

# Summary Report on Child Well-being

World Vision Uganda's Contribution  
to Child Well-being

FY 2012



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## Forward by the National Director

Welcome to World Vision Uganda's second Annual Child Well-Being Report 2012. As a National Office, we are happy to continue being part of the pilot on annual reporting of World Vision contribution to children well-being. As you may know, World Vision strives to achieve the *sustained well-being of children within families and communities, especially the most vulnerable*. This report is one among those that attempts to provide evidence on progress towards realization of this dream goal.

The production of this report was guided by a ten step process which was adopted by the partnership following learning the FY2011 piloting National offices including WVU. Further to this, it was useful for us in the spirit of twin citizenship to share our experiences with World Vision South Sudan team who joined to learn with us in preparing this Child Well-being report. We would like to encourage peer participation across the NOs at the different phases of the ten step process for developing the report.

In this report, we provide a summary on interventions implemented in FY12 in the sectors of Health and WASH; Livelihoods; Education and advocacy towards improving the well-being of the most vulnerable children and families in program areas as mapped out in the NO strategy 2010-12.

As the NO consolidates on the achievements of the first year pilot, we are glad to report on our contribution while focusing on the WV partnership Child Well-Being Targets (CWBT) that were identified and prioritized in the NO for reporting in FY2012 as well as key learning and recommendations for improvement.

Finally, I would like to express my sincere gratitude to the World Vision Uganda Quality Assurance team for ably gaining and maintaining the momentum that has culminated into this report within the agreed timeframe. To our partners, without your contributions, we would not be able to achieve the much being reported on now. I pray that you will continue to keep your hearts willing and your doors open to participate in this very enriching process of garnering evidence of our contributions to the wellness of children in this country.

Thank you.



Gilbert Kamanga

National Director

## EXECUTIVE SUMMARY

World Vision has been in Uganda for the last 27 years implementing relief, development and advocacy interventions that improve the well-being of children in Uganda. To date, our interventions benefit nearly two million people in 41 districts.

During the FY 2011 annual reporting on CWB pilot process, WVU implemented a duo faced strategy to help adopt and sustain measurement and reporting on CWB annually. These include standardizing program level outcomes for the different strategic objectives, adoption of CWBT measures in the NO strategy, contextualization of project models, piloting the appropriate CWBT methods and tools as well as capacity building of program staff on measurement, reporting and documentation.

This is the second CWB report for WV Uganda. The report is the result of a synthesis of 88 programme reports published in FY12: 15 baselines; 8 evaluations; 53 ADP annual reports; and 12 grant project annual reports. The report was discussed at a stakeholder's meeting for broader and deeper interpretation, analysis of findings and recommendations.

The evidence presented in this report is mainly deduced from FY12 following a data quality assessment on all data garnered from all the FY12 program reports. This evidence is categorized under the four key strategic objectives that link to the four CWB Targets:

- ✓ #1: Children report an increased level of well-being.
- ✓ #2: Increase in children protected from disease and infection 0-5 years.
- ✓ #3: Increase in children well nourished.
- ✓ #4: Increase in children who can read by age 11.

Below are key highlights of findings;

- ✓ In 11 out of 13 ADPs immunization for children aged between 12-23 months was above the national average at 52%; in 4 ADPs the coverage of immunization is above the MDG target of 85%.
- ✓ Use of LLINs among children under 5 years in 9 out of 11 ADPs that (re)designed was above the national average of 63%. All 11 ADPs are still below the MDG target of 100%.
- ✓ In 9 out of 11 ADPs, coverage of children with diarrhea who received ORT and ZINC was above the national average of 48%; all 11 ADPs are below the MDG target of 78%.
- ✓ All 8 ADPs which reported mothers who tested for HIV during pregnancy were above the national average of 72%.
- ✓ All the four ADPs measured primary numeracy rate at baseline where below the national average of 56%.

- ✓ In two ADPs that monitoring outcome of their education intervention, primary school net enrollment is above 85%. In one ADP that evaluated her 5 year education program, the primary school net enrollment increased by 21% from 68% at baseline to 89% at evaluation.
- ✓ Household expenditure on education in 5 ADPs ranges from 11% to 60%, although all is above the national average of 9%.
- ✓ The proportion of children aged 12 – 17 years with a birth certificate ranges from 48% to 64% across 4 ADPs. While 4 in 5 ADPs the proportion of households with children under 5 years who have a birth certificate was above national average of 17%, ranging from 28% to 66% at baseline.
- ✓ Over 4000 children actively participated in groups under Child protection interventions. Over 22,000 children received spiritual nurture through school groups and Sunday schools
- ✓ 14 MVC targeted in 13 ADPs, 77% of the ADPs reported 6 different MVC categories
- ✓ Over 20,882 children served during emergency responses in FY2012

## INTRODUCTION

### Purpose

This summary report present World Vision Uganda (WV Uganda)'s plausible contribution to child well-being. It is focused on learning what has and has not worked in our approaches and what changes in child well-being have been achieved, based on available data from one FY12, structured around the national office's strategy 2010-2012.

### Summary of Strategy 2010-2012

WV Uganda's strategy 2010-12 is premised on WVI's principle level choices, particularly the focus on empowerment moving away from service delivery. The strategic goal is to:

*"... Contribute to the wellbeing of 1,030,000 children, their households and communities in partnerships and through sustainable approaches in supporting local and national efforts in World Vision supported communities".*

To achieve depth in addressing the root causes of poverty, the strategy prioritized three sectors reflected in the strategic objectives presented in Table 1.

**Table 1:** Summary of WV Uganda Strategy 2010-2012

No.	Strategic Objective (SO)	SO Focus
1	Increased access for girls, boys, women and men to utilization of quality health and HIV/AIDS services in WVU-supported communities	Malaria, maternal and child health, nutrition, HIV & AIDS and psychosocial support
2	Increased percentage of girls and boys completing primary education from 30 Percentage to 50 Percentage by 2012	Primary school education
3	Improved livelihood security	Food production and utilization, household income and water, sanitation and hygiene (WASH)* in emergency and recovery contexts.
4	Increased utilization of safe water, sanitation and hygiene practices*	WASH in emergency and recovery contexts.
5	Emergencies responded to in a timely way and to a scale that saves lives and livelihoods	
6	Strengthen organizational and partner's capacity to advocate for policies, systems and practices that ensures the wellbeing of girls and boys.	

*\*At the end of 2010, WASH was upgraded to ministry priority sector, bringing the total of priority sectors to four.*

## CWB Targets

As part of the processes for setting up a NO M&E System, WV Uganda revised her Strategy results framework in 2011 to; refine the strategy indicators to improve their measurability; identify which CWBT the NO was contributing to; select standard outcome and monitoring indicators for appropriate adoption across the programs including indicators for CWBT; and provide a framework for mapping alignment of programs and projects to the NO Strategy. The Strategy contributes to 3 CWBT:

- ✓ CWBT2: Increase in children (0-5 years) protected from disease and infection,
- ✓ CWBT3: Increase in children (0-5 years) well nourished; and
- ✓ CWBT4: Increase in children who can read and write by age 11.

During the process of mapping programs alignment to the NO Strategy in 2011, several programs were identified to have interventions contributing to CWBT 1: *Children report increased level of well-being*. WV Uganda used the opportunity of program baseline surveys in FY2012 both to pilot measurement of CWBT1 using the Youth Healthy Behavior Survey (YHBS) tool; as well as garner evidence to inform the new NO Strategy 2013-2015. The results from using the YHBS are presented in this summary report.

## Progress so far

WV Uganda did not set levels of change for the CWBT indicators prioritized in the NO Strategy 2010-12. As mentioned above, the process of refining the NO Strategy results framework took place half way the strategy implementation period and ending at the time when discussions for reviews leading to new NO Strategy 2013-2015 were commencing. In consultation with the EARO Quality Assurance team, the NO Strategy Baseline, and setting levels of change were deferred to FY2013, for the new strategy 2013-15.

The progress made on the different sector outcome measures, presented in this summary report, is discussed against known thresholds and triggers for action as well as national and global targets for the health, education and food security sectors.

## METHOD

The process of preparing this CWB report has followed the standard methods and tools published<sup>1</sup> by the Global Centre drawing from learning across 13 NOs that participated in the FY11 CWB Report pilot. It is also based on our own learning<sup>2</sup> as a NO having successfully participated in this WV Partnership pilot on CWB. The report is a result of synthesis of 88 program reports published in FY2012; 15 Baselines; 8 Evaluations; 53 ADP annual reports; and 12 Grant projects' annual reports. Data entry was done by five research assistants under direct supervision and with participation of the NO DME Unit, for a period of two weeks. Technical specialists for each of the NO Strategy priority sector participated during preliminary analysis of the findings, preparation of NO Strategy Objective/Sector fact sheets, Stakeholder meeting and preparation of drafts informing this report.

An MS Excel data entry and analysis tool aligned to the NO Strategy 2010-12 revised results framework and used during the FY11 CWB report pilot, was used<sup>3</sup>. The tool allowed separating data by type of program report, and capturing evidence speaking to; a) the NO Strategy outcome and output indicators for the respective priority sectors; b) other indicators not listed in the NO strategy results framework; c) qualitative evidence on CWB including summaries for significant change stories, quotes, and other descriptive; and MVC.

A comprehensive data quality assessment was done to inform which data to include in the final sector summaries to inform detailed interpretation and analysis by stakeholders. A Data Quality Assessment (DQA) tool<sup>4</sup> was

<sup>1</sup> Available at: <https://www.wvcentral.org/cwb/Pages/Reporting.aspx>

<sup>2</sup> Senkaba G., 2012. *Lessons Learned: The Annual Report on CWB Pilot Experience*. World Vision Uganda

<sup>3</sup> Minor modifications were made particularly to improve capturing of qualitative evidences from the program reports. This data entry & analysis tool was commended as one of the strengths for WV Uganda's CWB report FY11 (*Ref: Child Well Being Targets 2011: Data Quality Report, Uganda. July 2012, World Vision International*)

<sup>4</sup> This tool helped to check if; similarity or not in indicators measured across programs similar to those list under each strategic objective; similarity or not in indicator definitions, tools and methods used, sampling, sources of primary data, project interventions, duration of program implementation, and analysis method. Indicators or pieces of data showed glaring gaps were dropped from further analysis.

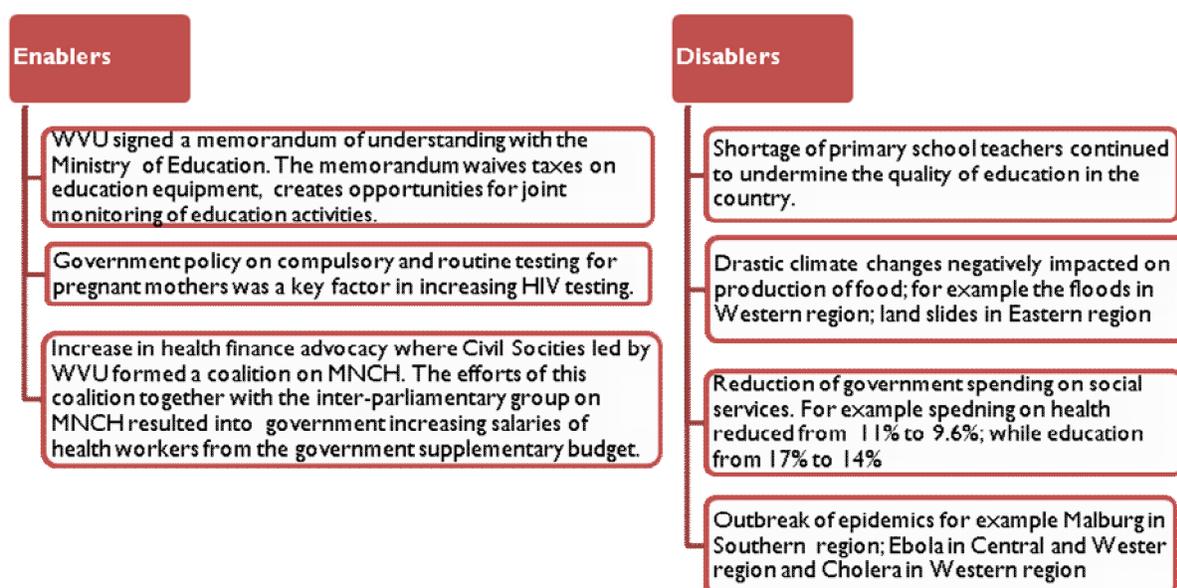
designed and applied to data garnered on a specific NO Strategic objective/Sector. The intent was to increase the level of confidence in the quality of the evidence and comparison of the measures across the programs. In addition, data on registered children from STEP was excluded from analysis as time was not enough to complete validation<sup>5</sup>.

After completion of preliminary analysis, 5 fact summary sheets were prepared: Education; Health and HIV/AIDS; Livelihood; and Advocacy; and MVC. The fact sheets guided discussion during a 2-day stakeholder meeting<sup>6</sup> held to provide deeper interpretation and analysis of findings by key stakeholders before the report was prepared. Data outside the program reports has been used to provide broader perspective interpretations and discussions.

## CONTEXT

### Influencing Factors

The following factors influenced our programming in FY2012



## STRATEGIC OBJECTIVES

### Strategic Objective on Health and HIV/AIDS



### Summary of logic chain

The NO Strategy 2010-2012 made big paradigm shift from mere HIV/AIDS prevention interventions to Maternal & Child Health (MCH) with HIV& AIDS prevention as one of the key pillars to ensuring child survival. According to

<sup>5</sup> The on-going mechanisms to improve RC data quality across sponsorship programs are promising particularly integration of DME and Sponsorship processes at field level. RC data will be used in the FY13 CWB report.

<sup>6</sup> 30 staff attended this meeting; Directors (7); Sector Specialists (10); DME (8); Regional Operations and Program Managers (4); Community Development Facilitators (5); Program Officers (3); and WV South Sudan Staff (Quality Assurance) (2).

the UDHS 2011<sup>7</sup>, infant mortality is at 54 per 1,000 live births; under-five mortality at 90 per 1,000 live births; Malaria accounts for 25% of deaths among under 5s; and Poor nutrition still accounts for 60% of deaths among under-five year olds with some 14% of children being underweight and 33% are stunted. In addition, maternal mortality ratio stands at 438 deaths per 100,000 live births in 2011; neonatal mortality at 27 deaths per 1,000 live births in 2011; less than half of all pregnant women attended the recommended four antenatal visits. Birth registration is less than 30% in all World Vision areas with the North and Southern western at less than 15%.

More than 75% of the overall burden of diseases is preventable, including malnutrition. Access to safe water, sanitation, hygiene, nutrition and living conditions are still poor, resulting in poor health in women and under five children. Other causes include; poor implementation and enforcement of health sector policies and strategies especially the Uganda National Minimum Health Care Package; shortage of human resources for health; poor health seeking behavior; food insecurity and poor infant and young child feeding practices; and a weak community health work structure greatly affects access to services especially by people in hard to reach areas.

To achieve better health outcomes across the programs, the NO strategy prioritized the implementation of the 7-11 model and community based management of acute malnutrition. Specific project models applied include: Timely and Targeted Counseling (10 ADPs); Community Case Management (8 ADPs); Community PMTCT; Community Led sanitation (12 ADPs (under the Uganda-WASH project); Voluntary Medical Male Circumcision (under the SPEAR project); Value Based Life Skills, Positive Deviance Hearth (16 ADPs); and Citizen Voice & Action/Child Health Now Campaign (21 ADPs).

As part of the health strategic results logic, several outcome indicators were prioritized but standardizing to improve measurement and reporting on progress across health programs was done in FY2011. It was only possible to have new or redesigning programs in FY11 to adopt them, and baseline results in FY2012 are presented below:

### Evidence of progress

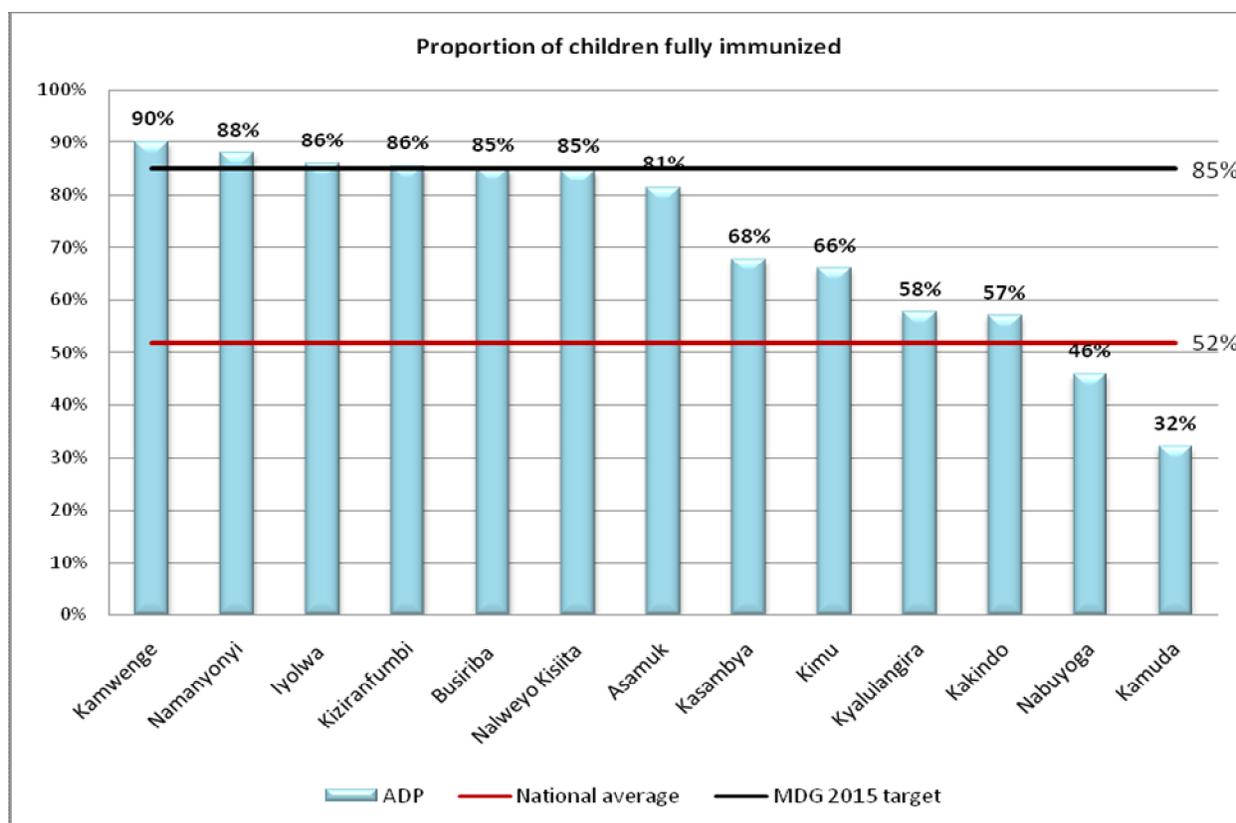
#### Coverage of essential vaccines among children

#### Analysis

Immunization is the first line of protection for children from infectious diseases. If children are to live and enjoy their 5<sup>th</sup> birthday then immunization is not an option. Immunization of children against the eight vaccine-preventable diseases (tuberculosis, diphtheria whooping cough (pertussis), tetanus, hepatitis B, Haemophilus influenzae, polio, and measles) is crucial to reducing infant and child mortality. Differences in vaccination coverage among population subgroups are useful for programme planning & targeting resources to areas most in need.

Presently the full immunization for age for children aged 12-23 months is 52% in Uganda accordingly to the UDHS 2011 while the MDG 2015 full immunization for age target for Uganda is 85%. Among 13 ADPs that completed baseline surveys in FY12 for new phase programs; 11 ADPs' full immunization coverage was above the national average (52%), with the highest recorded in Kamwenge ADP (90%); and 6 ADPs are have reached or surpassed the MGD target. All these ADPs except Kamwenge, Busiriba and Asamuk have implemented health interventions at least one phase.

<sup>7</sup> 2011 Uganda Demographic Health Survey, UBOS 2011



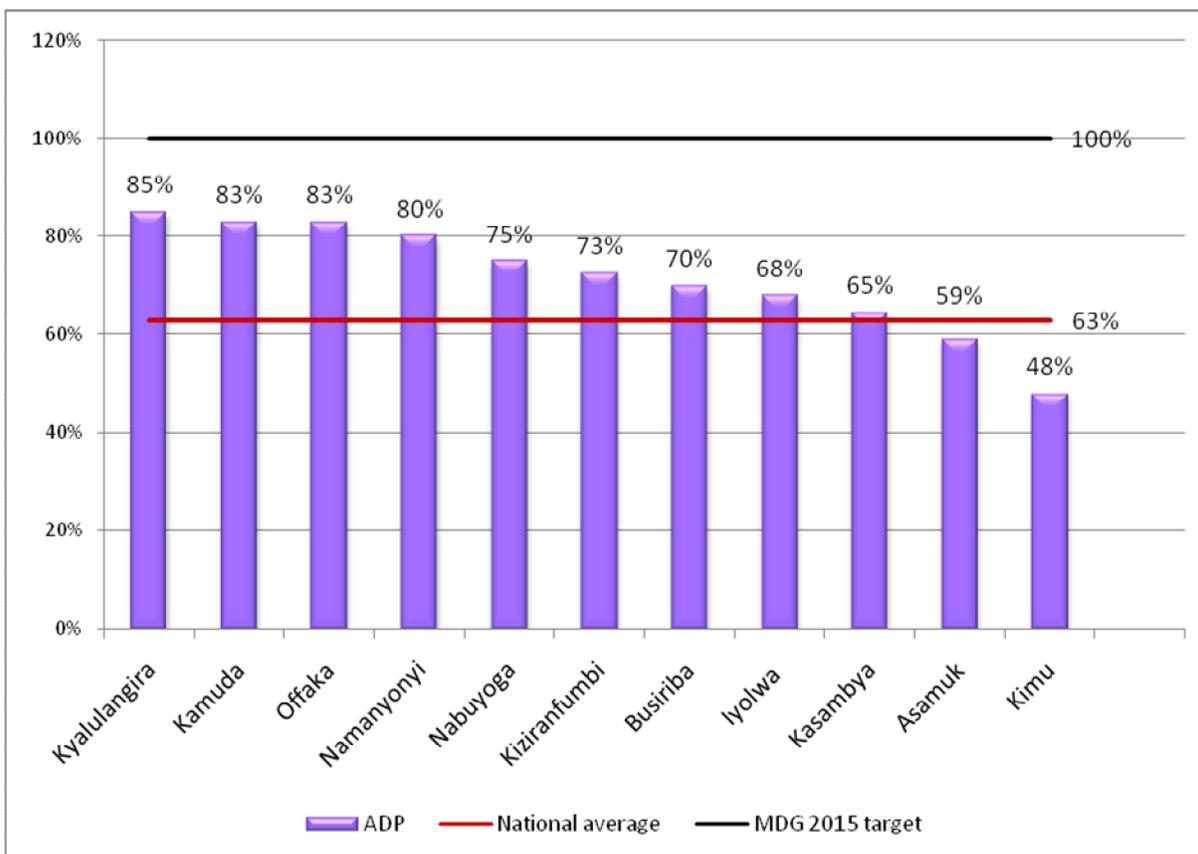
**Source:** 2012 Baseline reports for Kamwenge, Namanyonyi, Iyolwa, Kiziranfumbi, Busiriba, Nalweyo, Asamuk, Kasambya, KIMU, Kyalulangira, Kakindo, Nabuyoga, and Kamuda ADPs.

In both Namanyonyi and Kiziranfumbi ADPs, the performance is explained by investments in health systems strengthening particularly working with the Village Health Team (VHT) for primary health care. In Namanyonyi for example, training of 106 VHTs over the last phase, has been instrumental in improving awareness of and mobilizing caregivers to participate in immunization outreaches in their respective villages. While, in Kiziranfumbi, the ADP has been supporting the health centres to conduct routine immunization outreaches in the villages, bringing services closer to the people, improving overall access to immunization services. The low coverage in Kamuda ADP (32%) and Nabuyoga ADP (46%) is explained by the limited reach to immunization services to populations in hard to reach areas as health facilities are not able to conduct outreaches due to both human resource and supplies logistical challenges.

### Recommendations

- ✓ Strengthen the Village Health Team (VHT) and outreach based immunization interventions to include hard-to-reach and high risk households for better immunization outcomes.
- ✓ Take advantage of family days that have been introduced by MoH to support Health units to scale up immunization. The family days provide a great opportunity to mobilize families for immunization and other childhood services namely Vitamin A supplementation and de-worming. Men should especially be engaged to support immunization.
- ✓ Integrate Health advocacy/CHN in existing Immunization programs to enable create massive awareness and engage key duty barriers on key bottlenecks limiting access to immunization.

**Proportion of households where all children under 5 years slept under a long-lasting insecticide treated net (LLIN) the previous night**



**Source:** 2012 Baseline reports for Kyalulangira, Kamuda, Offaka, Namanyonyi, Nabuyoga, Kiziranfumbi, Busiriba, Iyolwa, Kasambya, Asamuk, and KIMU ADPs.

The MDG target for children sleeping under a net is 100%. Sleeping under a treated mosquito net is a key intervention for protection of children from disease. Nine out of 11 ADPs that conducted baseline in FY12 were above the national coverage of 63% (UDHS 2011) for proportion of under 5 sleeping under an LLIN. This is not surprising as most of the ADPs above national coverage have been implementing malaria prevention interventions especially behavioral change communication by VHTs targeting high risk households. For instance, Kyalulangira ADP have been working closely with other malaria implementing partners like Malaria Consortium to scale up LLIN coverage through ANC & EPI at health facilities during their last phase, and will continue in current phase.

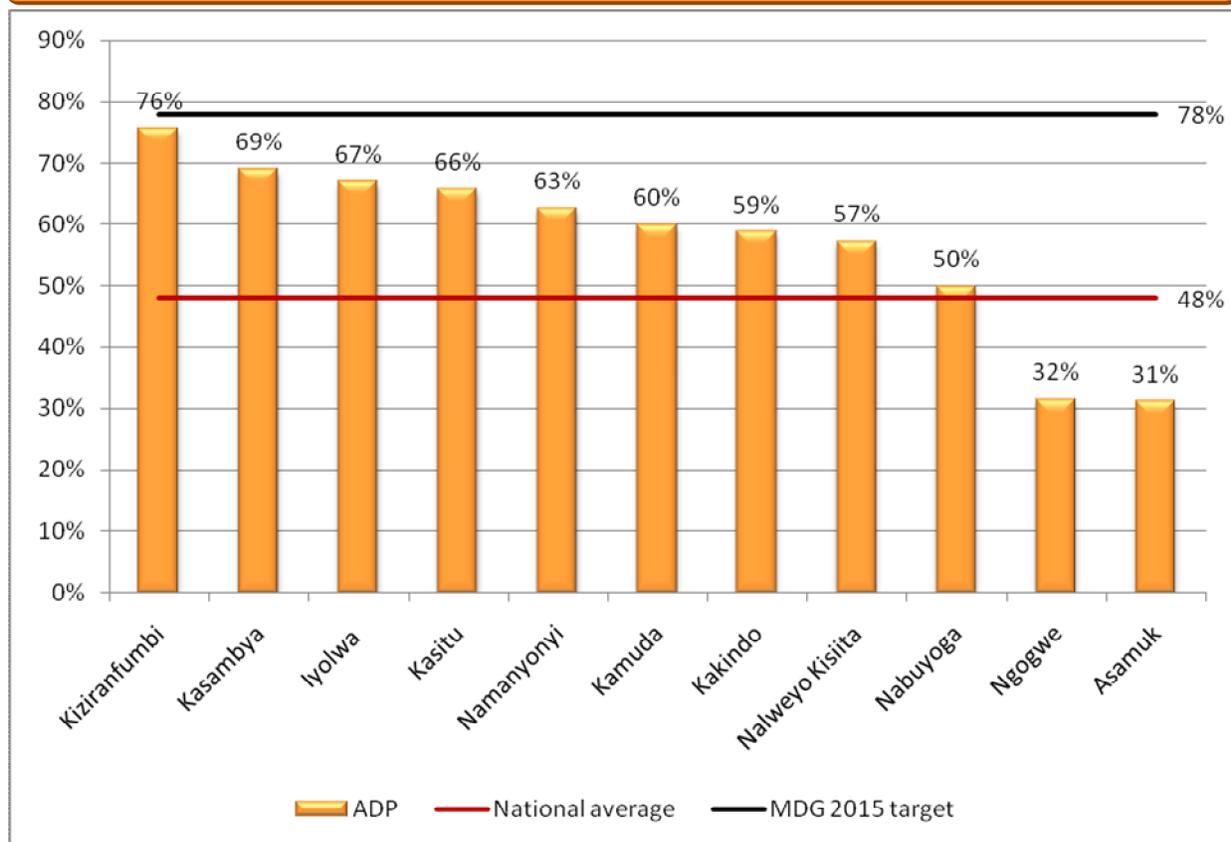
**Key learning**

- Poor net use culture is the biggest challenge to LLIN utilization.

**Recommendations**

- ✓ Map out high risk households in the communities for net distribution with integrated learning sessions on sustained net use.
- ✓ Conduct an operational research for social determinants of net use to inform behavioral change communication strategy for malaria prevention

**Proportion of children less than 5 years with diarrhea who received appropriate treatment (ORT, Zinc)**



**Source:** 2012 Baseline reports for Kiziranfumbi, Kasambya, Iyolwa, Kasitu, Namanyonyi, Kamuda, Kakindo, Nalweyo Kisiita, Nabuyoga, Ngogwe, and Asamuk ADPs.

**Analysis**

Among 11 ADPs that commenced new 5 year health interventions in FY12, treatment of diarrhea in children under 5 is above the national average of 48% (2011 UDHS); ranging from 31% to 76%. WV Uganda is implementing the Ministry of Health Integrated Community Case Management (ICCM) that recommends treatment of diarrhea with both ORS and Zinc. All the ADPs except Asamuk and Ngogwe (new ADPs) have been implementing this model. It is noted that also the MoH recommends ORT and Zinc, the 48% includes only children who received any ORT. The national coverage is still below the MGD target of 78% (ORT and Zinc).

WV Uganda continues to invest in sustainable access to water, sanitation and hygiene interventions in 10 ADPs covering Northern, Western and Central Uganda. For example under the U-WASH project, 265 water sources were established in partnership with the communities (28 shallow drilled wells, 16 hand dug wells and 171 boreholes) directly benefiting 62,445 people in various regions of the country in FY12. U-WASH focuses on access to safe water and complements this with community-based hygiene and sanitation software interventions; a reason why Kiziranfumbi ADP has better coverage on diarrhea management compared to the rest.

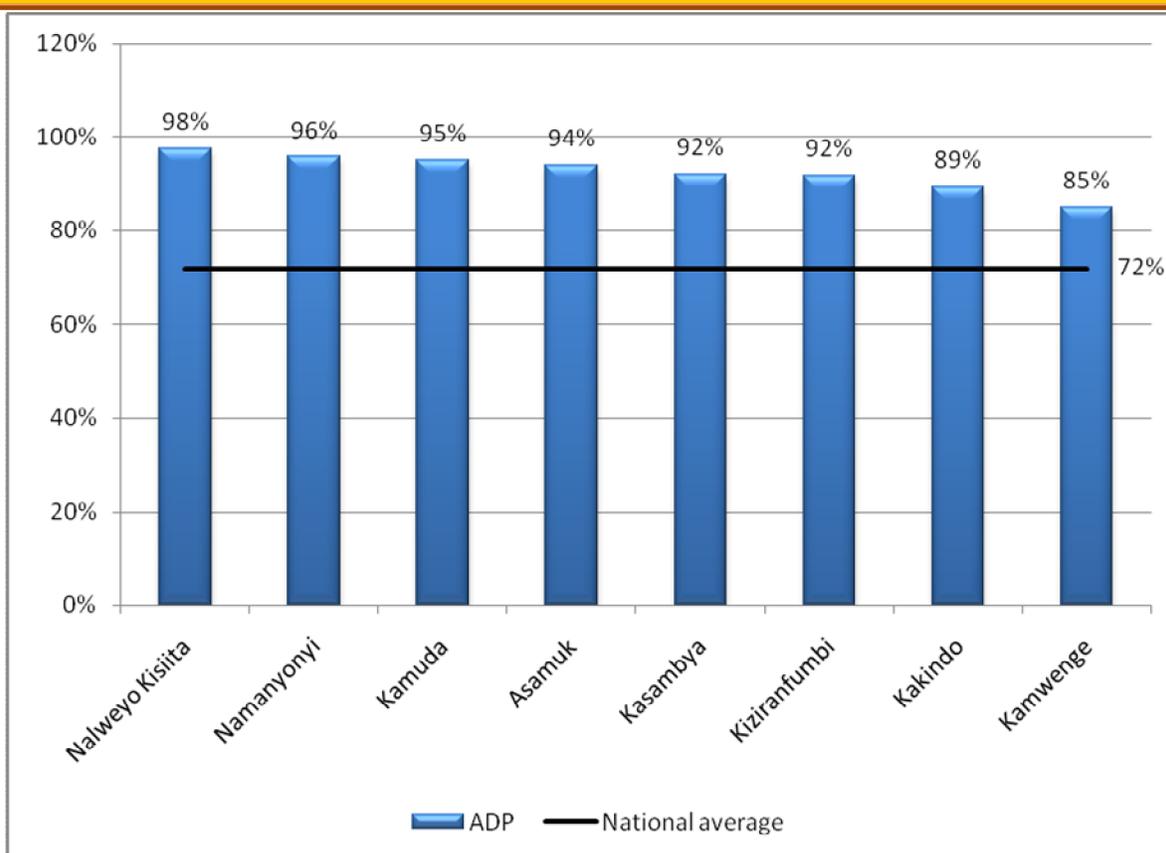
**Learning**

- ✓ ADPs integrating behavior change in their WASH interventions e.g., Community Led Total Sanitation (CLTS) have better outcomes on diarrhea management.

### Recommendation

- ✓ Integrate ICCM in WASH programs such that children who eventually suffer from diarrhea are able to be treated at household level.
- ✓ Scale up community led sanitation in ADPs to strengthen behavioral change and appropriate risk reduction practices like open defecation.

#### Proportion of women who were offered and accepted counseling and testing for HIV during most recent pregnancy, and received their test result



**Source:** 2012 Baseline reports, Nalweyo, Namanyonyi, Kamuda, Asamuk, Kasambya, Kiziranfumbi, Kakindo, & Kamwenge ADPs.

All women should be counseled about HIV during antenatal care (ANC) and offered a test. Treatment exists that can significantly reduce the chance of an infant becoming infected with HIV from an infected mother. WV Uganda implements three large projects with a major focus on HIV/AIDS, namely SPEAR, Care Treatment and Support, and Church Partnership project, all implemented through ADPs. For example, the SPEAR project covers 66% (35 ADPs) of all ADPs. The key components are; sexual and behavioral prevention, access to HCT and ART, PMTCT, and VMMC, and the activities have targeted the districts covering the following ADPs over the last 5 years; Nalweyo Kisiita, Namanyonyi, Kamuda, Kasambya, Kiziranfumbi, and Kakindo.

For the ADPs' beginning new 5 year interventions FY12, the targeted communities' coverage for women counseled, tested and received HIV results is higher than the national average of 72%. Communities targeted by 6 ADPs are close to the new national elimination strategy target of 100% (*for all pregnant women offered counseling, HIV test and received results*), including Asamuk which is a new ADP. The good performance by ADPs is attributed to working with health units and HIV/AIDS service delivery organizations; government's policy on compulsory and routine test for pregnant mothers; and community mobilization through the CHN campaign.

### Key learning

- ✓ The Uganda government policy on compulsory and routine testing for pregnant mothers both at facility and community is a key factor in increasing uptake for HIV testing.

- ✓ Working through partners, e.g., local governments and HIV/AIDS service delivery organizations broadens the service delivery package resulting into increased uptake of HIV testing among the pregnant women.

### Recommendations

- ✓ ADPs need to Identify Clinical AIDS service organization and work with at community level to scale up access to essential HIV services.
- ✓ Integrate Advocacy for to essential supplies especially Test kits and Human resource in the CHN to ensure there are no stock outs.

### Innovation and learning

The following are better practices approaches used in FY2012

- ✓ The Interactive Radio Distance Learning with a Mobile SMS implemented under the Innovation project in Kiboga District is contributing to reduction in malaria morbidity & mortality by providing case management for malaria through regular Radio Distance Learning training of VHTs.
- ✓ The SPEAR project working with partners piloted implementation of the Voluntary Medical Male Circumcision (VMMC). 15 VMMC camps in 13 districts across the five regional hubs of operation resulted into 5510 clients from the armed forces (Police, Prisons and their families) and communities.

The following practices can be replicated in other similar projects:

- ✓ Collection of data by village health teams using mobile phones
- ✓ Voluntary Male Medical Circumcision
- ✓ Using Village Saving and Loan Associations model as motivation strategy for Village Health Teams

### Strategic Objective on Education



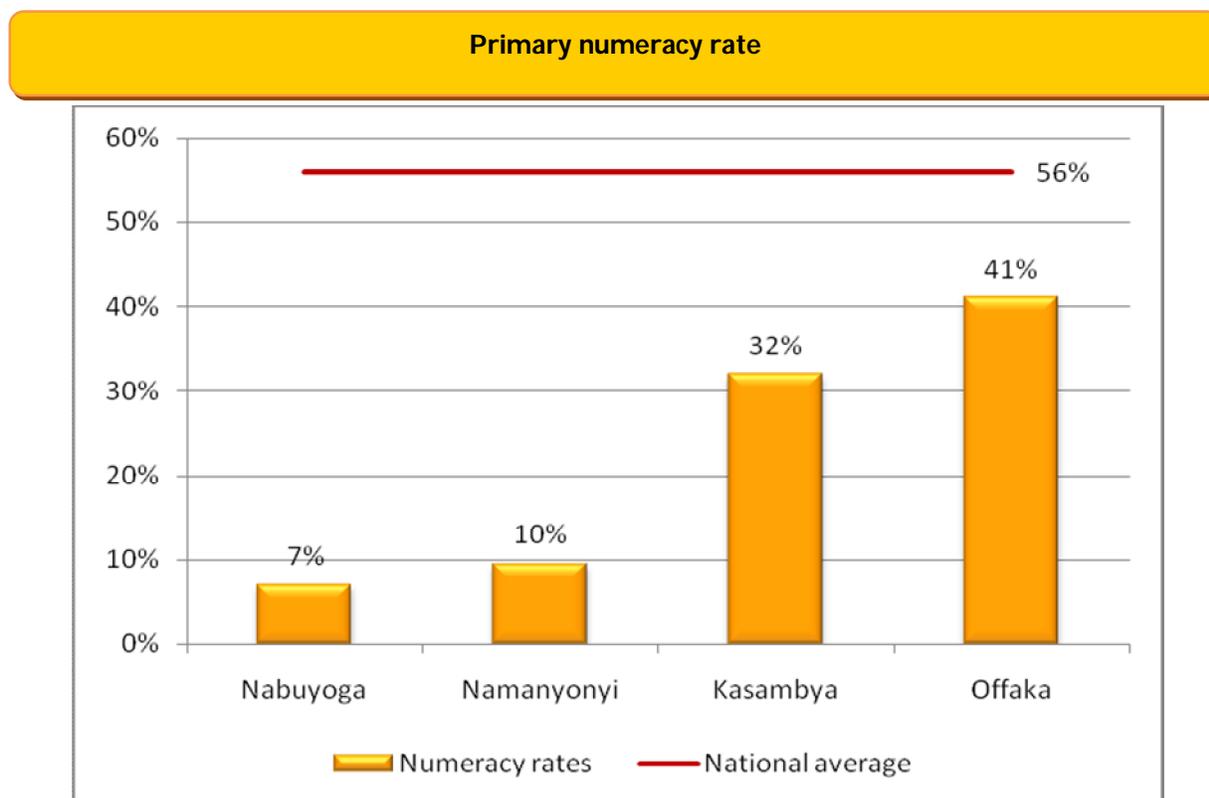
### Summary of logic chain

Uganda has made considerable progress towards access to primary education due to the implementation of universal primary education (UPE) with a total enrolment of 8.4 Million children, gross enrolment ratio of 121% and net enrolment ratio of 83%. Despite this improvement in access, the net intake ratio is 40%. More than 50% of children enroll for primary education at the age of 8 and 5% enroll to primary school below the age of 6 years. The dropout rate is between 6-12% per year and completion is only 34%. The quality of education is very low with literacy at 52% and numeracy at 56%. The problem is both poor quality and high dropout rates for children.

The main causes of this are inadequate parental support to education needs of children due to large scale poverty and illiteracy, very poor facilities that make schools unattractive, poor especially structures that accommodate girls e.g., latrines/ unfriendly teaching and learning methodologies, lack of relevant learning resources at school and in classrooms and weak community and school structures, systems and policies to protect and promote education.

To address the above causes, programs invest in improving the quality of school infrastructure like classrooms, teacher's houses and latrines to remove physical barriers to access; school governance, community engagement through CVA; Teacher Development and Management System (TDMS) (8 ADPs); instructional materials to schools to enable children access reading materials; Newspapers in Education to improve children's reading (33 ADPs).

As part of the education strategic results logic, several outcome indicators were prioritized but standardizing to improve measurement and reporting on progress across education programs was done in FY2011. It was only possible to have new or redesigning programs in FY11 to adopt them. For this reason data on some of these standard indicators has been presented in the following sections.



Source: Kasambya, Nabuyoga, Namanyonyi ADP Baseline reports 2012

### Analysis

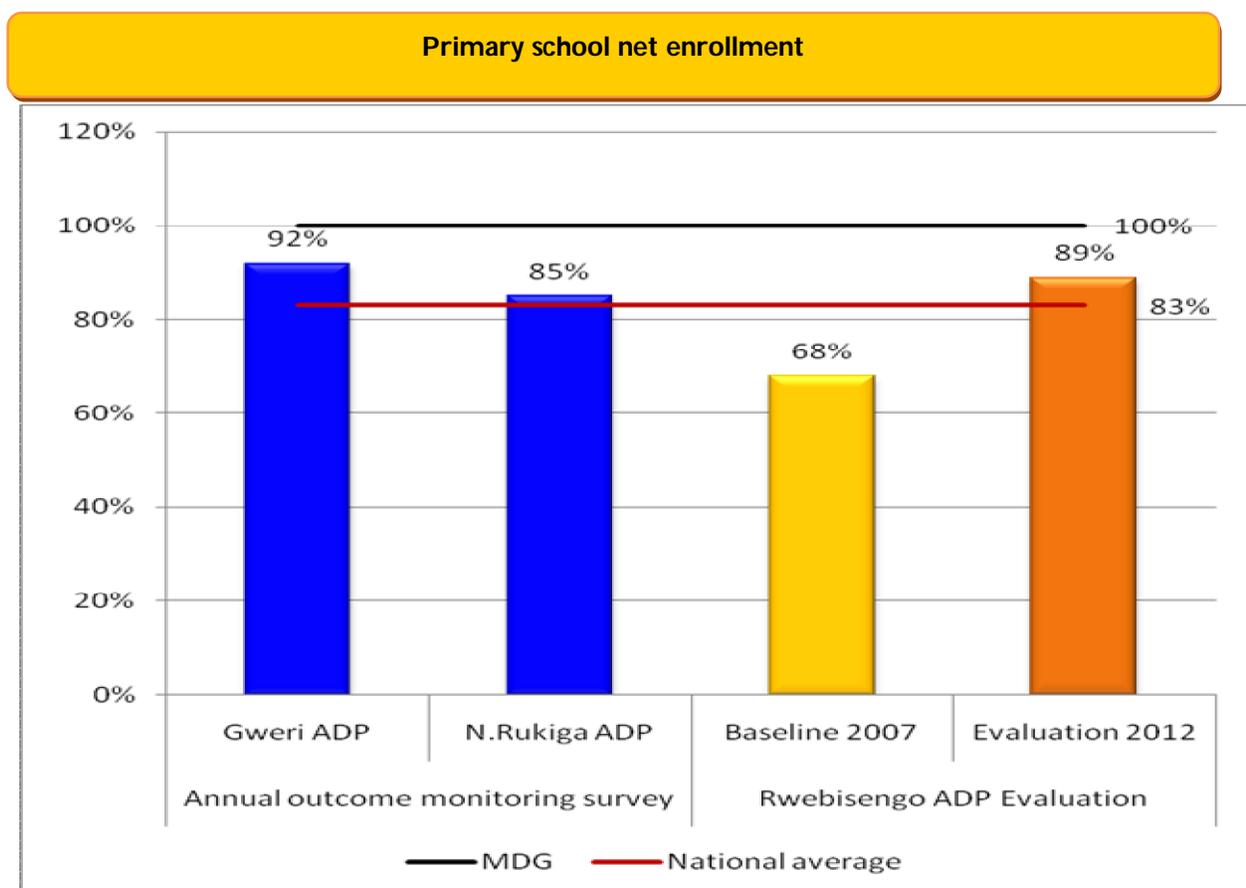
In the figure above the numeracy rates for all the ADPs fall below the national average of 56%. Although the ADPs are in their 2<sup>nd</sup> phase, it is clear that program interventions have not focused on literacy and numeracy. Numeracy of children is undermined by overcrowding in classes, a high pupil teacher ratio, limited teacher pupil contact, accelerated by inadequate instruction material and inadequate capacity of teachers to manage the large classes. A review of expenditure on education for the period 2008-2012 indicates that in all ADPs only 0.5% was spent on interventions that support teachers to teach numeracy and literacy as compared to 45% used for construction of classrooms, staff houses, latrines and provision of furniture. This major concern has led to a strategic shift in which expenditure on education will purpose to strengthen teacher's capacity to teach numeracy

### Learning

- ✓ Investment in infrastructure does not necessarily translate into improved numeracy rate for children.

### Recommendation

- ✓ Support continuous professional developments for teachers to enable them adopt child friendly pedagogical methodologies and relevant instructional materials.



**Source:** 2012 Program Management Reports for Gweri and North Rukiga ADPs; 2012 Program Evaluation report for Rwebisengo ADP

### Analysis

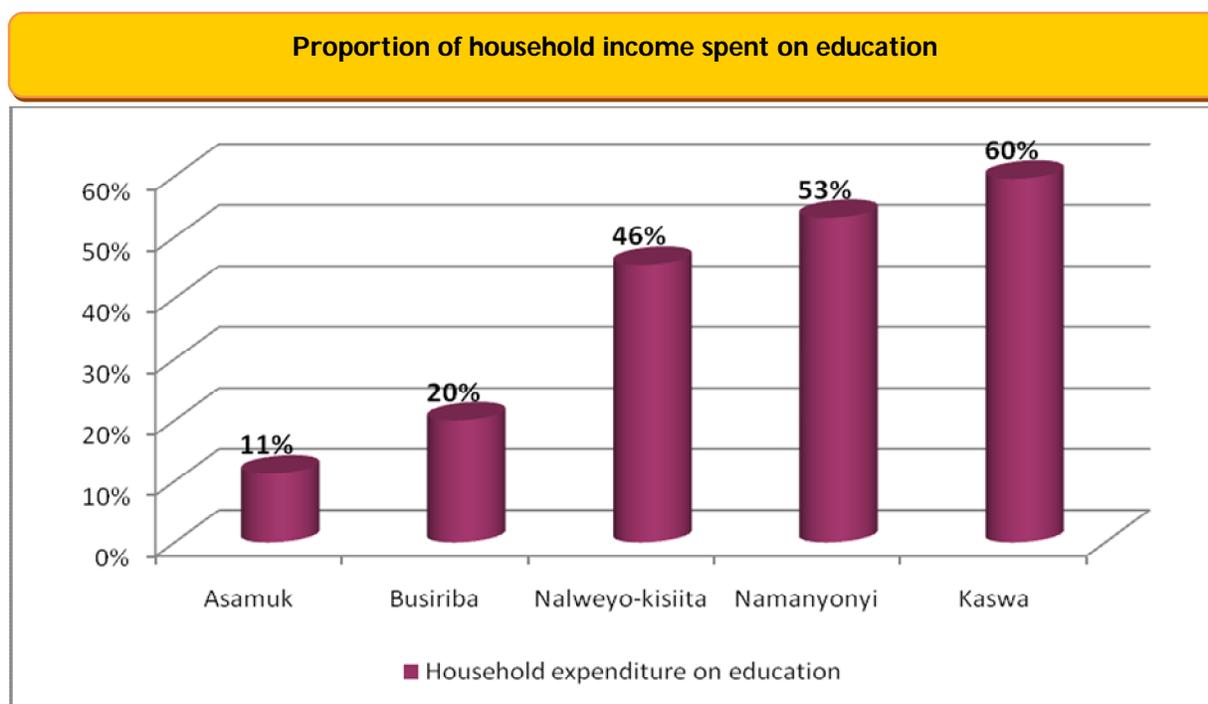
In three ADPs, North Rukiga, Gweri and Rwebisengo the more children of school going age are enrolling in primary school, quite higher than the national average of 83%, although still below the MGD target of 100%. In North Rukiga the improvement in pupils enrolment and performance is as a result of the strengthened PTAs and SMCs which are involved in the monitoring of pupils school attendance, enrolment and performance of children in school. For Rwebisengo ADP that completed an end of program evaluation, the results show a 21 percentage point difference over 5 years, from 2007 – 2012. In all these ADPs communities have been mobilized to take children to school. Improvements in classroom infrastructure, sitting desks and other scholastic material support, training of school management committees and community mobilization were the explanatory factors for this variability.

### Learning

- ✓ The use of advocacy through CVA significantly change community attitudes to education and leads to increased enrolment

### Recommendations

- ✓ Support District and Sub-County Local Government Education Advocacy campaigns to engage the parents on the importance of timely enrolment of girls and boys in school



Source: Baseline reports for Asamuk, Busiriba, Nalweyo-Kisiita, Namanyonyi, and Kaswa ADPs, 2012

### Analysis

Five ADPs reported household expenditure on education above national average of 9% (UNHS 2009/10). Namanyonyi and Kaswa ADPs reported household expenditure to be more than 50%. The percentage expenditure on education is high due to increased awareness of parents about the importance of education. Asamuk and Busiriba are in phase one and only started implementing during this financial year. In all these ADPs, there is a relatively good proportion of parents and guardians who believe that education will improve the lives of their children. This is a good starting step for the education intervention in the programs, as already households are likely to spend more on education if they believe that education will improve the quality of life of their children.

### Learning

- ✓ Engagement of key stakeholders and partners helps parents and communities to appreciate their roles in providing and supporting education

### Key Quote

“We have gone a long way because of World Vision support to education in Gulu. The improved Primary Leaving Examinations (PLE) grades in 2012 were due to the support provided by World Vision. Out of the 12 sub counties in the District, the 5 sub counties supported by World Vision contributed 72% of candidates who passed in division 1 and they have 50% of the total district enrolment.” (said the District Education Officer, Gulu District during a stakeholders meeting February 2013).

### Recommendation

- ✓ Strengthen community systems and structures that promote enrolment, retention and completion of primary education

## Strategic Objective on Advocacy



### Summary of logic chain for child protection outcome

According to the Uganda Police Crime report, 2011, more than 96% of children in Uganda are vulnerable to abuse and 50% involve children aged between 0-10 years. Since 2009 child trafficking had increased by 33%, early child marriages is at 46%. Defilement had increased by 1.7% from 7,564 cases in 2010. Desertion of children had increased by 14% up from 1,732 cases in 2010; child abuse and torture had increased by 35% from 1,315.

Child protection issues; stem from abdication of parental roles with breakdown of traditional support systems and poor enforcement of laws; are deep rooted in negative societal practices and behaviors such as early marriages for bride price and neglect; negative peer influences/peer pressure with limited parental guidance

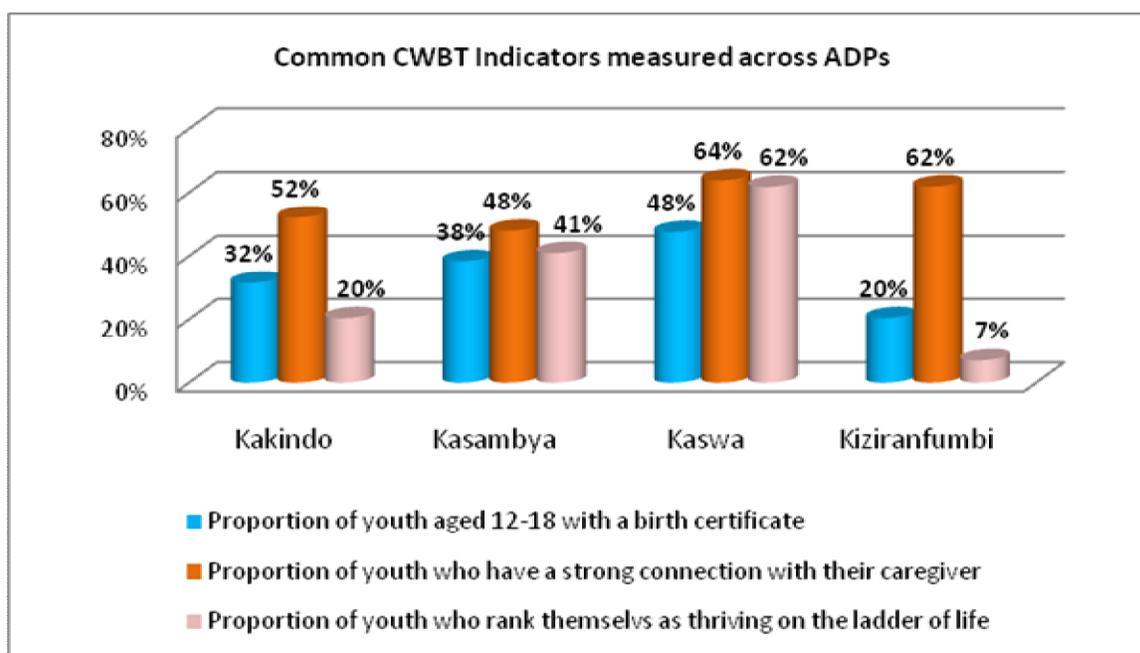
Approaches adopted by the programs include; Empowering Children as Peace builders (ECaP) (4 ADPs); Citizen Voice and Action is a local level advocacy methodology that transforms dialogue between communities and government child protection, health and education (5 ADPs); Child Protection and Advocacy (CPA) in partnership with EARO Advocacy Learning Centre (7 ADPs).

As mentioned in the introduction, WVU carried out a review of its NO strategy 2010-12 results framework with purpose to refine its outcome measures and selection of which CWBT the NO was contributing to. According to this review, the NO was contributing to CWBT #2, #3, and #4; based on the strategy outcomes. However, the resultant mapping of programs to identify which were contributing to the strategy and also the targets revealed evidence of interventions across programs, contributing to CWBT #1. These included interventions in child protection, spiritual nurture, child rights and participation, vocational training, life skills among others.

### Evidence of progress

#### Children report an increased level of well-being

To pilot measurement and reporting on CWBT #1, WVU included the Youth Healthy Behavioral Survey among the NO standard guide for baseline surveys and used it to train staff and consultants who completed baseline surveys for programs that redesigned in FY11. The results are shown in the graph below.



## Analysis

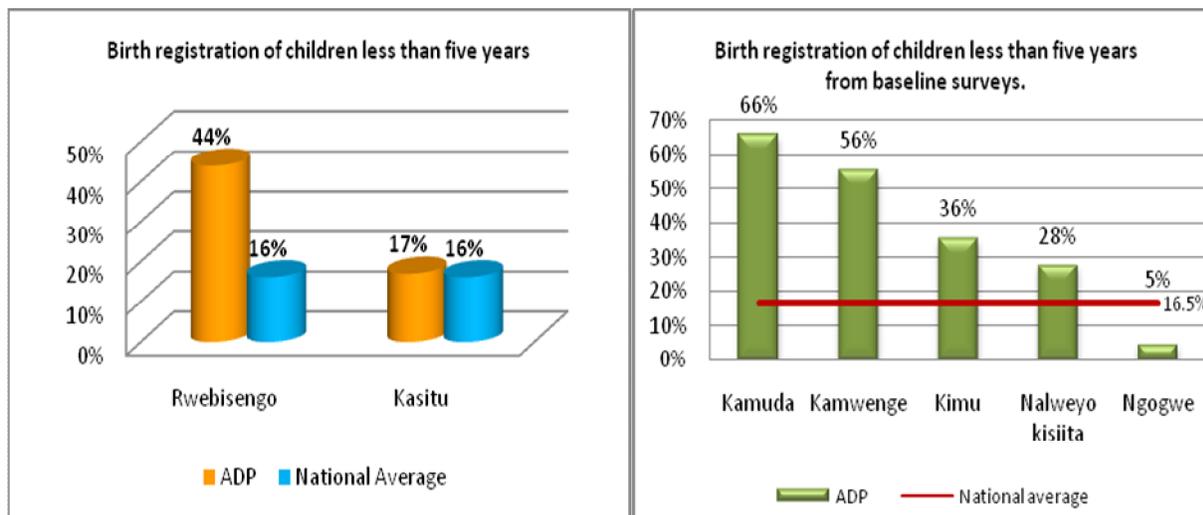
Among the key measures for children’s well-being, the proportion of children aged 12 – 17 years with a strong connection with their caregivers is comparative higher than other CWBT #1 measures in the four ADPs; Kakindo, Kasambya, Kaswa and Kiziranfumbi. The proportion of children whose overall self-assessment of well-being is high, was 3-times high in Kaswa ADP compared to Kakindo ADP. Kaswa ADP scored highly on all the 3 key measures for CWBT #1 compared to other ADPs. Kaswa has a dozen years of program implementation compared to the trio-Kakindo, Kasambya and Kiziramfumbi who are began their 2<sup>nd</sup> 5-year phase.

Noteworthy, less than half of the children 12-17 years in communities served by the four ADPs indicated they had a birth registration certificate. Although a birth certificate is every child’s right, birth registration is poor in the country. Kaswa’s progress on birth registration is commendable. At the launch of the National Birth Registration campaign in 2002, Kaswa was in its 1<sup>st</sup> phase and according to the 2001 UDHS, national coverage of birth registration for children under 5 years was 4%. Over the years, Kaswa has contributed towards increasing coverage from 4% to 48% which is above the UDHS 2011 national average for rural areas of 16.5%. Over the last phase phase, the ADP, supported the local government birth registration efforts by facilitating supply of birth registration cards, increased access of information on birth registration services, and awareness/mobilization campaigns which supplemented the national campaign; a learning that can be replicated by other ADPs.

Further, as the on-going national campaign on birth registration targets children under 5 years of age, a specific indicator to track progress among the under 5s is measured across programs.

### Birth registration among children less than 5 years of age

The government of Uganda birth registration system in Uganda aims to ensure that all children are registered. A collaborative effort led by UNICEF, the Ministry of Justice and Constitutional Affairs and other partners including WVU is supporting birth registration in the country.



Source: Rwebisengo and Kasitu ADP Evaluation Reports 2012

Source: Kamuda, Kamwenge, Kimu, Nalweyo-Kisiita, and Ngogwe ADP Baseline Reports 2012

Evaluation findings on birth registration in Rwebisengo and Kasitu in Western Uganda indicate the two ADPs are above the UDHS 2011 national regional coverage for Western Uganda at 16.1%. Kamuda, KIMU and Nalweyo ADPs attribute the observed coverage in birth registration to their last program phase efforts that involved funding birth registration processes and engaging the government and district officials to support the processes and structures. Ngogwe, as a new ADP, realized this apparent low coverage in birth registration and has planned for similar interventions.

Besides birth registration, WVU has implemented several other interventions to protect rights of children as well as increase their participation in development programs. The following progress is recorded in FY12 ADP management reports:

- ✓ *Cases of child abuse effectively managed:* a total of 54 child abuse cases were effectively managed across five ADPs: Iyolwa, Ngogwe, Tubur, Rwebisengo and Budumba. Despite this, there still inadequate knowledge and skills of community members and structures such as child protection committees to report and handle cases. In other ADPs, e.g., Buliisa, Gweri, Kimu, Nabiswera, Buwunga and Budumba; a total of 6,246 individuals were sensitized & equipped with skills on child protection, child rights & policies.
- ✓ *Children participating in children's clubs;* Four ADPs supported over 4,000 children to participate in children's clubs. This achievement is a result of WVU training community resource members and reviving the existing community child protection structures. WVU will continue to focus her effort on increasing opportunities for children & youth to participate and contribute to the development of their communities.
- ✓ *Collaboration with CBOs on child protection:* To strengthen and expand its networks and influence on child protection, WVU collaborated with 136 community based organizations, consolidated in 11 ADPs- Busiriba, Buliisa, Buyamba, Gweri, Kimu, Nabiswera, Buwunga, Tubur, Rwebisengo, Budumba and Kachonga. The collaborations provided opportunities for capacity building and opened up opportunities for communities and stakeholders to uphold WV values and participate in child protection interventions.
- ✓ *Spiritual nurture of children:* Under the Church Partnerships project, WVU collaborated with churches and faith based organizations across 25 ADPs in 10 districts to enhance spiritual nurture among children through school clubs and Sunday church schools. Through work with Scripture Union Uganda, children's clubs were established in 40 primary schools, benefiting 7,022 children (2,711 boys and 4,311 girls). Further, through building capacity of churches to promote child protection and development, a total of 15,000 children benefited from spiritual enrichment activities implemented through Sunday schools.

### Learning

- ✓ Children are the best agents of their own protection; therefore no amount of intense training of adults can yield good results without children intensively being involved in their own protection.
- ✓ Working with the religious leaders is a reliable strategy to mobilize community folks into development work. Communities are more receptive to programs rolled out through faith-based institutions in comparison to secular ones e.g. it is easy raise awareness on HIV/AIDS, credit, savings, etc through different congregations

### Recommendations

- ✓ Strengthen existing birth registration systems in the districts of operation. Birth registration interventions should be broadened beyond child rights and protection to other sectors particularly MNCH programs.
- ✓ Expand opportunities for faith institutions to contribute to other aspects of CWB. Currently, most ADPs partner with churches for mainly spiritual nurture; however these FBOs are key channels for development activities e.g. HIV, food security, child protection and health. Start by involving Apex leaders as stakeholders in planning processes.
- ✓ Mainstream in all ADPs Use of models such as CVA to engage children in decision making taking into consideration age, gender and levels of education and other context specific aspects

## HUMANITARIAN EMERGENCY RESPONSE

In 2012, WVU responded to several emergencies in different geographical locations of the country. The emergencies were as a result of both natural and manmade hazards which included disease outbreaks, floods, landslides and refugee influx due to conflict. In these areas where the disasters occurred, the risk was higher for the children, especially for the rapid onset disasters like the mudslides.

Acting to make a difference, WVU tailored its responses to specifically decrease vulnerability for children if not directly then to their families and communities. The responses implemented fell under; Child Protection, Health, Hygiene and Sanitation, Environmental Management and Provision of Non Food Items (NFIs).

**Table 2:** Summary of Responses in WVU in 2012

Emergency	Location/ District	Magnitude	No of persons affected	Number of ADPs affected	Response
<b>Ebola Outbreak</b>	Kibaale	CAT I	<ul style="list-style-type: none"> <li>17 people killed with a high potential of rapid spread and increased mortality rates (15 adults, 2 children (1 boy &amp; 1 girly)).</li> </ul>	4	<ul style="list-style-type: none"> <li>Social Mobilization for general masses</li> <li>Capacity Building of Village Health Teams</li> <li>Protective Gear for Medical Workers and Care givers</li> <li>Water Purification Tablets</li> </ul>
<b>Nodding Syndrome</b>	Kitgum	CAT I	<ul style="list-style-type: none"> <li>794 children aged 0-17 years. of these, 103 were Registered Children (46 boys, 57 girls)</li> <li>71 Adults aged 18 and above</li> </ul>	1	<ul style="list-style-type: none"> <li>Assorted Medicines as recommended by Ministry of Health</li> <li>Food for affected households</li> </ul>
<b>Landslides</b>	Bududa	CAT I	<ul style="list-style-type: none"> <li>130 in 21 households, 8 people buried in the Landslides</li> </ul>	No ADPs in this Area	<ul style="list-style-type: none"> <li>Relief items – Blankets, Mosquito Nets, Assorted clothing for children, Sanitary Pads and Kitchen ware</li> </ul>
<b>Floods</b>	Bundibugyo	CAT I	<ul style="list-style-type: none"> <li>2,496 people</li> <li>1,664 children</li> </ul>	1	<ul style="list-style-type: none"> <li>Relief items – tarpaulins, mosquito nets</li> </ul>
<b>DRC Refuge Influx</b>	Kamwenge and Kisoro	CAT III	<ul style="list-style-type: none"> <li>32,545 people. Of these, 18,424 Children (9,294 boys, 9,130 girls)</li> </ul>	No ADPs in this Area	<ul style="list-style-type: none"> <li>Provision of NFIs</li> <li>Establishment of Child Friendly Spaces</li> <li>Construction of staff accommodation for Health Workers</li> <li>Construction of Energy Saving Stoves in Transit Camp</li> </ul>

### Analysis

It is increasingly certain that the diversity and frequency of disasters is increasing in our areas of operation; for instance, Uganda experienced two outbreaks of Ebola in 2012, the first one in July and the second in November. All the emergencies except the DRC refuge influx remained at CAT 1, attracting ADP led response with NO support. Many of these emergencies affected mostly children directly e.g., death, morbidity, or indirectly i.e., limited or no access to social services including schools since many public social institutions are closed during the emergency period. It is not usually possible to garner complete data.

Despite the above, the nature and extent of our response to these emergencies in FY12 showed growing awareness among and DRR integration within programs, enabling programs to use part of their annual budgets for emergency responses as per standard. In addition, WVU has also grown in area of partnership for DRR as promoted by government. More successful responses were recorded were we partnered with government or agencies. i.e., Office of the Prime Minister, Ministry of Health, United Nations High Commission for Refugees, UNICEF, Oxfam, Save the Children and the Africa Humanitarian Alliance.

### Learning and Recommendation

- ✓ Working closely with organizations mandated to lead specific responses minimizes duplication of efforts, leading to better results. Higher results were noticeable where participation of children was ensured.
- ✓ Involve Children in actions to reduce disaster and climate change risk; if they are well informed and supported, they can be effective channels of information, role models and agents of change.



Child friendly spaces established in Rwamwanja refugee settlement (the settlement houses DRC refugees)

## MOST VULNERABLE CHILDREN

A key learning from the FY11 CWB report pilot for WV Uganda was that programs understood and targeted different kinds of Most Vulnerable Children (MVC); and further differed on the appropriateness of their interventions. To help achieve consistency in identification, profiling vulnerability and framing appropriate interventions for MVC consistent with the NO Strategy, deliberate attention was paid to the FY12 (re)design processes for 13 ADPs. All the ADPs adopted the WV Development Programming Approach (DPA), using the recommended tool for assessing vulnerability i.e., *"Identifying and listening to the MVC"* tool during Critical Path (CP) step 4.

### MVC targeted by FY12 (Re) designs

A review of 13 ADP PDDs provides a description of the MVC and the interventions to target them over the next 5 years see Table 3.

There are 14 different categories of MVC present in communities targeted by 13 ADPs that (re)designed in FY12. Over 77 percent of these programs report at least 6 different MVC types. Among the new ADPs; Buwunga ADP in Eastern Uganda had the most (8) known types of MVC. While in old ADPs (redesigns); Aber, Kyambigambire and Lunyo ADPs, there are up to 9 different MVC types.

The top 5 MVC categories across all the 13 ADPs are: Children with disabilities; Children living with HIV/AIDS; Orphans; Child labor; Neglected children; Children living with old parents/caregivers; and child headed households. Noteworthy, these MVC types are common in most of the communities targeted by WV interventions across the country, as documented in FY2011 WV Uganda CWB report.

Two emerging MVC categories however include; Child labor and Neglected children. Fifty percent (50%) of the 8 ADPs that identified Child labor are from eastern Uganda and this could be attributed to being near the border with Kenya where children get involved in smuggling goods across the two countries.

**Table 3:** Community categorization of MVC across ADPs that (re)designed in FY12

MVC Type	New ADPs					Redesign ADPs							Total	
	Asamuk	Budde-Kalamba	Buwunga	Morungatuny	Nabukalu	Aber	Aboke	Busitema	Kasitu	Kyabigambire	Lunyo	Lwamagwa		Ntwetwe
Children with disabilities	√	√	√		√	√			√	√	√	√	√	10
Children living with HIV	√	√	√		√		√	√	√	√		√		9
Orphaned children	√	√	√	√		√	√	√		√	√			9
Child labor		√	√	√	√		√	√			√	√		8
Neglected children	√	√		√				√		√		√	√	7
Children living with very old			√		√			√		√	√	√	√	7
Child headed HH			√	√				√	√	√	√	√		7
Children living with parents having HIV				√		√	√		√		√		√	6
Child mothers/early marriages	√			√	√	√				√				5
Domestic violence			√							√	√	√	√	5
Children living with very poor parents						√			√	√	√			4
Defiled children	√	√				√								3
Children living with step parents			√								√	√		3
Children out of school					√	√								2
Children whose parents are drunkards						√	√							2
Children not fully immunized						√								1
<b>Total number of MVC Categories</b>	<b>6</b>	<b>6</b>	<b>8</b>	<b>6</b>	<b>6</b>	<b>9</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>9</b>	<b>9</b>	<b>8</b>	<b>5</b>	

**Source:** Aber, Asamuk, Budde Kalamba, Aboke, Busitema, Buwunga, Kasitu, Kyabigambire, Lunyo, Lwamagwa, Morungatuny, Nabukalu and Ntwetwe Program Design Documents, 2012

The presence of the vulnerability categories across 13 ADPs is also in line with findings included in the Government of Uganda National OVC Strategic Plan 2011-2016 that showed children's vulnerability is widespread in all regions of Uganda but, the magnitude tends to be associated with wealth distribution. It also shows that approximately 51 percent of the children are either critically or moderately vulnerable, and at least one in every four households has an orphan.

Priority areas in the FY12 (re)designs are for both central and local governments as well as non-state actors. They include: economic strengthening, promotion of food and nutrition security, provision of health, education, psychosocial support and basic care as well as legal and child protection services.

### Key learning

- ✓ Challenges facing MVC households are integral and therefore for interventions to be effective, should also target care providers in the household
- ✓ Partnering with local structures like FBO, CBOs can be effective to address the needs of the MVC. However, developing these relationships is a process that will take some time and requires patience.

### Recommendations

- ✓ Create and provide age appropriate recreational programs, facilities, equipment and therapeutic activities for children with disabilities, formerly abducted children and those chronically ill
- ✓ Continual funding in the area of capacity building in order that CBO members could be multi equipped in order to provide holistic assistance and care to OVC and families.
- ✓ Provide home based care skills to enable parents look after their children with challenging disabilities; this could include expert counseling services for MVC, their caregivers and communities.

## CONCLUSION

### Key learning points from process of producing the report

- ✓ The quality and nature of program and project reports will inform the quality and type of report developed at national office for CWB. Insufficient evidence based data in the program reports undermines the quality of and magnitude of discussions that inform the final CWB report.
- ✓ Involving technical/subject matter experts in the child well-being report preparation process is good especially in providing insights explaining the observed measures in their area of expertise; as well as ownership and use of the report.
- ✓ For effective in contribution to CWB a realistic theory of change should be developed and adhered to by all programs and projects and a culture of result based measurement should be instituted.
- ✓ Training program staff on adoption/use of CWBT tools to support appropriate measures in their program evaluations or baselines. Better results can be achieved if limits are put on the extent to which the tools can be adapted or adjusted; else comparability of the findings is lost.

### Recommendations for next year's report

- ✓ Preparation of the CWB report should be phased in such a way that initial summaries are prepared at the program level and consolidated at the national office. For example, the existing LEAP program report tools include a section on 'program contribution to CWB'; this should be revised to reflect an abridged format for the CWB report. In order to reduce duplication since the program measures and reports on CWBT indicators as part of their program logic, specific summaries of interpretation and analyses should be required for the CWBT indicators
- ✓ Revise the protocols guiding implementation of DME activities like baselines and evaluations by external consultants to include a session of measurement of CWBT as part of the inception meeting with the program teams.
- ✓ Require and train the all technical staff and CDFs in report writing as a key competence. This will increase the critical resource base for program documentation and report writing in the organization beyond DME teams.
- ✓ Pilot measurement of contribution to CWB through conducting annual program outcome monitoring surveys. As these surveys will be conducted at the same time across programs and on the same indicators, this provides good comparisons. The baseline, evaluation and output monitoring data can be used as addition supportive evidence.

## ANNEX

### Acknowledgements

The preparation of this 2<sup>nd</sup> CWB report has been made possible by efforts of so many staff both within and outside WV Uganda. Much appreciate goes to the National Director, Gilbert Kamaga; and the Directors, George Ebulu (Quality Assurance), and Tom Mugabi (Integrated Programs) for the overall leadership, guidance and championing this CWBT programming, measurement and Report. To all staff especially the community development facilitators and program manager; thank you for the wonderful work you are doing in the lives of children; it is this we have summarized in this report.

Special credit goes to the DME team particularly, Omoro M., Walyaula P., Onama V., Amanyana A., Ajambo A., and Wanyama V. who committed untold hours analyzing the program reports, drafting the initial sector fact sheets, and data quality assessment. The technical specialists have played a key role in this CWB report preparation process especially preparation of fact sheets and drafting sector summaries upon which this report is based. Thank you Kanwagi R. (Health & HIV/AIDS), Tereraho J.W. (Education), Nyakato R. (Child Protection), Ebanyat P. (Livelihoods), Kabasinguzi E. and Barihihi M. (DRR/ACCRA), and Okonye E. (WASH). You have been a good team to work with. In addition, all staff who participated in the Stakeholder meeting that helped us to refine the interpretation, discussion and recommendation. Special mention; Twinomugisha M., Kaahwa J., Otyek L., Kadobera M., Tukei S., Eswap F., Tumusiime P., Namatovu J., Mwebe S., Muyomba J., among others.

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Godfrey Senkaba

Associate Director, Portfolio Quality and Performance Management

### Acronyms

ADP	Area Development Program
ANC	Ante Natal Care
CHN	Child Health Now
CLTS	Community Led Total Sanitation
CVA	Citizens Voice and Action
CWBO	Child Well-being Outcomes
CWBT	Child Well-being Targets
DME	Design, Monitoring and Evaluation
DQA	Data Quality Assessment
ICCM	Integrated Community Case Management
LLIN	Long Lasting Insecticide Treated Net
MNCH	Maternal New Child Health
MoH	Ministry of Health
MVC	Most Vulnerable Children
NO	National Office
PMTCT	Prevention of Mother to Child Transmission
SPEAR	Supporting Public Sector Workplaces to Expand Action and Responses against HIV/AIDS
UPE	Universal Primary Education
VHT	Village Health Team
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
WVU	World Vision Uganda

### List of Program Reports reviewed by Type

Programme name	Type of survey	Sample HHs	Date
Asamuk	Baseline	247	September 2012
Busiriba	Baseline	798	May 2012
Iyolwa	Baseline	407	June 2012
Kakindo	Baseline	454	August 2012
Kamuda	Baseline	541	June 2012
Kamwenge	Baseline	798	February 2012
Kasambya	Baseline	400	July 2012
Masaka Kaswa	Baseline	788	September 2012
Kimu	Baseline	400	May 2012
Kiziranfumbi	Baseline	402	June 2012
Nabuyoga	Baseline	445	August 2012
Nalweyo Kisiita	Baseline	416	June 2012
Namanyonyi	Baseline	400	July 2012
Ngogwe	Baseline	473	August 2012
Offaka	Baseline	414	September 2012
Rwebisengo	Evaluation	712HH	June 2012
Kasitu	Evaluation	576HH	June 2012
Kyalulangira	Evaluation	681 HH	June 2012
Lunyo	Evaluation	360 HH	March 2012
Kyabigambire	Evaluation	583 HH	November 2011
Aber	Evaluation	563 HH	March 2012
Lwamaggwa	Evaluation	719 HH	May 2012
Ntwetwe	Evaluation	909 HH	March 2012
# of ADP Annual reports 2012 reviewed – 53			
# of Grants/Project annual reports 2012 reviewed - 12			
<i>13 ADP provisional design documents 2012, were reviewed to complete MVC analysis; Aber, Asamuk, Budde Kalamba, Aboke, Busitema, Buwunga, Kasitu, Kyabigambire, Lunyo, Lwamaggwa, Morungatuny, Nabukalu and Ntwetwe Program Design Documents.</i>			

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