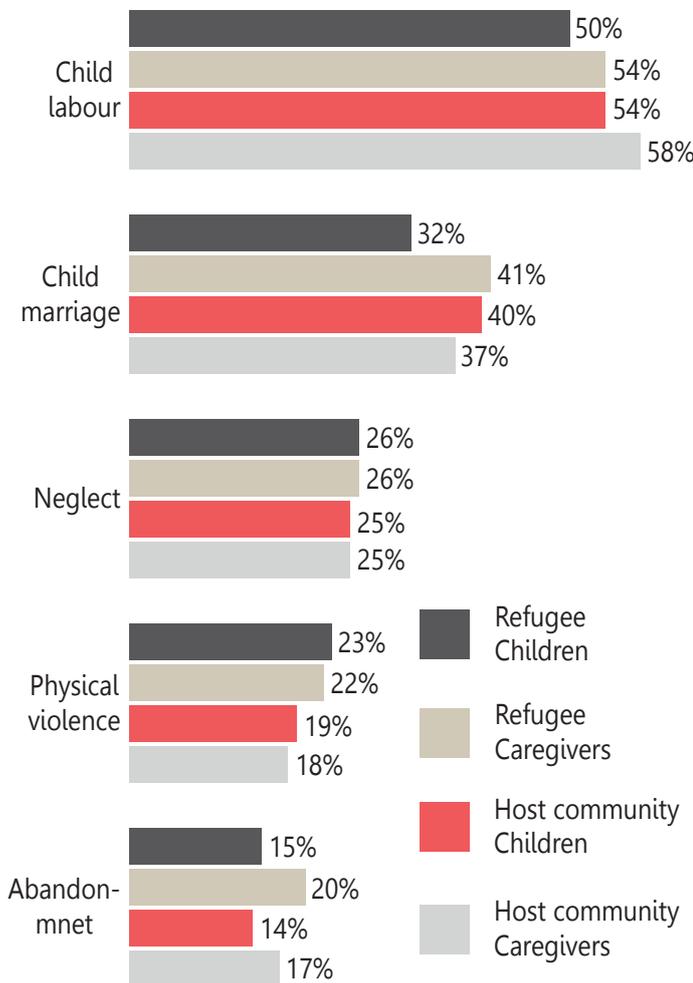
Refugee caregivers		Host community caregivers			
1	67%	Parents deceased	1	76%	Parents deceased
2	32%	Contact lost during relocation	2	24%	Children sent to stay with relatives
3	30%	Parents returned to country of origin	3	22%	Parents detained or jailed
3	19%	Children were sent for better education	3	21%	Children were sent for better education
3	17%	Parents are ill	3	18%	Parents are ill

Figure 45: Proportion of caregivers reporting economic factors contributing to the prevalence of child separation in their communities



46. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 46: Top five reportedly increased risks for separated children by community and survey type⁴⁷



Specific Child Protection Services Offered in Response to UASC

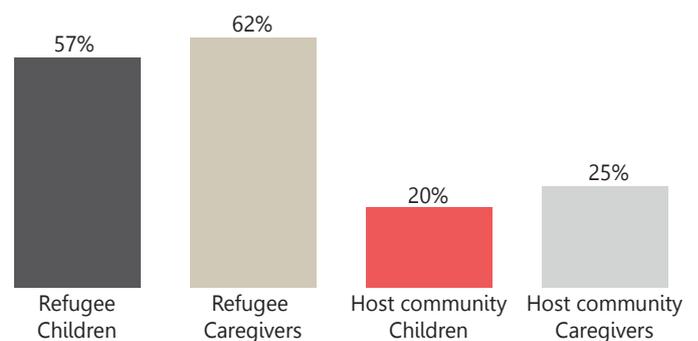
Services that target children who have been separated from their relatives or are unaccompanied, are reportedly more common amongst refugees as compared to the host community (see figure 47). Further, within each demographic group, respondents from the south-west were less likely to report that services targeting separated children are operating in their community. Specifically, only 53% of refugee children and 56% of refugee caregivers in the south-west reported that such a service exists in their communities compared to 60% and 67% respectively in the West Nile. Similarly, only 14% of host community children and 20% of host community caregivers reported knowing of a service targeting separated children in their community compared to 24% and 28% respectively in the West Nile.

Despite the reported inequality in service availability, a large majority of respondents from all demographic groups who reported that services for separated children are available in their communities, also reported that these services are easy for them and their family members to access. This proportion stands at 84% for both refugee children and caregivers and at 90% and 92% for host community children and caregivers respectively. Amongst the minorities of respondents in both communities that reported having

services available to them but not being able to access them, the most frequently reported reasons were delays in case management, sometimes due to a lack of sufficient staff, and a lack of knowledge on how to reach the services either via the phone or because the service's physical location was unknown.

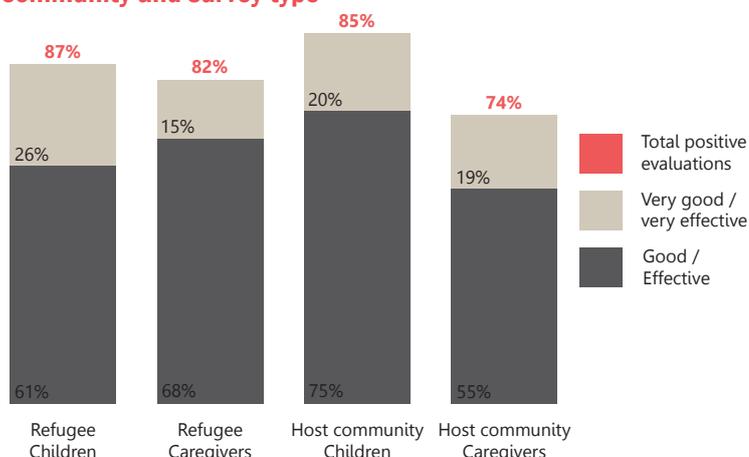
When those respondents who reported having services available to them were asked if they had ever made use of these services, 41% of refugee children and 33% of refugee caregivers reported that they had. For the host community, these proportions are lower at 34% and 25% for children and caregivers respectively. Of the respondents that reported having ever made use of protection services targeting separated children, majorities in each demographic group reported that these services were "good" or "very good" (in the case of child respondents) or "effective" or "very effective" (in the case of caregivers) (see figure 48).

Figure 47: Proportion of respondents by community and survey type reporting having access to services addressing child separation and UASC in their communities



47. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 48: Proportion of respondents reporting the effectiveness of services targeting child separation in their communities by community and survey type



Finally, refugee respondents agree that NGO and UN agencies, child protection committees and the government are the top three providers of services related to child separation. The top three types of services available to refugee communities to target this risk are reportedly, case management, basic support from para-socials, and alternative care. Host community respondents most frequently named community members, the government, and child protection committees as the sources of protection services targeting child separation in their communities. Similar to service providers in refugee communities, host community respondents most often reported that these providers make the

following services available: enforcement of bylaws on child rights, case management, basic support from para-socials, and alternative care arrangements.

Other Risks

Once respondents had been interviewed concerning child labour, VAC, family separation, and psychological distress including the impact of COVID-19, they were asked what other risks children in their community face. All four main demographic groups agree that environmental risks and road accidents are the top remaining risks that children face (see figure 49). Qualitative data shows that environmental risks can be linked to inadequate infrastructure or inability of parents to supervise their children during play among other factors. Male caregivers interviewed in FGDs pointed out:

“The bridges connecting these villages were poorly built and so they fill up and our kids [are] at risk of drowning if they are to cross these bridges when they are going to school.” (FGD with male caregivers Bidibidi)

and

“Children set fire on houses as they play (grass thatched houses). It is very risk to leave children home without an adult.” (FGD with male caregivers in Kiryandongo)

Encouragingly, all four groups also frequently reported that, aside from the risks previously discussed, children in their communities face no additional risks. Nevertheless, the data indicates that environmental hazards and road accidents are risks that should not be ignored. When asked about the frequency of these risks, about one fifth of the children from each community (19% of refugee and 20% of host community children) reported that they face these risks “often” or “very often”.

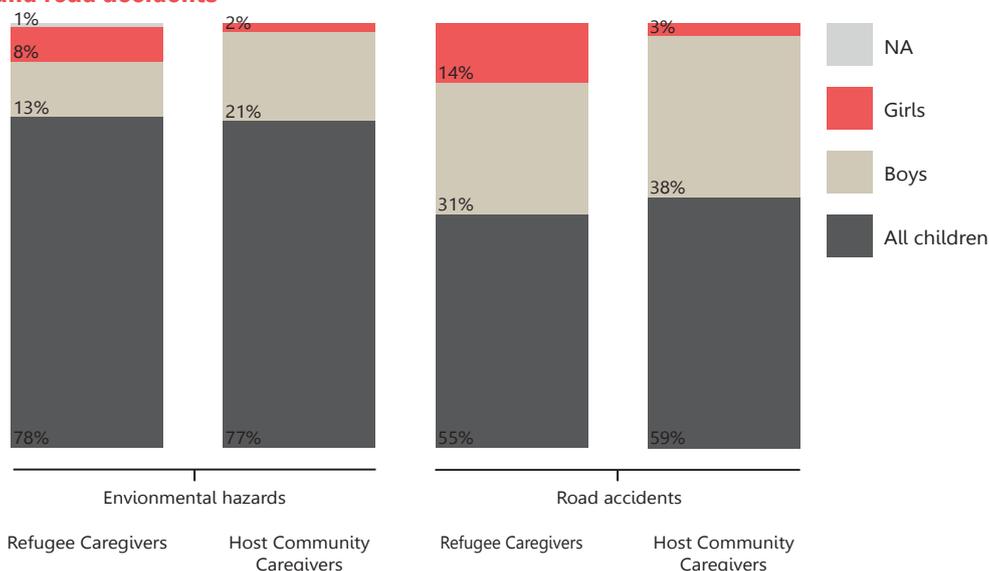
Caregivers agree that all children of all ages face environmental risks evenly. More specifically, 30% of refugee caregivers reported that children of all ages are affected evenly while 33% reported that each 5-11-year-olds and 12-17-year-olds were most at risk. Similarly, 38% of host community caregivers reported that all children are evenly at risk while 30% reported 5-11-year-olds and 29% reported 12-17-year-olds. Notably only small minorities of caregivers in each community reported that children under the age of five are at risk of environmental hazards.

Notably, a majority of caregivers (72% of refugee and 61% of host community caregivers) report that 12-17-year-olds are most at risk of road accidents. When asked whether boys or girls are more at risk of environmental hazards and road accidents, the majority of caregivers in both community groups agree that both genders face these risks evenly. However, minorities in each community reported that boys

Figure 49: Top three most frequently reported risks not already specifically discussed facing children by community and survey type⁴⁸

Refugee Children Refugee Caregiver		Host community Children Host community Caregivers	
1	26% Environmental hazards	1	31% Environmental hazards
2	30% None	2	27% Road accidents
3	20% Road accidents	3	20% None

Figure 50: Proportion of refugee and host community caregivers reporting which genders of children are particularly at risk of being affected by environmental hazards and road accidents



48. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

are particularly at risk whilst virtually no caregivers reported that girls are particularly at risk (see figure 50).

Specific Child Protection Services Offered in Relation to Other Risks

Services other child protection risks are reportedly more available to refugees as compared to host community members. On the national level, 56% of refugee children and caregivers each reported that such services are available to them while only 35% of host community children and 31% of host community caregivers reported this. Disaggregating by region shows that these services are also more available to people in the West Nile region as compared to the south-west (see figure 51).

Of the respondents reporting availability of services, large majorities also report that they are easily accessible. In particular, 88% of refugee children, 91% of refugee caregivers, 82% of host community children, and 82% of host community caregivers report this. Despite similarly low barriers to access, smaller proportions of host community respondents report having ever sought out these services. In fact, 46% of refugee children and 40% of refugee caregivers report having gone to a service targeting environmental hazards or road accidents for help in comparison to only 29% of host community children and caregivers each.

A majority of those respondents who have experience using these services, reported that they were effective or good. The data also shows that there were few differences between caregivers and children and between refugee and host community respondents for this finding. Eighty-four percent (84%) of refugee and 76% of host community caregivers reported that the services were “effective or “very effective” and 89% of refugee children and 79% of host community children reported they were “good” or “very good”.

Finally, figure 52 shows that the top three most frequently reported service providers amongst refugees were child protection committees, NGOs and UN agencies and the government. The top three most frequently reported service providers targeting other child protection risks amongst host community are the government, community members and religious leaders or VHTs.

The most common services provided to refugee respondents include case management, awareness raising and sensitization, and basic support from para-socials. Host community respondents most frequently reported the enforcement of bylaws on child rights, awareness raising and sensitization, and case management.

Figure 51: Proportion of respondents reporting the availability of services targeting other child protection risks by region, community and survey type

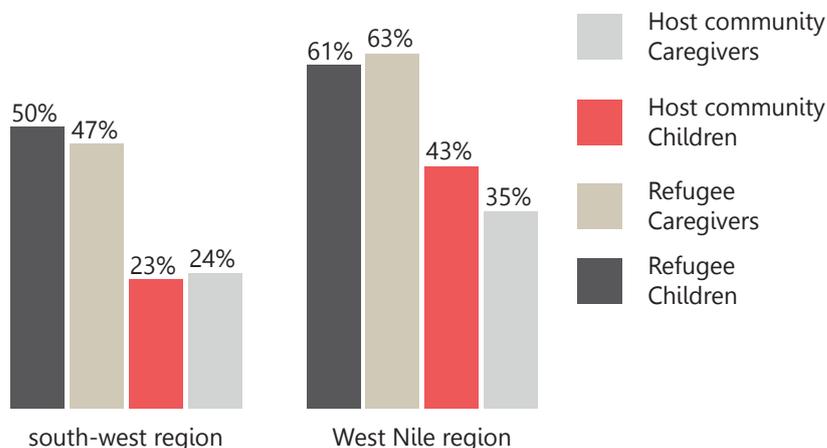


Figure 52: Top three reported providers of child protection services addressing other child protection risks by community and survey type⁴⁹

Refugee Children		Host community Children	
Refugee Caregivers		Host community Caregivers	
1	50% 51%	1	57% 78%
	Child protection committees		Government
2	48% 44%	2	52% 30%
	NGO and UN agencies		Community members
3	43% 38%	3	26% 16%
	Government		Religious leaders and VHTs

49. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

CHILD PROTECTION RISKS IN KAMPALA

The following section will follow the same structure as the general child protection risks section above. However, some of the indicators cannot be presented for Kampala, due to the smaller sample sizes for this location. Much of the data related to specific child protection risks is based on a set of follow-up questions that are only asked to a subset of the sample. If the subset for either of the Kampala samples (children or caregivers) is too small, the data will not be presented. Whenever data is presented for a subset, this will be indicated in the text and graph. Data for all indicators for Kampala can be viewed in the dataset, though care should always be taken when dealing with small subset sizes. Additionally, as opposed to the samples in the settlements and host communities, the caregiver and child samples in Kampala were not randomly sampled, meaning that the data is indicative only and should not be taken as representative for all refugees in Kampala.

Overview of Risks

When asked which child protection risks, they have been most concerned about (in the case of children) or which they have witnessed (in the case of caregivers) over the last three months, similarly high proportions of refugee children and caregivers living in Kampala reported “no particular risk” (see figures 53 and 54). This is notably higher than among children and caregivers in the settlements, where respectively 33% and 24% reported ‘no particular risk’. Child respondents in Kampala were somewhat more likely to report ‘no particular risk’ than the caregivers. In terms of concerns, children in Kampala most frequently reported to be concerned about child labour and physical violence. Among caregivers, these two risks were also the most commonly witnessed. A key difference in the reporting of children and caregivers is that 16% of caregivers reported having witnessed sexual violence, where this was not one of the six most commonly reported concerns among children. This may be related to under-reporting of this especially sensitive issue. In general, child respondents were less likely to report concerns compared to witness reporting from caregivers. In contrast, when asked about selected risks in particular, much higher proportions of interviewed refugee children in Kampala reported having experienced psychological distress (90%), physical harm / environmental risks (81%) and child labour (78%). These self-reported issues will be discussed in more detail in the dedicated sections below.

Figure 53: Top six risks that children in Kampala reported being most concerned about in the three months prior to data collection⁵⁰

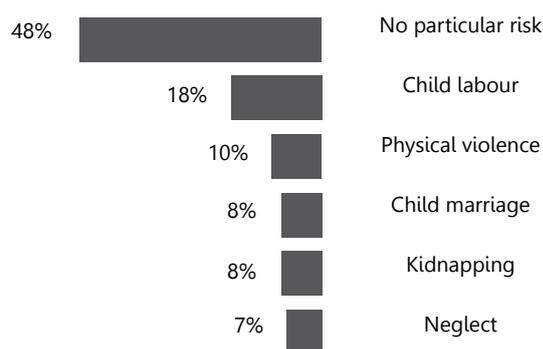
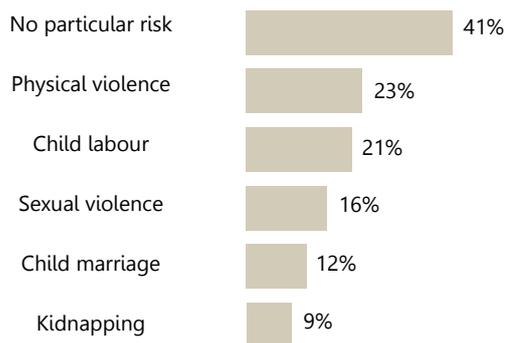


Figure 54: Top six risks that caregivers in Kampala reported having witnessed in the three months prior to data collection⁵⁰

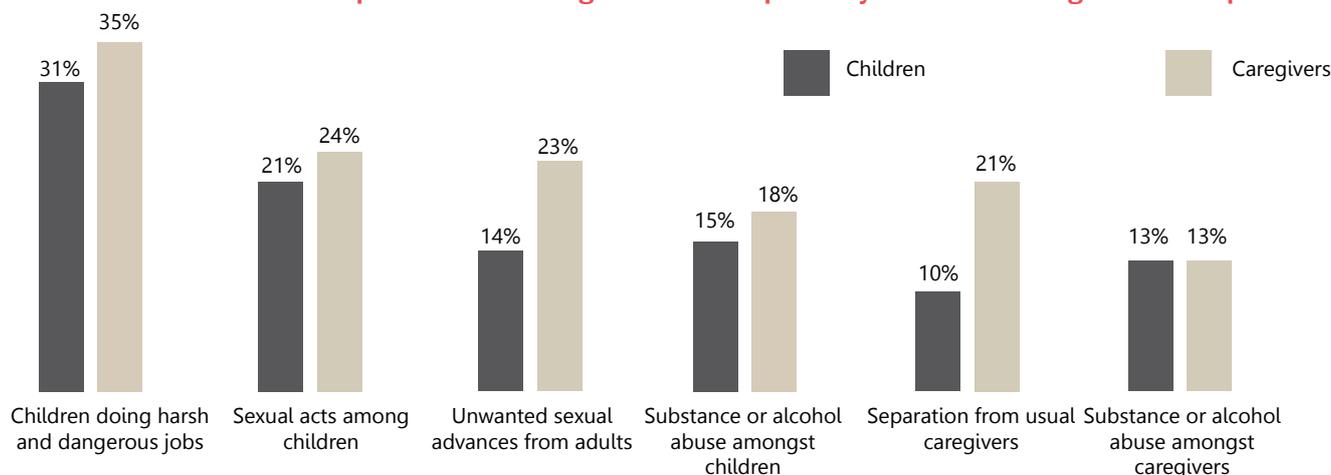


Impact of COVID-19

The majority of children and caregivers in Kampala reported at least one child protection concern that had increased during the COVID-19 period. Caregivers were somewhat more likely to report increases in child protection concerns, as 81% reported on at least one increased concern, compared to 65% of children in Kampala. In terms of the concerns that were most commonly reported to have increased, the findings are similar for children and caregivers (see figure 55). Both groups most commonly reported that children are engaging in more dangerous and harsh work, which also aligns with the findings from the settlements and host communities. The second most commonly reported increased concern

50. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 55: Top six child protection risks that have most frequently been reported as having increased in the communities in which respondents live during the COVID-19 period by children and caregivers in Kampala⁵¹



by both children and caregivers in Kampala during COVID-19 is sexual acts amongst children. In terms of the relation to the general concerns and witnessed risks presented above, child labour was both a common concern and argued to have increased. Interestingly, physical violence was commonly mentioned by caregivers and children on the first indicator, but rarely reported as to have increased during COVID-19.

Child labour

Among the caregivers in Kampala, 13% were found to have at least one child in the household that is engaged in child labour. Overall, 9% of child respondents in Kampala were found to be engaged in child labour. For the detailed child labour definition used for the classifications, as well as a potential explanation for the apparent under-reporting, see page 17. Overall, 65% of caregivers reported that at least one child in the household does domestic chores. In contrast, only 6% of caregivers in Kampala reported that a child is engaged in economic labour. Note that neither finding by itself indicates that a child is engaged in child labour. Among child respondents in Kampala, 79% reported to do domestic chores and 14% reported to be engaged in economic work.

Harsh and dangerous labour

Both children and caregivers were asked how common it was for children in the community to be engaged in harsh or dangerous labour. The definition of harsh or dangerous work can be found on page 17. Figure 56 shows the proportion of both children and caregivers in Kampala who reported that children in the community are involved in harsh or dangerous work rarely, sometimes, often, or very often. Children reported harsh and dangerous labour slightly less commonly, but a relatively large proportion was not willing or able to provide an answer to this question (13% compared to 1% of caregivers in Kampala).

Figure 56: Proportion of children and caregivers in Kampala reporting having witnessed that children in the community are involved in harsh or dangerous labour



Caregivers who reported that harsh or dangerous labour of children occurred in the community (70%, 97 respondents) were subsequently asked about the profile of children who were most likely to be involved with harsh or dangerous labour (see figure 57). In terms of the role of gender of the child, there was no clear consensus on who is most affected, though few caregivers reported that girls are most affected. There was a clear majority of caregivers in Kampala reporting that children aged 15-17 are most affected by harsh or dangerous labour. Considering the required physical fitness for some of the forms of harsh and dangerous labour, such as construction and stone quarrying, this is perhaps not particularly surprising. In terms of groups that are most affected, well over a third of caregivers in Kampala (43%)

51. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 57: Among caregivers in Kampala who reported on harsh and dangerous labour (70%, 97 respondents), proportion reporting on characteristics of most affected children

Figure 57.a: Gender of most affected children

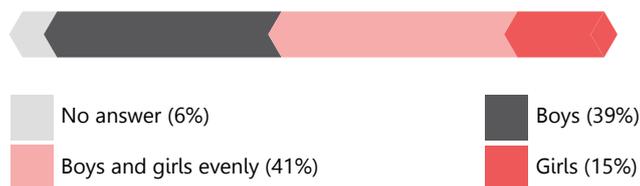


Figure 57.b: Age of most affected children

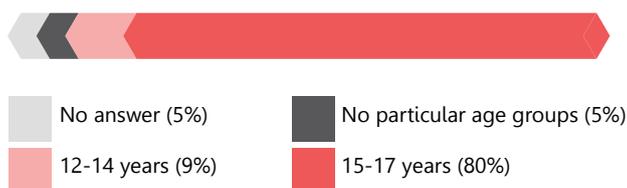
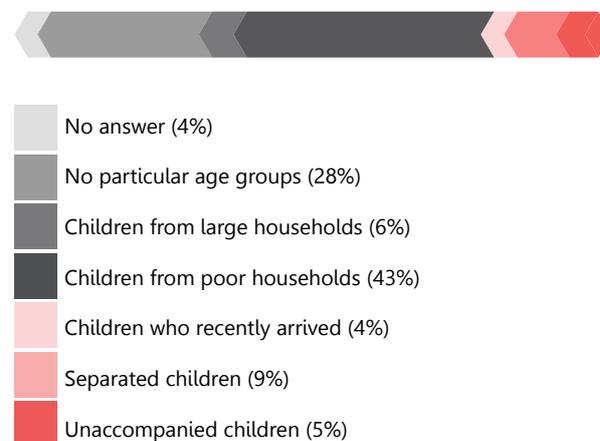


Figure 57.c: Specific groups of most affected children

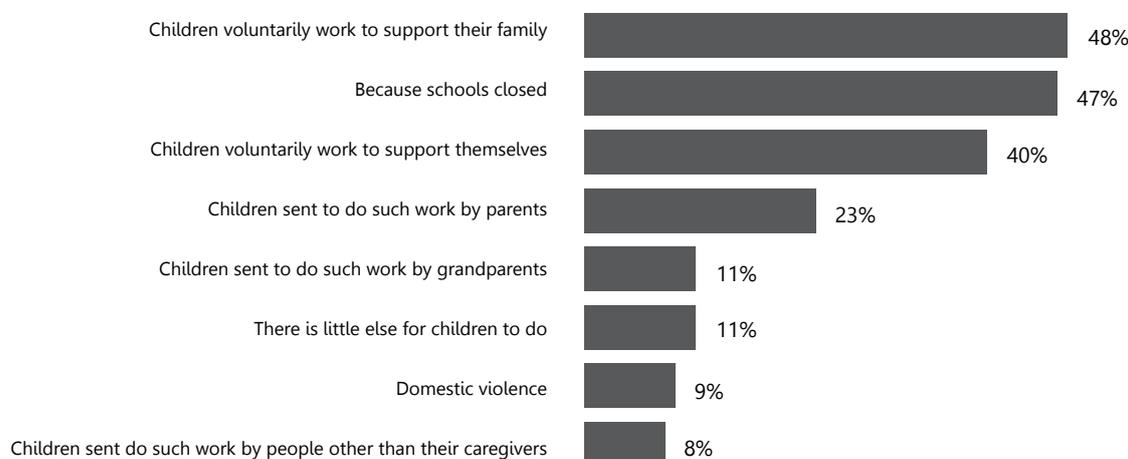


reported that children from poor households were most affected. Overall, caregivers in Kampala reported that both boys and girls, especially those aged 15-17 from poor households, are affected or involved with harsh or dangerous labour.

Causes for involvement in harsh or dangerous labour

Beyond the prevalence and profile of child involvement in harsh or dangerous labour, caregivers were additionally asked what the reasons were for children in the community doing harsh or dangerous labour. Caregivers commonly reported that children work in these jobs on a voluntarily basis, in order to support themselves and their family (see figure 58). Overall, 58% of the caregivers in Kampala reported that children do harsh or dangerous labour to either support their family, themselves, or both. This aligns with the findings presented in figure 57.c, where a large proportion of caregivers reported that children from poor households are most affected and most likely to be engaged with harsh and dangerous labour. Another commonly reported reason for child involvement in harsh or dangerous labour was school closures. Important to note is that data collection was conducted around the time that school closures in Uganda ended, hence these findings may look somewhat different if data were collected now that schools are generally open. Overall, the

Figure 58: Among caregivers in Kampala who reported on harsh and dangerous labour (70%, 97 respondents), proportion per reported reason for child involvement in harsh or dangerous labour⁵²



52. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

findings related to harsh and dangerous labour primarily indicate the relationship between poverty among refugees and children working in these types of jobs.

Impact of COVID-19 on the Prevalence of Harsh and Dangerous Labour

As per figure 54 on page 42, child involvement in harsh or dangerous labour was the most commonly reported child protection risk to have increased during the COVID-19 period by both children and caregivers in Kampala. As noted above, 31% of child respondents and 35% of caregivers in Kampala reported that children doing harsh or dangerous jobs has become more common in the COVID-19 period. Caregivers who reported that harsh and dangerous labour for children occurred in their community (70%, 97 respondents) were additionally asked directly about whether they thought this had become more prevalent in the COVID-19 period. To this question, 63% of the caregivers answered that they thought more children had become involved in harsh or dangerous labour. This discrepancy is likely related to the differences in how the questions are asked. The first question asks about an increase in prevalence that is observed, whereas the second question asks more broadly about perception. Regardless of the discrepancy between the two questions, the findings indicate that the prevalence of child involvement in harsh and dangerous labour has increased during the COVID-19 period.

Specific Child Protection Services Offered in Response to Child Labour

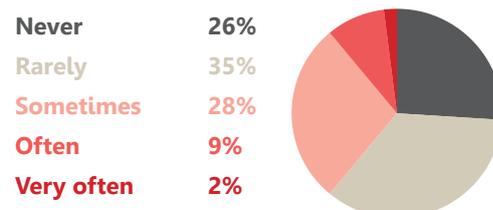
Both caregivers and children in Kampala were asked whether there were any services available to protect or support children who are involved in harsh or dangerous labour. Overall, 20% of children and 18% of caregivers in Kampala reported that such services were available. This is considerably lower than the proportion of refugees in the settlements that reported services were available (52% of children and 53% of caregivers in the settlements). Although the findings for Kampala are not similarly representative, it appears that service availability related to child involvement in harsh and dangerous labour is worse in Kampala than it is in the settlements.

Violence Against Children

For a definition of VAC see page 23. Among caregiver respondents, 9% reported that a child in their household had experienced violence in the three months prior data collection. When asked generally about the prevalence of VAC in their community, the majority of caregivers reported that it does occur (see figure 59).

The 74% of caregivers (103 respondents) who reported that VAC occurs in their community (regardless of whether they reported 'rarely' or 'very often') were subsequently asked whether there were any groups of children that are more likely to be affected by VAC. While for harsh or dangerous labour it appeared, boys were more likely to be affected, girls are more

Figure 59: Proportion of caregivers in Kampala reporting on the frequency of VAC in their community



commonly reported to be affected by VAC. Nevertheless, the majority still reported that the risks for girls and boys are even in this respect. A small majority of respondents reported that children aged 12-17 are most likely to be affected, while 34% reported that there is not major difference between age groups. In terms of specific groups, the most commonly reported group to be most affected were children from poor households. This group was also the most commonly mentioned for children affected by harsh or dangerous labour. Otherwise, the groups that were reported on differ substantially between these two kinds of risks. Overall, the profile that emerges for children most likely to be affected by VAC is not entirely clear, as for all indicators a large proportion of respondents indicated that no particular group was especially vulnerable (see figure 60).

Causes of Violence Against Children

Most of the caregivers reported multiple causes of VAC. The most commonly reported cause was substance abuse among adults (see figure 61) Caregivers were somewhat more likely to report on multiple causes, with all four suggested causes of VAC commonly reported. The findings and data generally align with the most commonly reported causes of VAC among both host community members and refugees in the settlements.

Figure 60: Among caregivers in Kampala who reported on VAC in their community (74%, 103 respondents), proportion reporting on characteristics of most affected children

Figure 60.a: Gender of most affected children

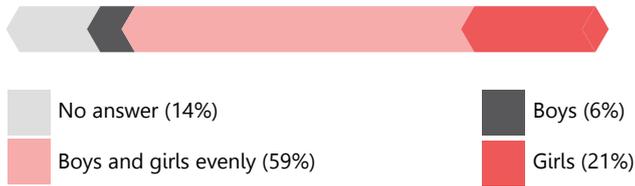
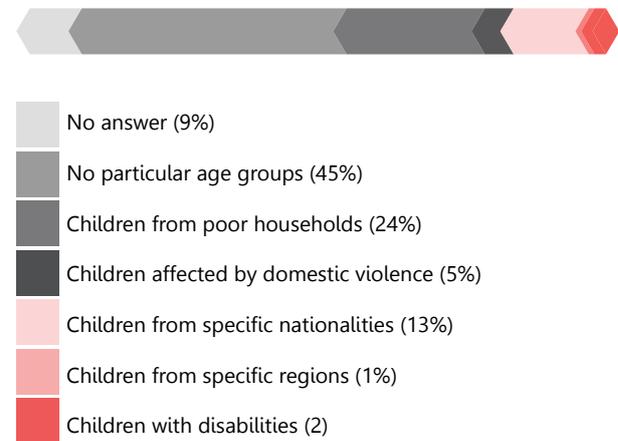


Figure 60.b: Age of most affected children



Figure 60.c: Specific groups of most affected children



Specific Child Protection Services Offered in Response to Violence Against Children

For services specific to preventing VAC or supporting children who have been affected, 24% of children and 19% of caregivers in Kampala reported they were available in their community. These findings are comparable to reported availability of services specific to harsh or dangerous labour in Kampala. Compared to the settlements, however, these percentages are low. The majority of refugee children and caregivers in Kampala reported that services related to VAC were available (65% and 66% respectively). As was noted in the child labour section, it appears there are less specialized child protection-related services available in refugee communities in Kampala than in the settlements.

Figure 61: Proportion of caregivers in Kampala reporting on the main causes of VAC⁵³



Sexual Violence, Child Marriage, and Teenage Pregnancy

The definition of sexual violence used for this assessment can be found on page 26. Among refugee caregivers interviewed in Kampala, 11% reported that children in the household had experienced sexual violence. This is roughly comparable with the reported experience of sexual violence by refugees in the settlements. In terms of the perceived prevalence in the community, 11% of caregivers reported that sexual violence occurs often or very often, 18% reported it occurs sometimes, and 24% reported it occurs rarely. Notably, 19% of caregivers were not able or did not wish to provide an answer, which is higher than for any other child protection risk, reflecting the sensitivity of this particular topic. The caregivers who reported that sexual violence occurs rarely, sometimes, often, or very often (53% total, 74 respondents), were also asked if any groups or children were more vulnerable. Just short of a majority of respondents reported that girls were most vulnerable (48%), with an additional 33% reporting that girls and boys are evenly affected by sexual violence. Children aged 12 to 17 were reported by the large majority of the caregivers in Kampala to be the most affected (96%). In terms of specific groups, the most commonly reported vulnerable group was children from poor households (29%).

Both children and caregivers were asked in what places or contexts sexual violence is most likely to occur (see figure 53. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

62). Interestingly, the top five most commonly reported places by children and caregivers in Kampala are the same, but the ordering of which places are most likely differing. Among child respondents in Kampala, at or on the way to the market was most commonly reported, followed by outside of the community. Caregivers in Kampala most commonly reported outside the community, followed by while around within the community. While the two types of respondents appear to agree generally on the most risky contexts in terms of sexual violence, there do also appear to be some differences in risk perception between children and caregivers in Kampala. Additionally, the reported places in Kampala do also differ somewhat from the reported places in the settlements and adjacent host communities. Activities such as collecting firewood or water were commonly reported outside of Kampala as contexts where sexual violence is most likely, while this was rarely reported in Kampala. This may indicate a key distinction

Figure 62: Top five places in Kampala where sexual violence is most likely to occur as reported by caregivers⁵⁴

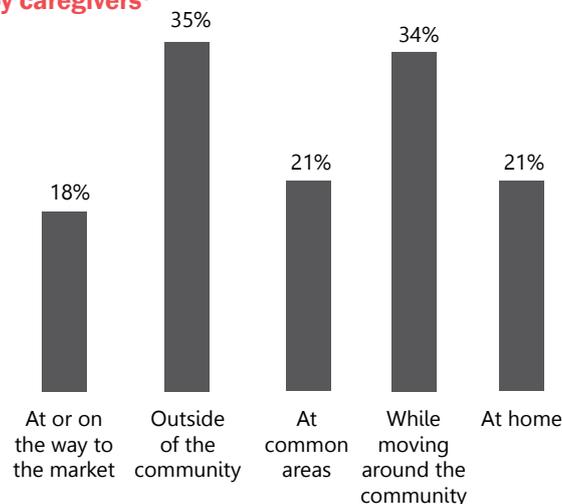


Figure 63: Top five most commonly reported likely perpetrators of sexual violence, by survey type in Kampala⁵⁴

Caregivers (72%, 100 respondents)

- 1 50% Community members
- 2 16% Household members
- 3 33% Youths
- 3 24% Police or security agencies
- 3 14% Relatives outside the household

in the risk environments between these contexts in relation to sexual violence.

All children in Kampala were asked who they believed to be the most likely perpetrators of sexual violence in their community. A subset of caregivers (72%, 100 respondents) was asked the same question. The top five most commonly reported likely perpetrators are the same for children and caregivers, as is the single most commonly reported likely perpetrator (community members) (see figure 63).

Among caregiver respondents in Kampala, household members were the third most commonly reported likely perpetrators of sexual violence against children. Additionally, caregivers reported on community members and household members to differing degrees (50% vs. 16%). It is not entirely clear where this difference in perception and reporting

may come from, though it may be related to caregivers being unwilling to report on the group they belong to. However, these findings align with those presented in figure 62, where 16% of caregivers indicate that sexual violence may occur at home.

Causes of Sexual Violence Against Children

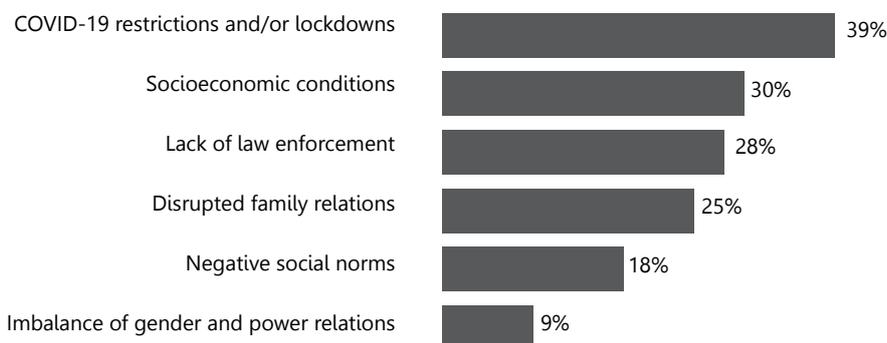
Among caregivers who reported the occurrence of sexual violence in their community (72%, 100 respondents), the most commonly reported cause was COVID-19 restrictions and lockdowns (see figure 64). As per figure 55 on page 42, sexual acts between minors and sexual advances by adults were two of the most commonly reported child protection risks to have increased during the COVID-19 period. Similarly, commonly reported causes of sexual violence were socioeconomic conditions and lack of law enforcement. The three most commonly reported causes of sexual violence in Kampala align with the most commonly reported causes by both refugees in the settlements and the host communities.

Specific Child Protection Services Offered in Response to Sexual Violence

Overall, 23% of children and 20% of caregivers in Kampala reported that there were services available in the community that aim to prevent sexual violence against children and/or support children who have been affected. This is again significantly lower than reported service availability in the settlements (70% of children, 72% of caregivers), further

54. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Figure 64: Among caregivers in Kampala who reported on sexual violence in their community (72%, 100 respondents), proportion per reported cause of sexual violence against children⁵⁵



indicating relatively limited service availability in Kampala with regards to child protection issues. Important to note, however, is that awareness of service availability does not necessarily directly speak to real availability. A comprehensive service mapping would have to be done to better understand this dimension.

Psychological Distress and Neglect

Psychological distress is a broad term to capture any and all forms of stress, anxiety, or depression. Child neglect encompasses a failure to meet any of a child’s basic physical or psychological needs, despite having the means to meet those needs (see complete definition of page 30). The most commonly source of worry or upset among children in Kampala was lack of food (see figure 65). This is considerably lower than for child respondents in the settlements, where 64% reported that this was a cause for concern. This is somewhat surprising, as a higher proportion of respondents in Kampala reported to have no source of income (29%) compared to refugee respondents in the settlements (18%) (see figure 14 on page 14). Half of the child respondents in Kampala (50%) reported that they believed their caregivers are often stressed. Among caregivers, the most commonly reported source of stress was inability to send their children to school (see figure 66). Lack of food and lack of shelter were also commonly reported by caregivers, both of which were also common among children in Kampala.

Impact of COVID-19 and School Closures

The impact of COVID-19 on child protection risks has already been observed and detailed in this report. Underpinning many of the increased concerns may be behavioural changes in part caused by COVID-19 and associated restrictions. Children were asked whether they have observed any negative or positive changes in their caregivers’ behaviour since the start of COVID-19. The majority reported that no such changes had been observed (68%). Less than a fifth of child respondents (17%) reported a mainly negative change and 13% reported a main positive change in their caregivers’ behaviour. The findings of caregivers are similar, as 22% reported a mainly negative change in other caregivers and 17% reported a mainly positive change since the start of COVID-19. In terms of the impact on child behaviour, 22% of caregivers in Kampala noted a mainly negative change and 19% reported that mainly positive changes had taken place. It is unclear from the data to what extent COVID-19 was a driving factors of these changes.

Figure 65: Top five most commonly reported sources of worry or upset by children in Kampala⁵⁵

- 1 28% Lack of food
- 2 25% Not being able to go to school
- 3 19% Bullying
- 3 19% Lack of shelter
- 3 16% Separation from family

Figure 66: Top five most commonly reported sources of stress by caregivers in Kampala⁵⁵

- 1 40% Inability to send children to school
- 2 29% Lack of food
- 3 17% Lack of shelter
- 3 14% Imbalance in household gender roles
- 3 14% Separation from their communities

55. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

Overall, more negative than positive behaviour changes have been observed, though changes appear to not have been uniform.

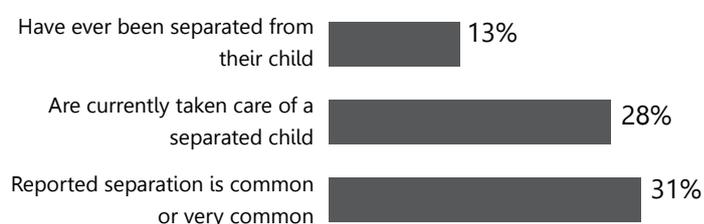
Specific Child Protection Services Offered in Response to Psychological Distress

In addition to formal services, informal support actors in case of psychological distress are also important to look at. If children are upset or stressed, the majority (60%) reported going to their parents or caregivers. The next most commonly reported sources of support were peer groups and relatives (10% each). One fifth of children in Kampala (20%) reported that there were specific sources available in their community to support children who are dealing with stress. Caregivers were asked for boys and girls separately who would be best placed to offer support in case of stress. For both boys and girls, 56% of caregivers in Kampala reported that parents or caregivers were best placed to support. The second most commonly reported support actor for both groups was other relatives (34% for girls and 28% for boys). Caregivers were also asked if there were any services available for them as caregivers in cases of stress - 12% reported this to be the case.

Unaccompanied and Separated Children

The distinction between separated children and unaccompanied minors is key. Separated children are children who have been separated from their primary caregivers (usually their parents) but are still accompanied by other family. Unaccompanied children have been separated from both their primary caregivers and other family, and have now responsible caregivers (for complete definition, see page 35). Among children in Kampala, 17%

Figure 66: Proportion of caregivers in Kampala reporting the prevalence of separated children in their households and communities



reported that either they or any of their siblings have been separated from their primary caregivers for a prolonged period of time. A slighter lower percentage of caregivers (13%) reported to have ever been separated from any of their biological children. In contrast, 28% of caregivers in Kampala reported giving care to separated children at the time of data collection. Similarly, 24% of caregivers reported that separation is common in their community, and 7% reported that the phenomenon is very common. Across all the presented indicators on the prevalence of separation among refugees in Kampala, the percentages are lower than they were for refugees in the settlements. It appears that separation may be more common among refugees who reside in the settlements.

It is typically less common for children to be unaccompanied than to be separated. Nonetheless, 23% of caregivers

Figure 68: Among caregivers in Kampala who reported on separated children in their community (91%, 127 respondents), proportion reporting on characteristics of most affected children

Figure 68.a: Gender of most affected children

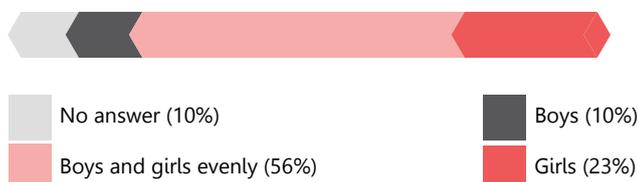


Figure 68.b: Age of most affected children

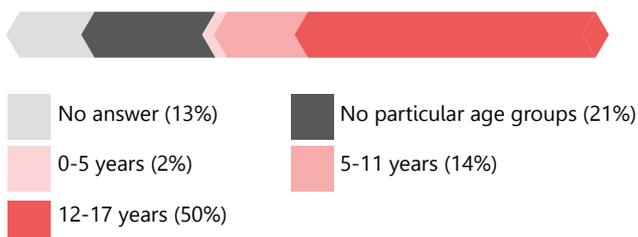
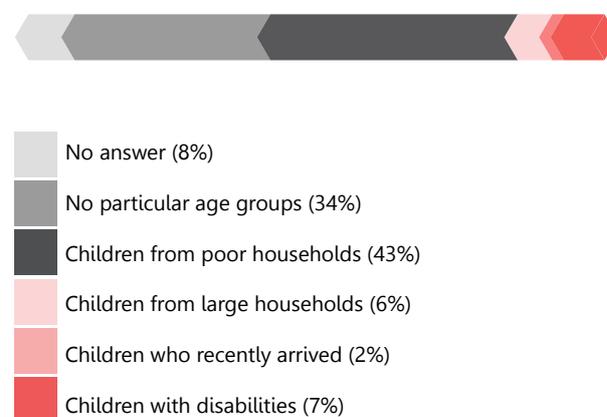


Figure 68.c: Specific groups of most affected children



in Kampala reported giving care to an unaccompanied child at the time of data collection. Additionally, 28% reported that children been unaccompanied is common or very common in their community, which is similar to the reported prevalence of separation in the community. It is important to reiterate here that the distinction can be hard to comprehend for respondents in a survey, and unaccompanied children may not be as common as the data suggests. The remainder of this section will focus on separated children.

A subset of caregivers in Kampala (91%, 127 respondents) were asked whether any sex, age, or specific groups were most affected in their community (see figure 67). It appears that girls are perceived to be slightly more likely to be separated from their caregivers. Half of the respondents additionally reported that children aged 12-17 are most affected. As with other presented child protection risks, children from poor households were most commonly reported as being most affected by the issue of separation from caregivers.

A small majority of caregivers in Kampala (52%) reported that the main cause of separation from caregivers is the death of the parents or regular caregiver (see figure 69). The most commonly reported causes roughly align with the findings from refugee settlements, with one major exception. The second most commonly reported cause of separation by refugees in Kampala is parents being detained or jailed. In contrast, this was only the sixth most commonly reported cause by refugees in the settlements (11%). These findings indicate that detaining and jailing of refugee caregivers may be a more a prominent issue in Kampala. This could be related to somewhat different status as well as livelihood status of refugees outside of the settlements.

In terms of the impact of separation, the majority of both children and caregivers in Kampala reported that separated children face additional risks. The most commonly reported risk that is increased for separated children is child labour, which was also the case for refugees in settlements and host communities (see figure 70). Among child respondents in Kampala, 17% reported that separated children do not face any particular additional risks. Among the caregivers that reported on child separation (91%, 127 respondents), 16% reported that separated children face no particular additional risks. There a few differences in the additional risks reported on by caregivers and children in Kampala. Physical violence, as well as psychological distress (18% of the caregiver subset), were more commonly reported by caregivers. In general, caregivers were more likely to report multiple risks would increase for separated children.

Specific Child Protection Services Offered to Respond to UASC

Service availability for separated children follows the same trend as services for other specialized child protection issues discussed above. Overall, 17% of both children and caregivers in Kampala reported that specific services are available for separated children. This stands in contrast to the 57% of children and 62% of caregiver refugees in the settlements who reported such services were available.

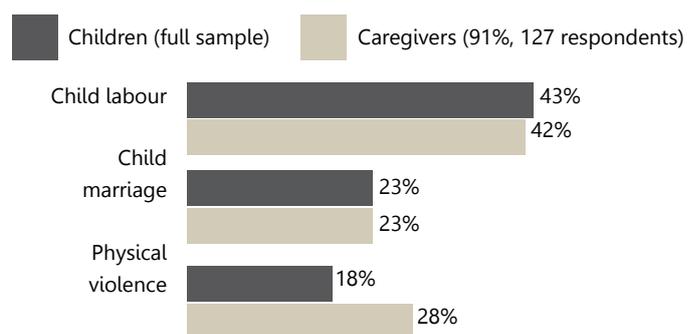
Other Risks

Towards the end of the survey, both children and caregivers were asked if there were any remaining risks that should be taken into account. The answered differed quite a bit between children and caregivers (see figure 71). The most common additional risks reported by children in Kampala was road accidents, whereas for caregivers this was

Figure 69: Among caregivers in Kampala who reported on separated children in their community (91%, 127 respondents), top five most commonly reported causes⁵⁶

- 1 52% Parents deceased
- 2 24% Parents detained or jailed
- 3 22% Contact lost during relocation
- 3 22% Parents are ill
- 3 22% Parents returned to country of origin

Figure 70: Top three risks that reportedly increase for separated children in Kampala, by survey type



56. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

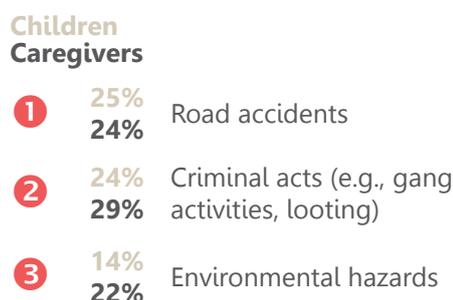
criminal acts. Children were also somewhat more likely to report that there were no additional risks (19%) compared to caregivers (12%). The answers provided in Kampala differ slightly from the findings from the settlements, especially as it relates to criminal acts. Criminal activities appear to pose more of a risk to refugee children in Kampala than to refugee children in the settlements.

For the reported remaining or additional risks, both children and caregivers most commonly reported that children are especially at risk at markets and trading centres, and at or around school. Among the 81% of children in Kampala who reported on additional risks (103 respondents), 32% reported that children were especially at risk at markets and trading centres, and 28% reported they are especially at risk at or around school. Among the 88% of caregivers in Kampala who reported on additional risks (122 respondents), 40% reported that children were especially at risk at markets and trading centres, and 37% reported they are especially at risk at or around school.

Specific Child Protection Services Offered to Respond to Other Risks

Among the 81% of children in Kampala who reported on additional risks (103 respondents), 29% reported that there were services available that aim to protect and support children affected by physical harm. Among the 88% of caregivers in Kampala who reported on additional risks (122 respondents), 17% reported that there were services available related to physical harm. The difference in reported may be due to different kinds of risks reported under physical harm, with potentially fewer services directly related to criminal acts.

Figure 71: Top three most commonly reported remaining risks facing children, by survey type in Kampala

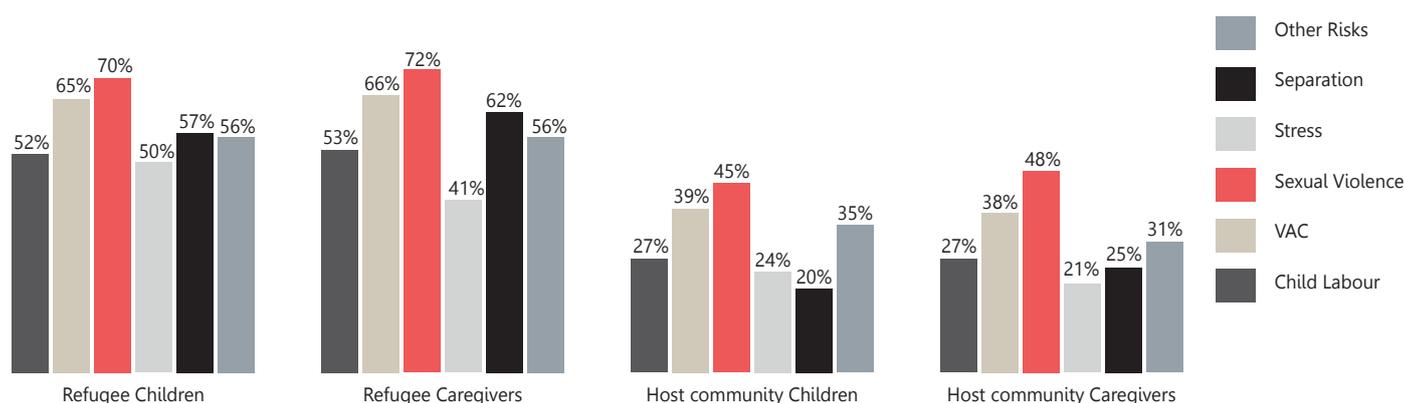


CHILD PROTECTION SERVICES AND BARRIERS TO THEIR ACCESS

Reported Gap in Service Provision

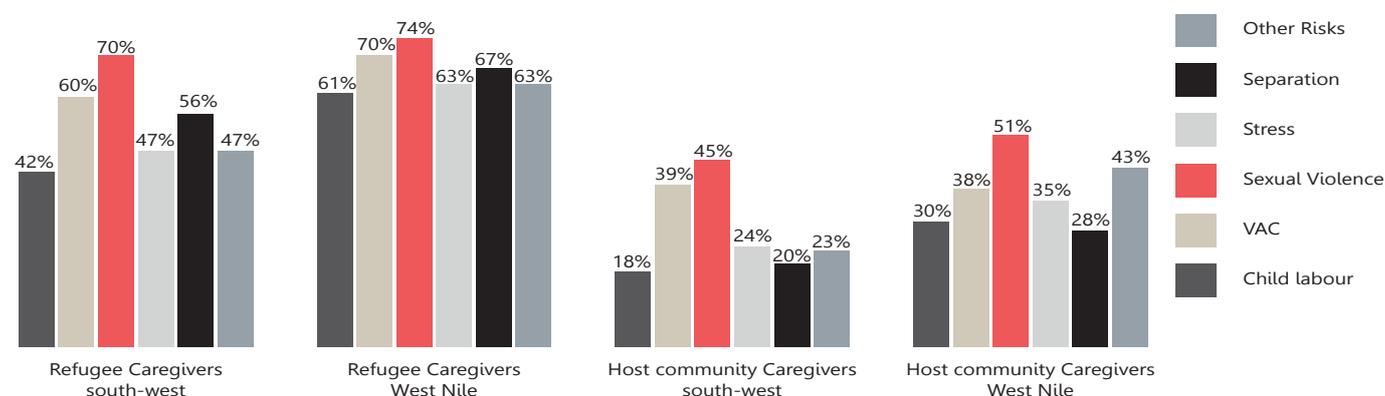
Qualitative and quantitative data shows that there may be gaps in child protection service provision. Proportions of refugee children and caregivers reporting that services for specific risks never exceed 72% and are lower, sometimes by 50%, amongst host community respondents (see figure 71). In particular, services targeting child labour, which was reported to have increased during the COVID-19 period, are reported to be available to only about half of refugee respondents and less than a third of host community respondents. For results by settlement (for refugee communities) and region (for host communities) please see the Annex.

Figure 72: Availability of services targeting specific child protection risks by community and survey type⁵⁷



In addition, the data presented in the above sections indicates that on average refugee respondents compared to host community respondents (figure 72) and respondents in the West Nile as compared to the south-west region (figure 73), are more likely to report having access to services targeting specific child protection risks. Given the often similar rates of prevalence reported for refugee and host community, the data suggests that the possible gap in service provision may be more pronounced for host communities as compared to refugees. However, the data also often showed that risks were reported to be more prevalent in the West Nile region as compared to the south-west (please see sections on specific risks for more details), indicating that a lower rate of service provision in the south-west region, may be appropriate.

Figure 73: Availability of services targeting specific child protection risks by region as reported by caregivers⁵⁷



Qualitative data also indicates an inadequate level of services even prior to the outbreak of the COVID-19 pandemic. Only two KIs report that there are no challenges in the provision of child protection services. Of the remaining 16 that reported challenges, a majority stressed that there is a lack of human resources to meet the need and half (8 KIs)

57. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

reported a lack of resources in general and a lack of funding specifically. A humanitarian worker in Kyaka explained:

“Case identification is easy but when it comes to issues of assessment, follow-up, case planning, the caseworkers that we have are overwhelmed, a case worker on average manages 50 cases a month and this makes it hard for them to follow-up and conclude them.”

This issue is mirrored by recipients of the services. Out of 20 interviews done with refugee and host community respondents, eight reported that services were insufficient and seven specifically reported a lack of follow-up as the reason for this. When asked whether or not child protection services in their community are addressing the issues at hand, a group of male caregivers in Kyaka explained:

“No, they are not sufficient because like if you report to police, most times they don’t follow up on the case to make sure the issue is fully settled.” (FGD with male caregivers in Kyaka)

This is concerning given that case management and follow-up services were the most frequently reported child protection service when community members in FGDs and IDIs were asked what services were available to them, indicating that even the type of service that is reportedly most widely available, is not effectively addressing the child protection risks prevalent in assessed communities.

Access to Services

Nevertheless, a majority of respondents from all demographic groups reported that children have accessed non-school based activities that encourage children’s play, socializing, and development in the last three months - e.g., social activities including those designed to reduce child protection risks. Specifically, 62% of refugee and 52% of host community children reported having accessed such activities in the last three months and 64% of refugee and 52% of host community caregivers reported that the children in their household have ever accessed such activities. The top three activities reportedly accessed by refugee and host community children include sports activities, child friendly spaces, early childhood activities, and peer-to-peer support groups (see figure 74). Other services reported to be available by fewer community respondents include sensitization activities on child protection and recreational and sports activities aimed at children. It is notable that, with the exception of sports activities, the proportion of host community respondents reporting access to services is lower than the proportions for refugees, further strengthening the conclusion that there may be a larger gap in service provision for the host community.

This is evidenced by the group of respondents which reported that further activities are still needed to encourage children’s wellbeing, play, leisure, development, and socializing in their community. Some of the most frequently reported needs by all demographic groups were sports activities, recreational activities in general, and child friendly spaces. More

Figure 74: Top three recreational activities reportedly accessed by children in the last three months⁵⁸

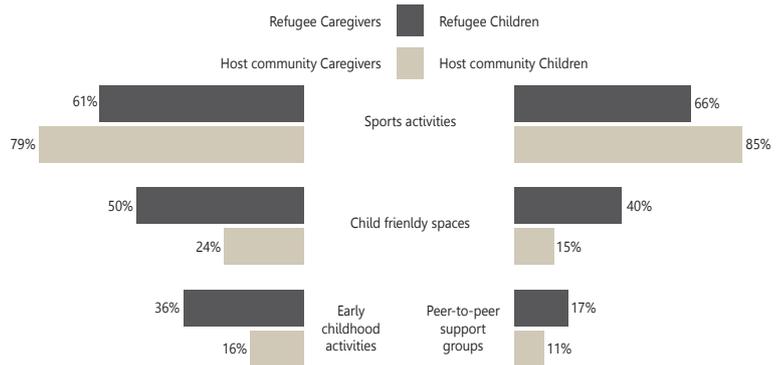
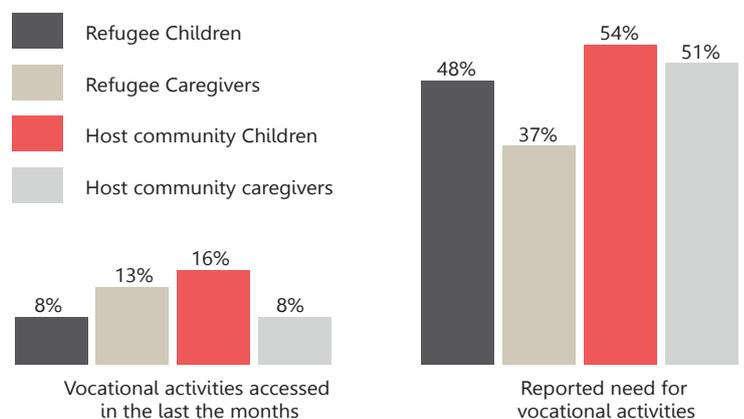


Figure 75: Proportion of respondents reporting that children have accessed vocational activities in the last three months and the need for further vocational activities by community and survey type



58. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

specifically, just over half of the respondents from all demographic groups reported the need for sports activities (55% of all refugee respondents, 56% of host community children and 62% of host community caregivers), about one third in each group reported the need for recreational activities in general (32% of refugee caregivers and host community children each, 29% of refugee children and 31% of host community caregivers), and 42% of refugee and 37% of host community children and 38% of refugee and 29% of host community caregivers reported the need for additional child friendly spaces. Notably, respondents from all demographic groups reported the need for further vocational activities (see figure 75). In fact, vocational activities was the second most frequently activity reported to be needed in both community groups and particularly in the host community with 54% of host community children and 51% of host community caregivers reporting a need for them. In contrast, reported access to vocational activities amongst host community children and caregivers were reported to stand at only 16% of and 8% respectively further emphasizing the need to increase service provision in host communities.

Barriers to Access

All groups agreed that the three most important barriers to access are that services either do not exist, are far away, or that restrictions introduced to curb the spread of COVID-19 prevented children from accessing them (see figure 76). Information from qualitative interviews reaffirms that distance and a lack of services are main barriers to service access. One humanitarian worker in Adjumani explained:

“Child protection services are available and accessible, but they are certain areas that are wanting e.g., in early childhood development and child friendly spaces and health facilities. Some children walk long distances to access the services.”

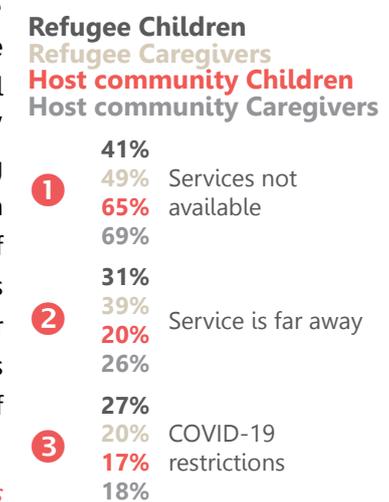
The lack of available services and distance to those that are available are reportedly also linked to a lack of funding which has reportedly further decreased during the COVID-19 period (see section titled “Impact of COVID-19” below for further details).

In addition, the proportions of host community members reporting barriers are higher when compared to those reported by refugees further indicating that the gap in addressed needs is wide amongst the host community. Further, although all demographic groups interviewed most frequently answered “no particular group” when asked if any specific group of children had more trouble than others in accessing services; the second most frequent answer to this question was “children with disabilities”. In fact, 43% of refugee and 42% of host community caregivers and 31% of refugee and 30% of host community children reported that children with disabilities have more difficulties than others accessing non-school based activities aimed at their learning and development in their communities. Both KIs and community respondents to qualitative interviews strengthen this conclusion. One KI working for the Office of the Prime Minister (OPM) in Bidibidi stated:

“Children with disabilities are the most excluded children regarding access to services ranging from health, education, recreational facilities and food distribution points.”

Understanding the reasons for the gap in services addressing the needs of children with disabilities, lies outside of the scope of this assessment. However, contextually, individuals with disabilities in Uganda have been found to face discrimination in addition to the physical or mental hurdles they face, and thus may be precluded from accessing services which others can. For example, a report by the Ugandan Ministry of Gender, Labour and Social Development entitled “Situational Analysis of Persons with Disabilities in Uganda” found that “While discrimination on the basis of disability is outlawed in Uganda, there are still many cases of prejudice and misunderstanding within communities.”⁶⁰

Figure 76: Top three most frequently reported barriers to accessing recreational services by community and survey type⁵⁹



59. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

60. [Situational Analysis of Persons with Disabilities in Uganda](#); Ugandan Ministry of Gender, Labour and Social Development; September 2020

Impact of COVID-19

Child protection risks have reportedly increased during the COVID-19 period while, simultaneously, qualitative data indicated that child protection services were disrupted. Increased risks were reported by all demographic groups interviewed with structured surveys. Specifically, respondents from all demographic groups agree that children doing harsh and dangerous labour, drug abuse amongst children and caregivers, and sexual acts both amongst children and sexual violence against children are key risks that have increased since the start of the pandemic (see figure 17).

Qualitative data suggests that, while child protection risks rose during the COVID-19 period, challenges in delivering and accessing these services also increased. A slight majority of the 18 key informants interviewed from amongst law enforcement employees and child protection professionals working with humanitarian and government organizations, reported that a key challenge hampering their work during the COVID-19 period was a decrease in funds. As one humanitarian worker in Kyaka explained:

“Because of COVID-19 many of the organizations left because the funding reduced and therefore service provision was affected as many partners could not afford the cost due to reduced funding.”

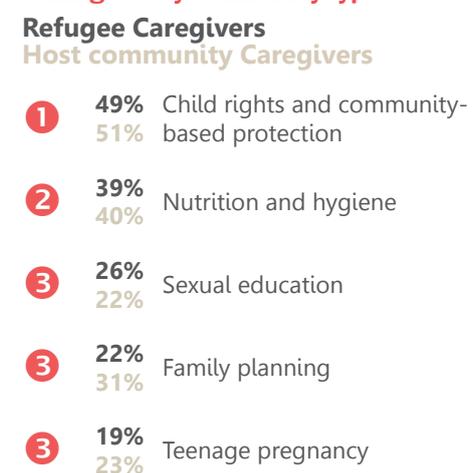
In addition, KIs reported that COVID-19 preventative measures like movement restrictions and reduced physical interactions hindered effective delivery of services. Simultaneously, child protection professionals and community members with the desire to access child protection services reported that services were harder to access due to increased transportation costs and reduced presence of actors in rural areas and outside of town centres, and due to the closure of offices. A humanitarian worker in Adjumani explained, that these factors reportedly compounded existing deficiencies in the response to child protection needs.

“Due to limited movement and SOPs, we could no longer engage children in FGDs and mass sensitization. Yet we already had staffing issues and could only reach a few children at a time.”

In sum, the COVID-19 pandemic and the associated restrictions designed to stop its spread, have impacted child protection service delivery, limited beneficiary access to these services, and curtailed funding streams that were reportedly already insufficient prior to the start of the pandemic.

One factor that could help alleviate this downturn in service provision and simultaneous uptick in risk prevalence, is the provision of training on child protection issues to community members and specifically caregivers themselves. When caregivers were asked if they would be interested in being trained to improve their ability to deal with childcare and protection activities, 82% of refugee and 78% of host community respondents replied that they would want to take part if such an opportunity were offered. More specifically, both caregivers in both communities most often reported to be interested in training on “child rights and community-based protection” and “nutrition and hygiene”. In addition, both groups of caregivers expressed interest in various topics relating to sexual education, family planning, and pregnancy (see figure 77).

Figure 77: Top five most frequently reported topics caregivers are interested receiving trainings on by community type⁶¹



61. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

CHILD PROTECTION SERVICES AND BARRIERS TO THEIR ACCESS IN KAMPALA

Throughout the sections on specific child protection risks in Kampala, it has been highlighted that specific child protection services appear less common and available in Kampala than they do in the settlements. For most types of specialized services, children and caregivers in Kampala had around 20% reporting that those kinds of services were available. Children and caregivers in Kampala most commonly reported getting their information from friends (32% of children, 42% of caregivers), community leaders (26% of children, 29% of caregivers), or neighbours and family (26% of children, 29% of caregivers).

The majority of children and caregivers reported that neither they or (other) children in the household engage in non-school based activities that include or encourage playing, learning, and socializing with other children (see figure 77). This too is a bit lower than the results for refugees in the settlements, where the majority of refugee children and caregivers reported access to these types of activities.

Figure 77: Proportion of children and caregivers in Kampala reporting children in the household engage in non-school organized social activities



As to why social activities were not accessed, the primary barriers according to both children and caregivers were that such services were not available, or restrictions related to COVID-19 prohibited access. Roughly a fifth of both child and caregiver respondents in Kampala reported the children with disabilities have an especially hard time accessing these types of services (21% of children, 22% of caregivers). Similarly, 20% of both children and caregivers in Kampala reported that children from poor households have less access to non-school social activities and services. In light of earlier findings that children from poor households are especially likely to be affected by various child protection risks, this findings is especially concerning.

Finally, children and caregivers were asked which activities they believed were needed to encourage children’s wellbeing, play, leisure, development and socializing. The most commonly reported suggestions were sports and vocational activities (see figure 78). A small minority of children (8%) and caregivers (6%) reported that none were needed. In general, however, there appeared to be substantial interest in social interventions and activities for children in Kampala.

Figure 78: Proportion of respondents in Kampala reporting on needed on social activities/services, by survey type (children on the left, caregivers on the right)⁶²



Generally, service provision relation to child protection appears to be relatively limited in Kampala, especially as compared to refugee settlements. Child protection issues are not necessarily less severe than they are in the settlements. As in the settlements, there does appear to be substantial interest from refugees in Kampala in more child protection and social activities, which could alleviate some of the risks and challenges faced by refugee children in the urban centre.

62. Results do not add to 100 because respondents were free to select multiple answer options when responding to this question.

CONCLUSION

This child protection assessment aimed to update baseline data on protection risks faced by children amongst refugee and host communities. To do this, qualitative and quantitative primary data was collected from amongst children and caregivers across all refugee settlements and refugee hosting districts in Uganda. Respondents were asked to identify which child protection risks they have been concerned about (in the case of child respondents) or witnessed (in the case of caregiver respondents) over the past three months. In addition, respondents were asked about the prevalence, underlying causes, and services for prevention and response to different forms of VAC including sexual and gender-based violence, child labour, family separation, and psychological distress.

Child respondents reported to have been concerned about child labour, physical violence, and child marriage in particular over the last three months. Similarly, over the same time period, refugee and host community caregivers reported having witnessed the same risks occurring in their communities. In addition, refugee and host community respondents reported that child labour, in particular harsh and dangerous work, sexual violence, and substance and alcohol abuse by both children and adults have increased during the COVID-19 period.

Qualitative and quantitative data shows that poverty is an underlying cause for all assessed child protection risks and that COVID-19 has exacerbated most of the risks reportedly due to the impact of related preventative measures' on household income. Although there are further and nuanced causes underlying the occurrence of each protection risk, poverty and its exacerbation during the COVID-19 period, recur throughout the data and in relation to all protection risks discussed with respondents.

The data indicates that there may be gaps in services overall with key informants who work in the sector reporting that human and financial resources are falling short of needs. In particular, the data indicates that service provision amongst the host community is particularly low despite often similar levels of reported prevalence of risk. In addition, although more research is needed on this, qualitative data does indicate that services are harder to access for children with disabilities. Further, the data shows that service provision is more widespread in the West Nile region as compared to the south-west. This may be appropriate given the often higher levels of prevalence of risk reported in the West Nile.

Finally, although the data collection from amongst refugees in Kampala is not representative, it does indicate that, similar to the context in and around the refugee settlements, child labour, physical and sexual violence, separations, psychological distress, and other child protection risks occur in the urban context. In addition, respondents indicated that COVID-19 has also increased the prevalence of some of these risks, including in particular child labour, in Kampala. Simultaneously, the data collected in Kampala, indicates that child protection service provision is very low.

In sum, this assessment has shown that both refugee and host community children living in refugee hosting districts, face a range of protection risks. In addition, child protection risks in the Ugandan refugee context have increased since the start of the pandemic. Notably, respondents identified factors such as school closures and idleness of children which reportedly act as amplifiers underlying the increases in child labour, child marriages, teenage pregnancies, physical violence, and psychological distress in children. However, the common thread repeatedly identified by all main demographic groups as underlying the continued occurrence of child protection risks, is poverty exacerbated during the COVID-19 period, coupled with underfunded and understaffed efforts to address these risks providing adequate child protection prevention and response services.

ANNEX - Reported Availability of Child Protection Services offered to Respond to Specific Child Protection Risks by Settlement

Table 08: Proportion of refugee children reporting the availability of services addressing specific child protection risks in their communities

Settlement	Child Labour	VAC	Sexual Violence	Stress	Separation	Other risks
Kyaka II	26%	47%	54%	23%	40%	31%
Kyangwali	36%	60%	59%	35%	48%	42%
Kiryandongo	37%	57%	61%	40%	46%	47%
Palabek	45%	60%	73%	45%	54%	51%
Adjumani	50%	55%	57%	42%	45%	45%
Oruchinga	55%	62%	66%	49%	55%	52%
Imvepi	56%	65%	64%	53%	56%	62%
Rwamwanja	58%	69%	75%	52%	65%	67%
Palorinya	58%	70%	72%	51%	53%	59%
Nakivale	60%	74%	83%	63%	64%	71%
Rhino Camp	65%	73%	81%	67%	67%	69%
Lobule	74%	80%	78%	65%	73%	71%
Bidibidi	74%	81%	84%	70%	80%	79%

Table 09: Proportion of refugee caregivers reporting the availability of services addressing specific child protection risks in their communities

Settlement	Child Labour	VAC	Sexual Violence	Stress	Separation	Other risks
Kyaka II	29%	52%	65%	19%	56%	39%
Nakivale	42%	49%	62%	29%	46%	34%
Adjumani	43%	52%	58%	34%	51%	42%
Kyangwali	47%	73%	77%	42%	61%	66%
Oruchinga	53%	66%	70%	50%	65%	48%
Palorinya	60%	72%	78%	36%	64%	68%
Kiryandongo	61%	70%	72%	52%	65%	61%
Palabek	62%	71%	75%	46%	64%	63%
Rwamwanja	63%	79%	85%	51%	70%	61%
Imvepi	66%	77%	76%	56%	72%	71%
Rhino Camp	67%	78%	76%	53%	77%	65%
Lobule	70%	76%	81%	55%	71%	60%
Bidibidi	70%	74%	79%	54%	74%	71%

Table 10: Proportion of host community children reporting the availability of services addressing specific child protection risks in their communities

Settlement	Child Labour	VAC	Sexual Violence	Stress	Separation	Other risks
West Nile	18%	45%	50%	28%	24%	43%
south-west	33%	31%	38%	18%	14%	23%

Table 11: Proportion of host community caregivers reporting the availability of services addressing specific child protection risks in their communities

Settlement	Child Labour	VAC	Sexual Violence	Stress	Separation	Other risks
West Nile	30%	38%	51%	22%	28%	35%
south-west	23%	39%	45%	20%	20%	24%



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